Joint Health Overview and Scrutiny Committee to review proposals for the provision of urological cancer surgery in Essex

15:00	**Tuesday, 06 September 2016**	**Committee Room 1, County Hall, Chelmsford, Essex**

PLEASE NOTE THERE WILL BE A PRIVATE PRE-MEETING FOR ALL MEMBERS COMMENCING AT 14:00 IN COMMITTEE ROOM 1

Quorum: 3 - with at least one member from each of the three participating authorities

Membership:

Braintree District Councillor Jo Beavis (Essex HOSC representative)
Essex County Councillor Ann Naylor (Essex HOSC representative)
Essex County Councillor Andy Wood (Essex HOSC representative)
Southend Councillor Helen Boyd (Southend HOSC Representative)
Southend Councillor Cheryl Nevin (Southend HOSC Representative)
Thurrock Councillor Tony French (Thurrock HOSC Representative)

For information about the meeting please ask for:
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www.essex.gov.uk/scrutiny

Essex County Council

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Part 1

(During consideration of these items the meeting is likely to be open to the press and public)

		Pages
1	**Membership, attendance and apologies for absence** To consider recent changes and note revised committee membership.	
2	**Declarations of Interest** To note any declarations of interest to be made by Members in accordance with the Members' Code of Conduct	
3	**Minutes of the meeting on 9 March 2016** To consider the draft minutes.	**5 - 10**
4(a)	**NHS England Project Update** To consider report UCJHOSC02/16 incorporating an appendix with activity plan.	**11 - 26**
4(b)	**Report of External Review Panel** To consider report UCJHOSC03/16.	**27 - 118**
5	**Date of Next Meeting** To be confirmed.	
6	**Urgent Business** To consider any matter which in the opinion of the Chairman should be considered in public by reason of special circumstances (to be specified) as a matter of urgency.	

Exempt Items

(During consideration of these items the meeting is not likely to be open to the press and public)

To consider whether the press and public should be excluded from the meeting during consideration of an agenda item on the grounds that it involves the likely disclosure of exempt information as specified in Part I of Schedule 12A of the Local Government Act 1972 or it being confidential for the purposes of Section 100A(2) of that Act.

In each case, Members are asked to decide whether, in all the circumstances, the public interest in maintaining the exemption (and discussing the matter in private) outweighs the public interest in disclosing the information.

7 **Urgent Exempt Business**

To consider in private any other matter which in the opinion of the Chairman should be considered by reason of special circumstances (to be specified) as a matter of urgency.

MINUTES OF A MEETING OF THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE TO REVIEW PROPOSALS FOR THE PROVISION OF UROLOGICAL CANCER SURGERY IN ESSEX HELD ON WEDNESDAY 9 MARCH 2016 AT 3.05PM AT COUNTY HALL, CHELMSFORD

Present:

Essex County Councillor A Naylor (Chairman)
Braintree District Council J Beavis
Southend Borough Councillor L Davies (for part of the meeting)
Thurrock Councillor L Gamester
Southend Borough Councillor C Nevin
Essex County Councillor A Wood

The following Officers were present in support throughout the meeting:

Fiona Abbott	- Lead Health Scrutiny Officer, Southend Borough Council
Graham Hughes	- Scrutiny Officer, Essex County Council
Jenny Shade	- Senior Democratic Services Officer, Thurrock Council

1. Committee Membership, apologies and substitutions

Southend Borough Council had given notice of a change to one of their nominees with Councillor Nevin replacing Councillor Betson. Councillor Nevin was welcomed to her first meeting.

As Councillor Betson had served as Vice Chairman of the Committee, the Chairman then proceeded to invite nominations for Vice-Chairman and the following nomination was received:

Councillor C Nevin (proposed by Councillor Wood and seconded by Councillor Gamester);

No other nominations were received. By general consent it was **agreed** that Councillor Nevin be appointed Vice-Chairman of the Committee.

2. Declarations of Interest

Councillor Nevin declared that she had had previous employment at both Basildon and Southend Hospitals. Councillor Gamester declared that he was employed in the Human Resources Department at …?

No other declarations were made.

3. Minutes

The draft minutes of the meeting held on 13 July 2015 were approved as a true record.

4. NHS England Project Update

The following joined the meeting:

Ruth Ashmore	-	Assistant Director of Specialised Commissioning
Pam Evans	-	Service Specialist, Specialised Commissioning, NHS England – Midlands and East;

The Committee considered a report (UCJHOSC/01/16) comprising a Project Update, Stakeholder Information Leaflet, Milestone Plan, and Provider Evaluation Criteria Template. All timings were provisional. During subsequent discussion the following was raised/highlighted and/or noted:

Submissions received

(i) All five Hospital Trusts had been invited to submit proposals to host the service. Whilst joint bids would also have been welcomed, in the end only submissions from Colchester Hospital University Foundation Trust (CHUFT) and Southend University Hospital Foundation Trust (SUHFT) had been received;

Evaluation of submissions:

(ii) An Independent Evaluation Panel will assess the submissions against the Specialised Urology Service Provider Evaluation Criteria document (included in the agenda papers) with the assessment including the sustainability of the model;

(iii) The Evaluation Panel will be comprised of two surgical clinicians, a clinical nurse specialist, a commissioning representative from outside the region and two patient representatives. One patient representative has yet to be confirmed. The finalised membership of the panel would be published in due course;

(iv) The Evaluation Criteria document asked for a robotic surgery facility to be available on site or for bidders to demonstrate access to an alternative robotic care pathway (for example into London) so that endoscopies and keyhole surgery can be undertaken. It was noted that Mid-Essex Hospital Trust had robotic surgery facilities at its Broomfield Hospital site which were unused at present. There

would be no change to the current provision of chemo Brachytherapy;

(v) The Evaluation Panel would visit both CHUFT and SUHFT in late April 2016 as part of their evaluation and pursue key lines of enquiry developed by the Panel. The Evaluation Panel was scheduled to complete their evaluation during May 2016;

(vi) The Evaluation Panel will make recommendations to NHS England, an oversight group established for the project (see below) and the seven clinical commissioning groups. The recommendation could be that both, only one or neither bidders fully met the criteria – if the later was the case then Hospital Trusts in Essex could be asked to investigate a third option and find a more collaborative approach.

(vii) Some JHOSC Members highlighted that there had been some media coverage of a south Essex solution muted by SUHFT – however, as this had excluded north Essex it would not have met the evaluation criteria for a pan-Essex solution;

(viii) As part of the formal evaluation process there would be more analysis of patient flows and travel analysis – it was stressed that this would include blue light and public transport;

(ix) Anticipated activity profiles had been validated by both CHUFT and SUHFT and these would be considered against current activity levels;

(x) Members were keen to see updated actual current activity levels – current activity profiles would be provided by NHS England for distribution to JHOSC members;
Action: Ruth Ashmore, NHS England

(xi) JHOSC Members highlighted that commissioners had indicated in their Evaluation Criteria document that patients may have to travel more than 60 minutes for the actual specialist surgery. However, bidders had to demonstrate the accessibility of other supporting services such as outpatient care and minimising the need for travel for those;

(xii) NHS England representatives advised that the proposals affected up to approximately 200 surgical cases per year with the numbers potentially reducing further as different alternative modalities of care developed. There would be clinical and financial pressure to meet at least a minimum 150 cases per year;

(xiii) Bidders would be asked if they could improve the current waiting times for referral and for commencement of invasive surgery;

Consultation and engagement

(xiv) As requested by the JHOSC at its first meeting, NHS England had consulted Healthwatch organisations in Essex, Southend and Thurrock regarding the format of the public information events that had been held;

(xv) There was discussion on further areas that should have public information events (notably in Basildon and Thurrock) and JHOSC members were invited to suggest suitable venues for these;

(xvi) JHOSC Members were concerned about the low level of public understanding about the project and the potential for confusion with the complex urological cancer surgery proposals that were also receiving significant local media coverage at the same time – a stakeholder briefing had been sent to local clinical commissioning groups for dissemination to local GP surgeries although it was acknowledged that such dissemination had not been done everywhere;

(xvii) It was stressed that the current public information events were to do with engagement rather than formal consultation (which would come later in the process) to inform the Evaluation Panel's considerations and help them develop their key lines of enquiry with CHUFT and SUHFT;

(xviii) JHOSC Members stressed that the focus of communication with the public should be to emphasise that the majority of care (pre-operative and post-operative) would continue to be in their local hospital;

(xix) Pam Evans had visited and consulted a sample of patients and service users across the county who had used the urological cancer services (prostate, kidney and bladder). Pam Evans would provide a report on these for the JHOSC by the end of April;
Action: Pam Evans, NHS England

(xx) A senior oversight body had been established for the project to ensure commissioner and provider engagement. All seven clinical commissioning groups were represented on the body which had approved the Terms of Reference, evaluation criteria and the governance process for the project;

(xxi) NHS England would also be engaging with the main commissioners in GP Groups;

(xxii) Healthwatch and/or patient representatives would be asked to give evidence to the JHOSC. **Action: Scrutiny Officers**.

West Essex

(xxiii) Princess Alexandra Hospital (Harlow) had indicated that they wished to be part of a pan-Essex solution. However, there would always be cases where West Essex residents chose to travel into London instead. Furthermore, it was acknowledged that less West Essex residents would likely be willing to travel to a specialist surgical centre based at SUHFT as opposed to CHUFT.

Timetable

(xxiv) NHS England would seek to consult the Committee on public engagement and consultation in June 2016;
Action: Pam Evans, NHS England

(xxv) Stakeholder engagement (formatted to include feedback from the Joint HOSC) was currently scheduled for September 2016;

(xxvi) Anticipated service start date was fourth quarter 2016;

(xxvii) The timetable may now be impacted by the EU Referendum and some items deferred until afterwards and certain timings slip as a result;

Success Regime

(xxviii) CHUFT are not included in the Success Regime and JHOSC members queried how this might impact on their submission. However, it was confirmed that, at the moment, the project was running separate to the Success Regime process although there would be a link to it to enable a feed-into the overall review;

(xxix) JHOSC Members emphasised the importance of retaining the specialist consultants, making Essex an attractive place to work, and the potential to repatriate from London providers.

Conclusion:

NHS England probably would not be able to further update on the evaluation of bids until June 2016. In the meantime, the JHOSC would seek Healthwatch and patient/service user input to their deliberations.

6. Date of next meeting

To be confirmed.- The meeting closed at 4.40pm.

Specialised Urological Cancer Surgery Services in Essex

A Report for the Essex Joint HOSC September 2016.

Document Title: Specialised Urological Cancer Surgery Services in Essex

Subtitle: Report for Joint HOSC September 2016

Version number: Version 1

First published: 22 August 2016

Updated:

Prepared by: NHS England SCT Midlands and East (East of England)

Classification: Official

Contents

1 Project Update

1.1 Project Background

- In 2013 responsibility for commissioning a specialised urological cancer surgery service came under the remit of NHS England Specialised Commissioning Teams
- A new national service specification for the service was published, this reflected national commissioning guidance (Improving Outcomes Guidance IOG) published by NICE in 2002
- 2013/14 the Specialised Commissioning Team (SCT) took a stocktake of all specialised services in the east of England and found that the specialised urology services in Essex did not meet the minimum population requirements cited by the national guidance
- Clinical Model for Essex discussed with National Clinical Reference Group (CRG)
- SCT advised by the CRG that a single site service was appropriate for the Essex population as current population requirements for this service is at least 1 million, and also noted that future service requirements are likely to be higher

1.2 Project Progress to Date

- Service model as advised by the CRG was agreed with stakeholders
- A service description (service criteria) was written by and agreed by stakeholders. This document reflected national guidance and also described a local networked service to meet the needs of the population
- NHS England SCT engaged with the Joint HOSC about the project and were advised to inform the public about the project
- A public information leaflet was produced and a series of public information events were arranged to give background explanation and information about the project to members of the public.
- NHS England also engaged with individual patients who had experienced the service first hand, this survey helped with an understanding of the patient's own experience and what aspects of the service were most valued. The findings of this survey will be fed into the project implementation.
- A Senior Oversight Group was formed. Senior representatives from every acute hospital trust in Essex, every CCG in Essex and NHS England are represented on this group set up to oversee the project and process
- The Senior Oversight group agreed the project process as set out by NHS England
- All providers were invited to express an interest in providing the service
- Two of the Essex hospital trusts submitted bids to host this centre and provide the service for specialised urological cancer surgery in the county:
  - Colchester Hospital University NHS Foundation Trust
  - Southend University Hospital NHS Foundation Trust.
- Expert Panel recruited, bids and background information sent to the panel

- Expert Panel visits and assessments took place on the 13th and 14th June 2016
- Expert Panel made a recommendation that the proposed service at Southend was best placed to deliver the county wide specialised urological cancer surgery single site service in Essex
- The Senior Oversight Group (Senior representation from all providers and CCG's in Essex) agreed that the panel had fulfilled their remit and endorsed the recommendation

1.3 Project Next Steps

NHS England is meeting with the Joint HOSC to share their proposals for the next steps in the project:

- NHS England decision making process
- Continuing public engagement
- Project implementation

1.3.1 NHS England Decision Making process

NHS England will be asked to make a decision on the site of the specialised surgical service following consideration of the expert panel recommendation and project progress at their meeting on the 20th September 2016.
There will be immediate notification of this decision to all of our stakeholders these include:
All Providers and CCG's in Essex, Essex MP's, Essex Healthwatches, Essex HOSC Officers, Patient Groups, Clinician Groups and individuals requesting information.
We will communicate with the Essex Success Regime (ESR) and ensure any stakeholder communication is aligned with their ESR communication processes.

1.3.2 Further Public Engagement

Once a final decision is known further public engagement is planned, the recommendation that a single site service based in Southend will mean a change in service provision for those people in the north of the county and it is important to seek comments on how we can minimise the impact of the proposed service change and influence pathway development and service delivery. Looking at the practical and operational considerations of running this specialist surgical service is an important part of this engagement and we are seeking comments and thoughts about how we can make the proposed new service as accessible and appropriate as possible for patients and their families.

We will be asking specifically for views and thoughts for improving access to this this single site service ensuring that people have access to the right care at the right time. These views will be fed to the implementation team to ensure that where possible the proposed new service reflects the views and needs of all stakeholders.
We plan that this engagement will run between October and December 2016 and will make use of the following:

Circulation of Public Information - We will circulate a public information sheet informing the public how to give their views and comments about this proposed service change.
E-mail contact - We will encourage direct e-mail contact
By Post – we will provide a postal address for those that prefer to post comments to us
Twitter - People will be able to Tweet us
Public events - We will encourage attendance at planned public events which will take place between October 2016 and December 2016 throughout Essex.
Visits/meetings with local patient groups - We will encourage individuals and groups to contact us and ask us to join a meeting being held between October 2016 and December 2016.

1.3.3 Project implementation

The Senior Oversight Group are meeting on the 16th September to plan project implementation, this will include the following:

- Agreeing terms of reference, membership and accountability of the implementation group
- Commencement and activities of the Specialist MDT (SMDT) this will ensure a consistent clinical pathway for all patients
- Agree what constitutes local care and specialised care and ensure that local care is delivered locally
- Undertake a change impact assessment, this will include financial impact and the impact on workforce
- Undertake an Equality Impact Assessment on the new service
- Oversee the public engagement process to ensure patient comments and views are fed into the new service to enable co-production of the service.
- Discuss implementation of the suggestions and comments from patients that participated in the Lived Experience Survey

In the initial phase of the project implementation NHS England will seek assurance that all surgical intervention will take place under the governance of the Specialist MDT. In January –March 2017 it is anticipated that the surgical work will start to transfer to the single site and this transition completed by the end of March 2017. The contract for the Specialised urology cancer surgery service will commence with the single provider from the 1st April 2017.

REVISED PROJECT TIMELINE

6thJuly 2016	Panel recommendation to be endorsed by the Senior Oversight Group	SCT	Completed
6thJuly 2016	Stakeholder Communication re recommendation	SCT	Completed
4thAug 2016	Update to Regional Executive Management Team	RA	Completed

Aug/Sept 2016	Further stakeholder engagement planning	SCT	In progress
Aug/Sept 2016	NHS England assurance testing	SCT	In progress
6th September	Joint HOSC meeting To endorse NHS England plan for further stakeholder engagement and project implementation plans	SCT	In planning
16th Sept 2016	Senior Oversight meeting to plan project implementation and agree membership of implementation group	SCT/CCG's and providers	In planning
20th Sept	Regional Executive Management Team Asked to make a final decision on the site of the specialised surgical service following consideration of the expert clinical panel recommendation and project progress.	SCT	In planning
20th Sept	Stakeholder Communication re decision of single site, ensuring alignment with the Essex Success Regime (ESR) communication process.	SCT	Not started
Oct/Nov/Dec	Implementation group convenes and oversees the following activities • Commencement and activities of the Specialist MDT (SMDT) • Ensuring a consistent clinical pathway for all patients • Change impact assessment to include financial and workforce • Equality impact assessment • Public engagement process to ensure co-production of the service	SCT/CCG and providers	In planning
Oct/Nov/Dec 2016	Stakeholder engagement commences and will feed into the implementation plans throughout this period	SCT/CCG and providers	In planning
Dec 2016	Analysis and summary of stakeholder engagement and evaluation of implementation process	SCT	Not started
Dec 2016	Update to Regional Executive Management Team	SCT	Not started
Dec 2016	Update to Joint HOSC if requested	SCT	Not started
Jan-March 2016	Project implementation continues, it is anticipated that all surgery taking place will be governed by the SMDT, before transfer of work begins.	SCT/CCG and providers	Not started
Q1 2017/18-	Specialised urological cancer surgery service contract commences with the provider.	SCT/ Provider	Not started

Activity Plan, Activity Assumptions and Actual Activity

The information contained in the paper titled above has been taken from the following documents:

Activity plan and activity assumptions

Taken from the **Urology Service Criteria (Prostate, Bladder, Renal)** a document prepared by the Strategic Clinical Network and agreed with all stakeholders and published in November 2015 and circulated widely. This paper was written to describe the agreed service model for specialised urology cancer surgery services.

Actual activity

Taken from the **Baseline Assessment Data** document for the Essex Specialised Urological Cancer Service prepared by the Strategic Clinical Network as background information for the expert review panel. This document was published in March 2016.

August 2016

- A single Urology Specialist MDT reviewing the diagnostic data and agreeing the treatment plans of all patients with urological cancers meeting the referral criteria;
- An increased expertise within the Urology Specialist MDT members, the surgeons and their supporting teams, generated by the higher number of patients seen and treated, enabling innovation in the treatment of patients with urological cancers;
- The majority of non-surgical care being provided at a location that is as local as possible to the patient.

See Section 8 for the details of service outcomes to be measured.

7 Urology SMDT and surgical activity plan

7.1 Current activity levels within the Essex Cancer Network

Please note that these figures **exclude** West Essex CCG populations as their figures are not yet available. They are provided to allow a comparison between current activity and future predicted activity only.

This data has been collated by Essex Cancer Network from their own records.

Data on brachytherapy and radiotherapy has been provided for contextual purposes only.

		2010/11	2011/12	2012/13	2013/14	2014/15
Prostate Cancers						
	Incidence	**924**	**866**	**930**	**735**	**979**
	Prostatectomy Numbers	**56**	**82**	**119**	**124**	**106**
	Brachytherapy Numbers	*61*	*75*	*118*	*112*	*141*
	Radiotherapy Numbers		*272*	*322*	*377*	*306*
Bladder Cancers						
	Incidence	**>227**	**278**	**312**	**153**	**307**
	Cystectomy Numbers	**66**	**78**	**79**	**53**	**57**
	Radiotherapy Numbers		*31*	*26*	*34*	*26*
Renal Cancers						
	Incidence	**229**	**197**	**189**	**157**	**190**
	Partial Nephrectomies	**23**	**38**	**52**	**35**	**48**
New patients discussed at SMDT		**412**	**472**	**765**	**829**	**981**

7.2 Expected activity levels within the new urology cancer surgical service

These future activity levels are calculated using a set of assumptions outlined in Appendix C.

The prostatectomy figures include those patients who may choose to have a robotic prostatectomy, if offered.

Please note that these figures **include** West Essex CCG populations as Princess Alexandra Hospital have said they are likely to offer patients the choice of the Essex IOG-compliant centre.

Data on brachytherapy and radiotherapy has been provided for contextual purposes only.

		Notes	2016/17	2017/18	2018/19	2019/20	2020/21
Prostate Cancers							
	Incidence		408	1797	1977	2174	2392
	Prostatectomy Numbers	1	41	180	198	217	239
	Brachytherapy Numbers	*1*	*41*	*180*	*198*	*217*	*239*
	Radiotherapy Numbers	*1*	*41*	*180*	*198*	*217*	*239*
Bladder Cancers							
	Incidence		105	463	509	560	616
	Cystectomy Numbers	1	16	69	76	84	92
	Radiotherapy Numbers	*1*	*5*	*23*	*25*	*28*	*31*
Renal Cancers							
	Incidence		87	381	419	461	507
	Partial Nephrectomies	1, 2	19	91	109	129	152
New patients discussed at SMDT		1	224	987	1086	1194	1314

Notes

1 2016 numbers reflect one quarter of the fiscal year prediction, based on service launch in Q4 2016/17

2 These figures include any complex full nephrectomies that may also be carried out at the surgical centre

7.3 Capacity requirements

Current national guidance states that each pelvic surgeon should carry out a minimum of 5 prostatectomies/cystectomies per year. The centre overall should carry out a minimum of 50 such operations per year.

Guidance on behalf of the Department of Health from Frontier Economics 2010 indicates that an optimal Uro-oncology CNS workload is 100 new patients plus 500 in follow-up.

Appendix C – Activity Level Forecasting

Assumptions

1. Calculations will be based on incidence figures of urological cancer in Essex provided by Public Health England.
2. An annual rate of increase of incidence of 10% will be used – as endorsed by Ref 1. This is much higher than actual incidence rates over the period of Q4 2008/9 to Q3 2013/14, so should be going some way to cater for age and population growth impacts as well.
3. Incidence numbers will be split prostate (66%), bladder (17%) and renal (14%), based on NCIN Urology Hub figures for 2010-2012 which are in alignment with evidence from Ref 2 (of a 66%/17%/17% split) and endorsed by Ref 1. [The remaining 3% of incidence from the NCIN Urology Hub figures is for testicular cancer incidence.]
4. Numbers of patients estimated to have radical treatment plans agreed will be calculated as 30% of prostate incidence, 20% bladder incidence, and 75% renal patients – based on Ref 2 but with prostate figures amended by input from Essex clinicians on 08/06/15.
5. For prostate cancer radical treatments to be managed by the Specialist MDT with surgery at the specialist surgical centre, the expected split between surgery, brachytherapy and radiotherapy is calculated as one third to each (Ref 1).
6. For bladder cancer radical treatments to be managed by the Specialist MDT with surgery at the specialist surgical centre, the expected split between surgery and radiotherapy is 75:25 based on the opinion of Essex clinicians on 08/06/15. Both of these can be with or without neo-adjuvant chemotherapy. Only those with metastases are likely to have chemotherapy alone.
7. For renal cancer, the proportion of patients expected to have surgical treatment carried out at the specialist surgical centre is approximately 20% of all renal cancer patients (Ref 3), rising to 30% at the end of the next 5 years, as agreed by Essex clinicians on 08/06/15. This number should reflect all partial nephrectomies plus full nephrectomies for patients with an advanced stage of the disease.
8. To estimate activity levels for **new prostate and renal cancer patients** to be discussed at SMDT, the assumption is that this will equate to all prostate and renal cancer patients being considered for specialist radical treatment (surgery/radiotherapy/brachytherapy as appropriate).
9. To estimate activity levels for **new bladder cancer patients** to be discussed at SMDT (muscle-invasive and high-risk superficial non-muscle invasive cancers), Ref 4 refers to 20%-25% of bladder cancer patients having muscle-invasive cancers. This

14 Appendix B – Detailed Activity Levels

These figures were collated from local records by Michael Scanes of Southend Hospital, in collaboration with the other 3 Trusts and Public Health England (whose figures are in Red).

No comparable figures from Princess Alexandra have been made available.

Year	Trust	SMDT New Patients	New diagnosis	Prostate				Bladder				Renal				Brachy	Radiotherapy	
			From all sources	Diagnosed	PHE Nos*.	Surgery	PHE Nos	Diagnosed	PHE Nos*	Surgery	PHE Nos	Diagnosed	PHE Nos*	Surgery	PHE Nos		Prostate	Bladder
2010/11	SUHFT			252	157	24	20	63	164	41	19	56	43	38	28			
	BTUH			118	150			84	165			23	58		26			
	MEHT			314	129				140			83	63					
	CHUFT			240	141	32	30	80	170	25	10	67	45	48	30			
	TOTAL	**412**	**1425**	**924**	**577**	**56**	**50**		**639**	**66**	**29**	**229**	**209**	**86**	**84**	**61**		
2011/12	SUHFT			259	140	37	38	67	141	44	15	66	52	57	37		148	14
	BTUH			175	139			56	136			41	40		20			
	MEHT			151	157			90	142			36	53		29			
	CHUFT			281	255	45	40	65	159	34	13	54	45	55	29		124	17
	TOTAL	**472**	**1341/ 1459**	**866**	**691**	**82**	**78**	**278**	**578**	**78**	**28**	**197**	**190**	**112**	**115**	**75**	**272**	**31**
2012/13	SUHFT			230	167	58	38	60	136	36	20	47	47	53	32		141	8

	BTUH			179	141			58	121			45	40		21			
	MEHT			227	165			67	125			32	55		23			
	CHUFT			294	232	61	48	127	168	43	13	65	45	72	44		181	18
	TOTAL	**765**	**1431/ 1442**	**930**	**705**	**119**	**86**	**312**	**550**	**79**	**33**	**189**	**187**	**125**	**120**	**118**	**322**	**26**
2013 /14	SUHFT			254	225	34	36	61	128	25	12	67	43	46	31		122	8
	BTUH			66	136			24	128			9	49		17			
	MEHT			154	179			70	143			19	64		33			
	CHUFT			261	197	90	73	33	142	28	10	62	60	60	42		255	26
	TOTAL	**829**	**1045/ 1494**	**735**	**737**	**124**	**10 9**	**153**	**541**	**53**	**22**	**157**	**216**	**106**	**123**	**112**	**377**	**34**
2014 /15	SUHFT			397	202	9	14	67	117	23	12	94	67	77	51		154	10
	BTUH			92	152			19	132			6	50		20			
	MEHT			176	197			69	113			19	46		20			
	CHUFT			314	303	97	87	152	156	34	8	71	73	74	54		160	16
	TOTAL	**981**	**1476/ 1608**	**979**	**854**	**106**	**10 1**	**307**	**518**	**57**	**20**	**190**	**236**	**151**	**154**	**141**	**306**	**26**

Specialised Urological Cancer Surgery Services in Essex
Report of the External Review Panel Visit 14th June 2016

Specialised Urological Cancer Surgery Services in Essex
Report of the External Review Panel Visit 14th June 2016

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Contents

1 Context

In 2013 NHS England became responsible for commissioning specialist urology cancer surgery. The National Institute for Clinical Excellence Improving Outcomes Guidance (IOG) provided the framework to be used by the NHS in England to support the planning and delivery of evidence based care to improve outcomes. The IOG Guidance for urology cancer states clearly that a specialised surgical service should serve a population base of at least 1 million and that there should be a dedicated, multidisciplinary team delivering high quality care in a single specialist surgical centre. This is reflected in the service standards set out in the NHS England Service specification for specialised urology cancer surgery.

A major review of specialist cancer services in the east of England in 2013/14 found that the two existing services in Essex did not meet the population requirements outlined in IOG requirements.

2 Background

2.1 Why the Review was required

The review of urology services in Essex agreed with IOG recommendations; that complex surgery requiring the right skills and facilities to provide patients with the best possible care, is best achieved at larger specialist centres where the expert team will deal with adequate numbers of patients to maximise clinical expertise, leading to improved outcomes.

The review concluded that the specialised urological cancer surgical service cannot be sustained at both Southend and Colchester in the future, as this arrangement would result in insufficient numbers of patients at both sites to maintain the expertise required and will not meet the current IOG. As a result of these findings a project to look at a different service model for specialised urology cancer services in Essex was initiated.

A stakeholder group was established to review the best clinical model for Essex. This group had broad representation from all hospitals, all clinical commissioning groups, clinicians and patient representatives. The group reviewed and contributed to a document that describes the service model for Essex. This document describes in detail the service that will be provided by a single specialised urological surgical centre which will reflect national guidance and standards and also include any specific local requirements of the service.

The underlying principal for this work is to ensure that people needing this service are cared for by the most appropriate healthcare professionals across the network of local and specialised care, collaborating throughout the care pathway with as much treatment as deemed necessary, being delivered locally.

It is important to note that all major hospitals in Essex currently provide cancer and non-specialist urology services, and perform a range of urological cancer surgical procedures. It is not envisaged that this local care will change. GPs and other health

professionals will continue to refer patients with suspected urological cancer to their local hospital for investigation, diagnosis, and treatment of a non-specialist nature; ensuring most urological cancer care will continue to be provided locally, whilst specialist surgery as outlined in national specifications is undertaken within an Essex Urological Cancer Centre.

Specialised care for testicular and penile cancer already occurs in supra-regional specialised centres outside of the county and these arrangements will continue.

The core aim of this project is to ensure that we can have confidence that our services are able to achieve best possible outcomes for patients and their families, whilst meeting the commissioning requirements for specialised services.

3 The Need for Change

3.1 The Need for Change

The IOG model ensures that individual team members develop and maintain skills whilst the MDT as a whole becomes the expert provider of specialised urological cancer surgery. Together these elements support improved outcomes and patient experience for this group of people. Larger units are better able to measure outcomes and produce comparative data and are equipped to offer a wider range of both clinical trials and other research to inform commissioning policy.

The impetus to have a single surgical team is not only driven by the aim of improving surgical skills but also to increase better decision making based on consistent diagnostics, knowledge of the treatment options available and the associated outcomes. With a single critical mass, research and development becomes more possible. The concentration of surgical activity will also allow clinicians to develop organ specific practices with increased activity to ensure economically viable mechanisms to invest in new technologies such as robotic surgery.

The review of urology services in Essex found a wide variation in the types of treatment offered over the two services. A single site service will aim to be more consistent in the treatment options than can be offered to patients. In addition to this, when multiple sites are each seeing fewer patients, there is potential for variation in diagnostic protocols and varying thresholds to determine which patients are considered for various treatment options and trials.

It is widely accepted that best patient outcomes can be correlated to surgical volume. This is also true for care associated with the specialty of urology such as urology intensive care and other supportive care.

3.2 Remit of the External Review

The remit of the External Review Panel was to make an assessment of the submitted service proposals to provide a network wide service. Two service proposals were received; one from Colchester Hospital University Foundation Trust (CHUFT) and one from Southend University Hospital Foundation Trust (SUHFT). Both of whom

expressed an interest in providing the Specialised Urological Cancer Surgery single site Service for Essex (Appendix 7.1 External Team membership, Appendix 7.2 Terms of Reference).

The panel was specifically asked to advise whether each of the service proposals received could meet the service criteria (Appendix 7.3). In addition to this the review panel was asked to provide guidance as to what the service would need to develop in order for the criteria to be met and were also asked to advise which of the services were better placed to be the single surgical centre detailing the reasons why.

3.3 Criteria Scoring Process

The Expert Review Panel received the service proposals from SUHFT and CHUFT four weeks before the site visits.

The Review Panel had a pre meeting the day before the visits to discuss their individual assessments of the service proposals and agree some Key Lines of Enquiry (KLoE) for the clinical teams during the site meetings. At this meeting it was agreed that the scoring would be completed for the providers after each of the site meetings (Appendix 7.4 panel itinerary).

The Chair of the Panel for both of the meetings was Mr Vijay Sangar; who is also the Chair of the Clinical Reference Group for specialised urology.

The panel met with the team at SUHFT in the morning and the team at CHUFT in the afternoon (Appendix 7.5 & 7.6 list the provider attendees at these meetings).
Mr Alan Hudson from Thurrock Healthwatch was also in attendance at both meetings.

In assessing this bid the panel utilised: the provider bidding documents, NHS England data on epidemiology/public health, incidence, current services and needs, population coverage, travel times, B14Sa NHS England specification, information from the team meetings and presentations.

It should be added, the service model and understanding the holistic needs of the population is prerequisite to a successful bid. The panel has taken these needs into account.

3.4 External Review Panel Findings against the Criteria

The discussion of scoring the services was carried out at the end of the site visits. Each of the criterion in the provider evaluation document (Appendix 7.7 provider evaluation criteria) was scored with either 1 for yes (criteria met) or 0 (criteria not met). The panel discussed each of the criterion and made notes, before reaching an approximate score. At the end of both visits each panel member scored each site individually.

3.5 SUHFT Score

The team at Southend showed true understanding of the need to provide the service for the entire population and presented an inclusive outreach model that showed, very clearly they had thought about each element of the patient pathway, regardless of area of residency. This was clearly encompassed in their mobilisation and capacity plans.

They were able to show how the patient pathway can be integrated into patient data collection and research. In addition they showed a significant move towards subspecialisation of Clinicians to each cancer site, which is now seen as the modern approach to urological cancer surgery.

Importantly they demonstrated true ability to offer an inclusive approach to developing a system that functions for the patient rather than the provider, in terms of outpatient, inpatient and urgent care.

As a side issue, the need for Essex to maintain a Pelvic Cancer and Gynaecology Cancer system that will serve the population must not be underestimated, and SUFT have been able to grasp this complex specialised need. The model for complex pelvic cancer care is difficult to align in many areas of England. It currently exists for some Essex patients, and should be nurtured for the whole population.

The management team was able to demonstrate the leadership required for such a vast project, which instilled definite assurances. The Panel was especially reassured by the ability of the Project Management element of the Team, which had given clear consideration to the enormity of the task required.

Additionally it was apparent that the populations this Team was able to serve would be significantly higher than that for Colchester; hence this model was more likely to provide an equitable and sustainable provision for Essex.

(Appendix 7.8 SUHFT scoring)

3.6 CHUFT Score

As the Team currently stands it appeared they were able to provide a good service for its immediate population.

However, the team at Colchester, failed to show wider understanding of the need to provide a service for the wider population of Essex. The service presented was exclusive rather than inclusive. The Team did not adequately show how services for the south of Essex would function, and be integrated.

The Team were clearly passionate about their Trust and service, however there was minimal evidence of will to modernise e.g. the lack of inclusion, minimal attempts at subspecialisation. There was some concern regarding the ability for the model to safely serve urgent or emergency clinical events from ‘new’ incorporated areas. The Panel was not reassured by the Trusts ability to task and finish the project, should they be awarded the service.

(Appendix 7.9 CHUFT scoring)

3.7 External Review Panel Recommendations

The external review panel considered a range of evidence submitted a month before the site meetings and considered information presented by the clinical and management teams on the day of the meetings.

The panel was in no doubt that both providers had good services that currently met the needs of the local population.

The panel found that the proposed service at Southend was best placed to deliver the county wide specialised urological cancer surgery single site service in Essex.

The panel found that whilst the service at Colchester had considered a single site service, there had been no real consideration of the service expansion required in providing a whole county approach in terms of coordination of and communication with the services across the wider geographical area.

4 Summary

In summary the external review panel considers that the Specialised Urological Cancer Surgery single site service for the population of Essex should be developed at Southend. The panel firmly believes that The Southend Team is very likely to be able to push Specialised Cancer Urology and its related disciplines to a level beyond current IOG, if they are able to retain their current thinking.

All The CNS Teams across both sites are to be commended for their collaborative working and their ability to keep the system running, these teams will clearly be fundamental to the future Urology service across Essex and should be nurtured.

The review panel would like to thank the teams at SUHFT and CHUFT for their comprehensive service proposals, their participation in the meetings and their hospitality.

5 Visiting Expert Team

Chair Mr Vijay Sangar Consultant Urological Surgeon, The Christie Hospital Manchester
Professor David Nicol Consultant Urologist, The Royal Marsden Hospital London
Mr David Heason, Specialised Commissioner East Midlands
Patient Representative Lindsey Cook, East of England Citizen Senate
Patient Representative Tony Rollo, East of England Citizen Senate
Helen Johnson Clinical Nurse Specialist, The Christie Hospital Manchester

6 References

National Institute for Clinical Excellence. Improving Outcomes in Urological Cancers. National Institute for Clinical Excellence: London, 2002.
NHS England Service Specification B14/S/a Urological Cancers –Specialised kidney, bladder and prostate cancer services.

7 Appendices

7.1 External Review Panel Membership

7.2 External Review Panel Terms of Reference

7.3 SCN Urology Service Criteria (prostate, bladder, renal)

7.4 Review Itinerary

7.5 Review Attendees from SUHFT

7.6 Review Attendees from CHUFT

7.7 Provider Evaluation Criteria

7.8 Panel Score SUHFT

7.9 Panel Score CHUFT

External Review Panel Membership

Mr Vijay Sangar, Consultant Urological Surgeon, The Christie Hospital Manchester
Professor David Nicol, Consultant Urologist, The Royal Marsden Hospital London
Mr David Heason, Specialised Commissioner East Midlands
Lindsey Cook, Patient Representative, Citizen Senate
Tony Rollo, Patient Representative, Citizen Senate
Clinical Nurse Specialist input from:
Helen Johnson, The Christie Hospital Manchester (Helen was unable to attend in person)

In attendance: Alan Hudson Thurrock Healthwatch.

Specialised Urology Cancer Surgery Services In Essex.

Expert Review Panel (ERP) Terms of Reference

Background

The Urology Cancer (IOG) states that the specialised urology cancer service should be delivered to a population base of at least 1 million, with all surgery taking place on the site of the trust hosting the Specialist MDT. This recommendation is also followed through in the NHS England Service Specification B14/S/a for Urological Cancers – Specialised kidney, bladder and prostate cancer services.

In 2013 NHS England became responsible for commissioning specialised urology cancer surgery, a major review of specialised rare cancer services in the East of England in 2013/14 found that the two existing services in Essex did not meet the population requirements for compliance with this commissioning guidance.

Working in partnership with the Strategic Clinical Network (SCN) the Specialised Commissioning Team (SCT) undertook a review of urology service in Essex. This review found that all acute hospitals in Essex currently provide urology cancer services, 3 hospitals provide diagnostic and local care and two provide diagnostic and local care plus specialised urology surgery. Specialised care for testicular and penile cancer already takes place in specialised centres outside of the county and these arrangements will continue.
The review concluded that the specialised surgical service cannot continue to be provided at the two hospitals (Southend and Colchester) in the future.

As a result of this review a stakeholder group was established to review the best clinical model for Essex. This group had broad representation from all hospitals, all clinical commissioning groups, clinicians as well as patient representatives. The group reviewed and contributed to a document that describes the service model for Essex. This document, known as the Service Criteria Document, describes in detail the service that will be provided by a single specialised surgical centre, it reflects national guidance and standards and includes any specific local requirements of the service. The guiding principle of this model is to ensure that people needing this service are cared for by the most appropriate healthcare professionals across the network of local and specialised care, collaborating throughout the care pathway with as much treatment as possible being delivered locally.

Provider evaluation criteria were developed from the service criteria document described above. All five acute hospitals in Essex were invited to express an interest in providing this new service. Interested providers were asked to submit a service proposal that will enable them to deliver the service model as described by the documents above.

Purpose/Remit
The ERP is a time limited (task and finish) group whose remit is to make an assessment of the submitted service proposals from providers within Essex.
The purpose of this assessment is to advise:

1. If the service proposals meet the service delivery criteria.
2. If they do not meet the criteria, provide guidance as to what would the service need to develop in order for the criteria to be met
3. The ERP will also advise which of the services is better placed to be the single surgical centre detailing the reasons why as defined by the criteria

A final report detailing the recommendations and preferred option, will produced for the Senior Oversight Team for formal sign off.

The ERP is accountable to the Senior Oversight Team who, through the Assistant Director of Specialised Commissioning, report initially to the Midlands and East Senior Management Team (SMT) and through to the Regional Executive Meeting (REM).

Membership
Members of the panel shall be appointed by the SCN/SCT representatives on behalf of the Senior Oversight Team.
The panel shall be made up of at least six members.
Only members of the panel have the right to attend meetings.
Appointments to the panel shall be for the period of the project duration which is expected to be a maximum of 2 months.
The External Review Panel will consist of:
Two specialist expert clinicians sourced from the Royal College* one of which will chair the panel discussions.
An external expert commissioner, who if possible is from an area with similar geographical challenges *
A Clinical Nurse Specialist in urology*
At least one Patient Representative, preferably two who can represent the position from all areas.
A Panel Coordinator from the specialist commissioning team.

*Panel members will be external to the East of England

Secretary
The coordinator from specialist commissioning shall act as the secretary to the ERP.

Quorum
The quorum necessary for the transaction of business will include one of the two specialist expert clinician members, the commissioning member, a patient representative and the coordinator.
A duly convened meeting at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the panel.
If any member of the panel believes they have a potential conflict of interest this should be disclosed to the coordinator at the outset. Any conflict of interest will be declared at the first meeting of the panel.

The panel will be requested to sign a formal confidentiality agreement at the outset.

Meetings, Duration and Frequency

The ERP shall be appointed for a 6 week period following receipt of the service proposals from trusts.

It is expected that the panel will meet over 2-3 days, this will include a visit to each of the providers.

The ERP will be coordinated by specialist commissioning and all communication with the ERP and between the ERP, providers and Senior Oversight Team will be facilitated by the Coordinator. Panel members are asked not to liaise with providers directly forwarding any communication from providers to the panel coordinator.

Remuneration: All travel expenses for members of the panel will be met if not met by the panel member's employer.

Duties

Service proposals and relevant background information will be sent to members of the ERP for their individual assessment.

Members of the ERP can request clarification of any point of query in the service proposal through the panel coordinator only.

The ERP will meet to discuss their individual assessments and discuss the provider visits and through the Coordinator notify the providers of any specific needs during the provider visits, this may include the requirement to visit to a particular area or meet with a specific member of the provider team.

The ERP will visit each of the providers that have submitted a service proposal to meet with the clinical and managerial teams. This visit may include a visit to clinical areas, if this is the case there will be prior notification.

The coordinator will facilitate any other visits or appointments as requested by the ERP.

The ERP will meet for a final time to discuss their assessment, make their recommendations and draft the final report to Senior Oversight Team.

Output of Review

A final report will be produced and made available to the Senior Oversight Team in the first instance for review. Senior Oversight Team, through the Assistant Director of Specialised Commissioning, who will be responsible for communicating the recommendation to the to the Midlands and East Senior Management Team (SMT) and through to the Regional Executive Meeting (REM).

The recommendation will be communicated to all stakeholders via the Senior Oversight Group

Written on behalf of the Senior Oversight Team
April 2016.

Urology Service Criteria (Prostate, Bladder, Renal)

Version 1

Prepared by: Sarah Steele, SCN

Date: 26 November 2015

1 Introduction

This document is being provided to the Midlands and East Specialised Commissioning Team (M&E SCT) East of England Hub as clinical guidance on the criteria that an Essex Cancer Network Urology Service is expected to demonstrate compliance with, to support them in their commissioning of an IOG-compliant specialised Urology cancer service.

It is acknowledged that an overarching National Specialised Kidney, Bladder and Prostate Cancer Service Specification (B/14/S/a) has been published by the NHS England Clinical Reference Group for Specialised Urology. It is intended that this document is complementary to that national service specification. As such, the ordering of section 3 and beyond aligns with the order that topics are discussed in the national service specification.

In that context, the content of this document has been validated by the Chair of that expert group.

Please note that, in the rest of this document, any reference to urological cancer encompasses the surgical service for prostate, bladder and renal cancer only. It is accepted that the current Essex pathways for penile and testicular cancer are in place and robust.

2 Guiding principles

This service criteria document focuses on the detail of the elements of the service that are changing and must now be provided by a single centre, and sets them in the context of the overall patient care pathway.

It is important to recognise the contribution to the current service that staff across the Network make, and a major part of the role of the single centre is to sustain this contribution to ensure appropriate local care continues to be considered in the future service model, and to ensure that all opportunities for joint working by healthcare professionals across the region are considered.

The guiding principle is that patients are cared for by healthcare professionals across the Network collaborating throughout the care pathway, with as many elements as possible of that care pathway delivered locally to the patient. By default, only surgery and immediate follow up should occur at the centre (unless the centre is also the patient's local Trust).

During the implementation process the emphasis will be on collaboration with referring hospitals and key stakeholders to ensure that pathway planning around local services will be considered. Evidence of collaboration will be an on-going requirement of this service.

3 National/local context and evidence base

The NICE guidance on Improving Outcomes in Urological Cancers (IOG) was published in 2002. It recommends that the more complex cases (as defined in section 5.3 of this document) should be referred to a single Specialist MDT hosted by a single surgical centre with a catchment population of at least 1 million.

Whilst many aspects of the IOG were implemented within the Essex Cancer Network some time ago, there have continued to be two separate surgical centres in operation, despite the total population base being only of the order of 1.4 million. There has been a single Specialist MDT operating, and the responsibility for hosting it has alternated every 2 years between the current 2 surgical centres.

This document forms part of the process for achieving full IOG compliance of the Essex Urology Cancer Service.

4 Aims and objectives of the service

The overarching aims of this service are:

- To ensure equitable access to surgery and other radical treatment for patients with urological cancers;
- To continue to improve the survival rates for patients with urological cancers by commissioning a surgical service with outcomes in line with the best in this country and Europe;
- To provide information to support ongoing development of the service.

These aims are in line with the Improving Outcomes: A Strategy for Cancer 2011 publication which promotes the delivery of high quality outcomes for patients.

The objectives are:

- To have an IOG-compliant service for urological cancers within the Essex Cancer Network, providing a local centre of choice for the population of Essex;
- To have a single surgical centre within the Network for patients with urological cancers;
- To have a single Urology Specialist MDT within the Network, hosted at the same site as the single surgical centre, to whom all patients meeting the referral criteria are referred (see section 5.3 for referral criteria);
- To have the majority of non-surgical care provided at a location that is as local as possible to the patient.

5 Service description/care pathway

Appendix A provides a diagrammatic overview of the care pathway.

5.1 Governance

Any patient referred to the Urology Specialist MDT shall remain the responsibility of the referring clinician until a clinician from the Urology Specialist MDT has formally written to the referring clinician stating that they will take on (temporary) responsibility for the patient.

Responsibility for the patient will be handed back to the party agreed within the treatment plan (normally expected to be the initial referring clinician) when treatment, and any agreed period of follow up at the centre, has completed.

Following discussion at the SMDT it is the responsibility of the Chair of the SMDT to ensure that a comprehensive opinion is communicated using a proforma. The completed proforma (patient details, clinical history and action plan) shall be distributed by the SMDT co-ordinator within one working day to the following:

- Electronic copy to core and extended members;
- Electronic (or faxed) copy to GP;
- Electronic copy to referring clinician;
- Electronic copy to local key worker;
- Electronic copy to referring MDT Coordinator and/or pathway tracker.

The Chair may also dictate a letter to the referring consultant with a copy to the GP and other relevant clinicians, summarising the treatment options to be recommended.

Following any treatment at the specialist centre, a detailed end of treatment record shall be returned within one working week to the referring local MDT /clinician including the operation record, radiotherapy and chemotherapy treatment, complications, final pathological stage and details of follow up requirements.

Further details of the governance principles to be embraced by this service can be found in the document Guidelines for Governance between LMDTs and SMDTs (see Appendix B).

In a similar manner, the patient shall remain the responsibility of their local key worker/CNS until a key worker/CNS from the specialist centre has made their first contact with the patient. Responsibility for the patient will be handed back to the local key worker/CNS when treatment, and any agreed period of follow up at the centre, has completed. During the period of treatment and follow up at the centre, the local key worker/CNS shall be kept fully informed of their patient's progress and likely discharge date.

5.2 Patient and carer information and experience

The service shall support patients and their families throughout the pathway.

Patients and their families/carers shall initially be provided with written information about urological cancers and their treatment by their local MDT or key worker, either at or before the clinic appointment where they receive their diagnosis.

The specialist centre, in conjunction with referring Trusts, shall ensure that referring hospitals also have written information to provide to their patients which clearly shows where the patient will need to go to if invited to the specialist centre for further diagnostics or joint oncology clinics. This information should clarify public transport and car parking arrangements, as well as signpost them to local sources of travel grant and other benefits advice. The information shall be given to them prior to the patient's first appointment at the specialist centre.

For prostate cancer patients, the specialist centre shall provide joint clinics at which the patient can discuss the treatment modalities and their potential side effects with a range of healthcare professionals with experience of all the treatment modalities, including as a minimum a clinical nurse specialist, a surgeon and an oncologist.

The specialist centre shall provide written information on local accommodation, car parking, public transport, social support, benefits, and facilities within the centre at the point at which the patient agrees to treatment at the centre. This should be provided with the initial contact or appointment letter.

Note that information should be provided in a number of different formats and as a minimum in Braille, Large Print, British Sign Language DVD, Sign Supported English DVD, and translated into local minority languages.

5.3 Referral Criteria

All patients in the age range 16 – 24 (known as TYA patients) must be referred to the TYA MDT applicable to Essex – currently at UCLH – where their treatment plan will be decided. Patients in the age range 19 – 24 will then be given a choice as to where they receive their treatment.

All adult patients (25+ years of age) meeting the urology cancer referral criteria must be referred to the Essex Urology Specialist MDT.

In order to keep within the 62 day cancer waiting times target for GP referral to first treatment, patients shall be referred to the Specialist MDT by day 38 at the latest.

In outline, this service will be for patients who meet the following criteria:

- Adult urology cancer patients with diagnosed prostate cancer who are being considered for radical treatment (surgery, brachytherapy, external beam conformal radiotherapy);

- All adult urology cancer patients with diagnosed high-risk superficial or muscle-invasive bladder cancer;
- Adult urology cancer patients with suspected or diagnosed renal cancer who are being considered for partial nephrectomy surgery;
- Adult urology cancer patients with suspected or diagnosed renal cancer where the tumour may have invaded the renal vein or inferior vena cava or the heart;
- Adult urology cancer patients with metastases who might benefit from surgery or combined surgery and systemic therapy;
- Any adult with suspected urology cancer who is proving difficult to clearly diagnose.

A more detailed specification of referral criteria will be found in the network clinical guidelines.

An important part of this service will be for the service provider to ensure that referring hospitals improve their referral rates to this specialist service. It is anticipated that this will be done through policy development and ensuring that enhanced referral information is available. Evidence that hospitals with poor referral rates have had specific centre intervention will be required.

Templates for referral to the Urology Specialist MDT and the Specialist MDT Outcome Proforma are to be defined by the Specialist MDT.

The referral template must include, as a minimum:

- Full medical history of the patient, including current or presenting symptoms;
- Histology of primary tumour, including a specimen for review;
- Relevant imaging as defined in the Urology Clinical Guidelines;
- Name of referring clinician and referring MDT;
- Reason for referral;
- Known co-morbidities;
- Views on eligibility for surgery;
- 62 day target date.

The outcome template must include, as a minimum:

- Full description of treatment plan or rationale for endorsement of the referring MDT's recommendation;
- Names of key worker and clinician taking on responsibility for the patient at the surgical centre, if applicable.

Patients referred to the Urology Specialist MDT are considered to be covered by all Cancer Waiting Times targets including the 31 day target (Decision to Treat to start of Second or Subsequent Treatment), and the 62 day target (Consultant Upgrades).

5.4 Urology Specialist MDT

The Urology Specialist MDT shall be hosted by the same Trust that provides the urology surgical service. Leadership of the MDT can and should be drawn from any of the disciplines represented in order to reflect the multidisciplinary nature of this service, particularly taking into account developments in oncology.

It is expected that the Urology Specialist MDT shall be a video-conferenced MDT giving all referring Trusts and clinicians the opportunity to participate fully in the discussion of their patients. A whole team approach to the MDT with input from pathology, oncology and radiology from all referring hospitals is to be encouraged.

If the Urology Specialist MDT decision is to treat the patient at the surgical centre

- a key worker shall be identified for the patient and their name recorded in the patient notes;
- the follow-up team shall be decided based on clinical/geographical need and patient choice, with due regard to the guiding principle outlined in section 2 of this document.

5.5 Clinical Guidelines

The Urology specialist MDT may only operate under guidelines that have been agreed and signed off by the Essex Urology Network Cancer Group and the Clinical Director (Cancer) of East of England Strategic Clinical Network. These guidelines must be reviewed regularly (at least every two years)

5.6 Urology Specialist MDT operational policy

The Urology Specialist MDT shall produce an operational policy for the proposed service which articulates the service vision and guiding principles, describes the high level objectives and clearly sets out the service configuration and operational model which should comply with the National Peer Review Measures for a Urology SMDT.

It is essential that the centre actively engages with the referring Trusts to encourage the embedding of best practice with respect to referrals of patients to the Urology Specialist MDT and their ongoing treatment. The centre should be responsible for auditing best practice across the Network service and reporting the results to commissioners.

The operational model shall demonstrate how communication, joint learning and joint working amongst clinicians across the Network will be achieved (for example, through a programme of visits by the centre's clinicians to other cancer units, or through joint data collection and analysis).

The operational model shall also demonstrate that it has service accessibility for patients at its heart.

The operational policy must include the following:

- Name of Organisation;
- Organisational arrangements for prostate and haematuria clinics;
- Organisational arrangements for MDT working, and for any decisions required outside of the normal MDT meeting times;
- Organisational arrangements for joint oncology clinics;
- Clinical Leadership of the service and how this will develop to ensure appropriate clinical engagement in the patient pathway across the network, ensuring a standardised approach is achieved and maintained;
- Membership of the core MDT*;
- Extended membership of the MDT;
- Clinical expertise available*;
- Clinical facilities available*;
- Referral arrangements into the MDT (including an MDT referral template) and policy for clinical responsibility for patients at different points in their pathway;
- The Model of Care and operation of the MDT and the role of local services in the following:
    - Pre-diagnostics
    - Diagnostics
    - Pre-treatment
    - Treatment
    - Emergency care
    - Follow-up
    - Supportive care
- Communication to referrers and how the MDT will manage whole system relationships, sharing information between all constituent organisations and clinicians in order to manage patients across their care pathway. To include:
    - Key Worker policy
    - SMDT outcomes and treatment planning decisions
    - Emergency cover arrangements*
    - Re-referral arrangements;
- Service User information policy which outlines how patients will be communicated with and provided with informed choice throughout their pathway;
- Service User feedback policy which will describe how patient experience data will be used to improve and develop working practice within the Trust and in the wider Network of care;
- Patient access, transport and accommodation information, ensuring these are considered across the whole Network area;
- Proposed working with the urology network cancer group and other relevant groups;
- Demonstration of how system wide priorities for improvement will be identified and agreed;
- Plans for data collection and audit;
- Evidence of a positive culture of research within the organisation and an assessment of how this is implemented for patient benefit. This should include leadership arrangements for research and the arrangements for promoting access to high quality clinical trials;

- Description of video-conferencing equipment – make, model, year of installation and duration of current maintenance contract.

*where posts need to be appointed to or facilities increased a clear recruitment/development plan needs to be available to meet the implementation date.

5.7 Treatment

The surgical centre shall carry out all complex surgery, including all radical prostatectomies (open and laparoscopic), cystectomies (open and laparoscopic) and partial nephrectomies (open and laparoscopic), on the same site and shall have ITU and HDU facilities on site that support the forecast volume of patients (see section 7.2). A full list of specialist procedures can be found in the national service specification (B/14/S/A).

The provider shall ensure that there is an emergency care specialist surgical service available with 24/7 cover and access to expert opinion for both patients and clinicians. The emergency care pathway shall be defined within both the Network Clinical Guidelines for Urology and the SMDT Operational Policy. The emergency care pathway shall clarify the management responsibilities falling to both specialist and local clinicians in the case of a post-operative emergency, wherever the patient first presents.

The service should have access to the following services, which need not be sited within the surgical centre:

- Brachytherapy
- Cryoablation
- Radiofrequency ablation (RFA)
- Radiotherapy.

It is anticipated that a robotic prostatectomy service will continue to be commissioned from NICE compliant providers undertaking a minimum of 150 procedures per annum. Until this figure can be reached and the surgical minimum numbers maintained for such a service within Essex, the centre is expected to form a sustainable relationship with a compliant provider of robotic services.

The service is expected to demonstrate that it has robust links between the Urology Specialist MDT and the supra-network teams for penile and testicular cancer, to ensure that any care given by the Urology Specialist Centre is under the overall management and under the agreement of the supra-network MDT.

It is anticipated that the service will have the potential to provide a full range of modern technology as NHS England develop their commissioning policies for the treatment of urological cancers. However, these technologies are likely to be the subject of separate national policy and service specification documents and thus remain outside the scope of this service criteria document.

5.8 Service dataset

The service must submit Cancer Services Outcomes Dataset (COSD) data on a regular basis in conformance with the COSD instructions – see https://nww.cancerstats.nhs.uk/users/sign_in

The service must also submit chemotherapy data on a regular basis in conformance with SACT instructions – see http://www.chemodataset.nhs.uk/home – and radiotherapy data in conformance with NATCANSAT instructions – see http://www.rtds.nhs.uk/microsite/rtds/.

The service is also expected to contribute data, where requested, to any relevant national audit such as the National Prostate Cancer Audit.

Responsibilities for upload of data to COSD

The Local MDT is responsible for the initial upload of data.

The treating Trust is responsible for uploading treatment data.

The MDT that finalises the patient's staging data is responsible for uploading that data to COSD. This could therefore be the local MDT for some prostate and bladder patients, but will always be the Specialist MDT for renal patients.

5.9 Key Relationships for the Urology Specialist MDT

Key relationships shall be with all Essex Cancer Network urology MDTs, the Essex Cancer Network Urology Network Cancer Group, and GPs.

The Specialist MDT shall ensure that they have a programme of frequent visits and communications with all referring local urology MDTs.

The Lead Clinician of the Urology Specialist MDT (or their representative) must attend at least two-thirds of the Urology Network Cancer Group meetings.

Referring MDTs, and the patient's GP, must be informed of the decision of the Urology specialist MDT in writing within one working day of the Specialist MDT meeting.

6 Key service outcomes

- All urology cancer patients in Essex having access to the full range of treatments as per NICE Guidelines;
- A single, high volume surgical centre for all Essex Cancer Network patients with prostate, bladder or renal cancer;

- A single Urology Specialist MDT reviewing the diagnostic data and agreeing the treatment plans of all patients with urological cancers meeting the referral criteria;
- An increased expertise within the Urology Specialist MDT members, the surgeons and their supporting teams, generated by the higher number of patients seen and treated, enabling innovation in the treatment of patients with urological cancers;
- The majority of non-surgical care being provided at a location that is as local as possible to the patient.

See Section 8 for the details of service outcomes to be measured.

7 Urology SMDT and surgical activity plan

7.1 Current activity levels within the Essex Cancer Network

Please note that these figures **exclude** West Essex CCG populations as their figures are not yet available. They are provided to allow a comparison between current activity and future predicted activity only.

This data has been collated by Essex Cancer Network from their own records.

Data on brachytherapy and radiotherapy has been provided for contextual purposes only.

		2010/11	2011/12	2012/13	2013/14	2014/15
Prostate Cancers						
	Incidence	**924**	**866**	**930**	**735**	**979**
	Prostatectomy Numbers	**56**	**82**	**119**	**124**	**106**
	Brachytherapy Numbers	*61*	*75*	*118*	*112*	*141*
	Radiotherapy Numbers		*272*	*322*	*377*	*306*
Bladder Cancers						
	Incidence	**>227**	**278**	**312**	**153**	**307**
	Cystectomy Numbers	**66**	**78**	**79**	**53**	**57**
	Radiotherapy Numbers		*31*	*26*	*34*	*26*
Renal Cancers						
	Incidence	**229**	**197**	**189**	**157**	**190**
	Partial Nephrectomies	**23**	**38**	**52**	**35**	**48**
New patients discussed at SMDT		**412**	**472**	**765**	**829**	**981**

7.2 Expected activity levels within the new urology cancer surgical service

These future activity levels are calculated using a set of assumptions outlined in Appendix C.

The prostatectomy figures include those patients who may choose to have a robotic prostatectomy, if offered.

Please note that these figures **include** West Essex CCG populations as Princess Alexandra Hospital have said they are likely to offer patients the choice of the Essex IOG-compliant centre.

Data on brachytherapy and radiotherapy has been provided for contextual purposes only.

		Notes	2016/17	2017/18	2018/19	2019/20	2020/21
Prostate Cancers							
	Incidence		408	1797	1977	2174	2392
	Prostatectomy Numbers	1	41	180	198	217	239
	Brachytherapy Numbers	*1*	*41*	*180*	*198*	*217*	*239*
	Radiotherapy Numbers	*1*	*41*	*180*	*198*	*217*	*239*
Bladder Cancers							
	Incidence		105	463	509	560	616
	Cystectomy Numbers	1	16	69	76	84	92
	Radiotherapy Numbers	*1*	*5*	*23*	*25*	*28*	*31*
Renal Cancers							
	Incidence		87	381	419	461	507
	Partial Nephrectomies	1, 2	19	91	109	129	152
New patients discussed at SMDT		1	224	987	1086	1194	1314

Notes

1 2016 numbers reflect one quarter of the fiscal year prediction, based on service launch in Q4 2016/17

2 These figures include any complex full nephrectomies that may also be carried out at the surgical centre

7.3 Capacity requirements

Current national guidance states that each pelvic surgeon should carry out a minimum of 5 prostatectomies/cystectomies per year. The centre overall should carry out a minimum of 50 such operations per year.

Guidance on behalf of the Department of Health from Frontier Economics 2010 indicates that an optimal Uro-oncology CNS workload is 100 new patients plus 500 in follow-up.

8 Service improvement and outcome measurement

Service improvement shall be driven, as a minimum, by the outcome measures listed in Section 4 of the National Service Specification.

In order to assess the effectiveness of the urology cancer service, the SMDT and the surgical centre, particular emphasis should be placed on:

- COSD staging data completeness at MDT discussion
- Percentage of patients diagnosed at Stages 1 and 2, as this can be an enabler for greater access to surgery
- Percentage of patients with WHO performance status of 0, 1, 2, 3 and 4 at point of SMDT treatment plan decision
- Percentage of patients having
    - Prostatectomy
    - Cystectomy
    - Partial nephrectomy
    - Brachytherapy
    - Radiotherapy as a prostate cancer patient
    - Radiotherapy as a bladder cancer patient
    - No planned cancer treatment – and why.
- 30 day mortality following surgery
- 1 year survival
- 5 year survival

The M&E SCT, the East of England SCN and the Essex Urology NCG will take an active role in reviewing these standards on a regular basis.

A specific report, one year after service implementation, demonstrating the audit of referral and resection rates, mortality and readmission rates is required for local authority health scrutiny purposes.

The service shall be subject to peer review and shall produce a Work Programme, Annual Report and Operational Policy that clearly reflect how the service is being monitored and how recommendations for service improvement are derived.

9 Evidence of Agreement

Version	Agreed By	Date	Comments
Draft 0.4	Essex Urology Information Day Group	08/06/15	Subject to comments raised at the 8th June 2015 meeting being incorporated
Draft 0.5	Shared with Essex Joint Health Oversight Scrutiny Committee	13/07/15	No changes required
Draft 0.5	Financial Directors of each of the 4 Essex Trusts in question	30/07/15	Acknowledged by all four recipients and contact names provided. BTUH had no specific comment or input. SUHFT provided no comment. MEHT provided no comment. CHUFT agreed the document and provided some comments for the evaluation criteria.
Draft 0.6	Essex Senior Oversight Group	26/10/15	Agreed subject to any final comments from Trusts and CCGs being received by 13/11/15. Comments from CHUFT received 12/11/15. An acknowledgement received on 13/11/15 from NHS Thurrock CCG to say that they had no further comments.
Version 1	Published as agreed	26/11/15	

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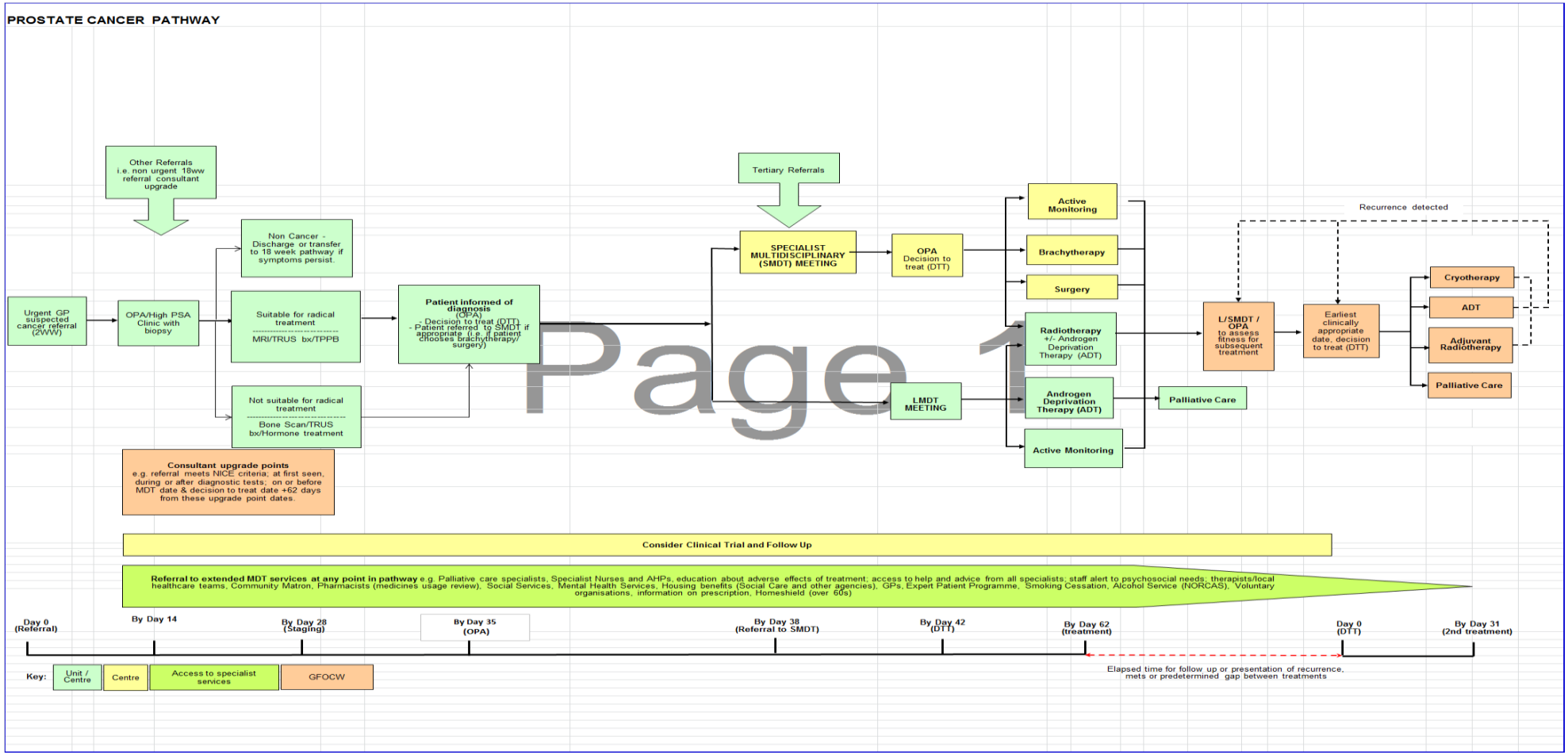
10 Appendices

Appendix A – Patient pathway

Please note that this is the current Network Cancer Group approved pathway for Urology patients in Essex.

There is work being carried out in the latter half of 2015/16 to agree a best practice pathway for prostate cancer patients which may differ slightly from the pathway as represented below.


PROSTATE CANCER PATHWAY
Other Referrals i.e. non urgent 18ww referral consultant upgrade
Tertiary Referrals
Non Cancer - Discharge or transfer to 18 week pathway if symptoms persist.
SPECIALIST MULTIDISCIPLINARY (SMDT) MEETING
OPA Decision to treat (DTT)
Active Monitoring
Brachytherapy
Surgery
Recurrence detected
Urgent GP suspected cancer referral (2WW)
OPA/High PSA Clinic with biopsy
Suitable for radical treatment
MRI/TRUS bx/TPPB
Patient informed of diagnosis (OPA)
- Decision to treat (DTT)
- Patient referred to SMDT if appropriate (i.e. if patient chooses brachytherapy/ surgery)
Radiotherapy +/- Androgen Deprivation Therapy (ADT)
L/SMDT / OPA to assess fitness for subsequent treatment
Earliest clinically appropriate date, decision to treat (DTT)
Cryotherapy
ADT
Adjuvant Radiotherapy
Palliative Care
Not suitable for radical treatment
Bone Scan/TRUS bx/Hormone treatment
LMDT MEETING
Androgen Deprivation Therapy (ADT)
Palliative Care
Active Monitoring
Consultant upgrade points
e.g. referral meets NICE criteria; at first seen, during or after diagnostic tests; on or before MDT date & decision to treat date +62 days from these upgrade point dates.
Consider Clinical Trial and Follow Up
Referral to extended MDT services at any point in pathway e.g. Palliative care specialists, Specialist Nurses and AHPs, education about adverse effects of treatment; access to help and advice from all specialists; staff alert to psychosocial needs; therapists/local healthcare teams, Community Matron, Pharmacists (medicines usage review), Social Services, Mental Health Services, Housing benefits (Social Care and other agencies), GPs, Expert Patient Programme, Smoking Cessation, Alcohol Service (NORCAS), Voluntary organisations, information on prescription, Homeshield (over 60s)
Day 0 (Referral)
By Day 14
By Day 28 (Staging)
By Day 35 (OPA)
By Day 38 (Referral to SMDT)
By Day 42 (DTT)
By Day 62 (treatment)
Day 0 (DTT)
By Day 31 (2nd treatment)
Key:
Unit / Centre
Centre
Access to specialist services
GFOCW
Elapsed time for follow up or presentation of recurrence, mets or predetermined gap between treatments

Appendix B - Guidelines for Governance and Communication between Local and Specialist Multi-Disciplinary Teams

Document available separately

Appendix C – Activity Level Forecasting

Assumptions

1. Calculations will be based on incidence figures of urological cancer in Essex provided by Public Health England.
2. An annual rate of increase of incidence of 10% will be used – as endorsed by Ref 1. This is much higher than actual incidence rates over the period of Q4 2008/9 to Q3 2013/14, so should be going some way to cater for age and population growth impacts as well.
3. Incidence numbers will be split prostate (66%), bladder (17%) and renal (14%), based on NCIN Urology Hub figures for 2010-2012 which are in alignment with evidence from Ref 2 (of a 66%/17%/17% split) and endorsed by Ref 1. [The remaining 3% of incidence from the NCIN Urology Hub figures is for testicular cancer incidence.]
4. Numbers of patients estimated to have radical treatment plans agreed will be calculated as 30% of prostate incidence, 20% bladder incidence, and 75% renal patients – based on Ref 2 but with prostate figures amended by input from Essex clinicians on 08/06/15.
5. For prostate cancer radical treatments to be managed by the Specialist MDT with surgery at the specialist surgical centre, the expected split between surgery, brachytherapy and radiotherapy is calculated as one third to each (Ref 1).
6. For bladder cancer radical treatments to be managed by the Specialist MDT with surgery at the specialist surgical centre, the expected split between surgery and radiotherapy is 75:25 based on the opinion of Essex clinicians on 08/06/15. Both of these can be with or without neo-adjuvant chemotherapy. Only those with metastases are likely to have chemotherapy alone.
7. For renal cancer, the proportion of patients expected to have surgical treatment carried out at the specialist surgical centre is approximately 20% of all renal cancer patients (Ref 3), rising to 30% at the end of the next 5 years, as agreed by Essex clinicians on 08/06/15. This number should reflect all partial nephrectomies plus full nephrectomies for patients with an advanced stage of the disease.
8. To estimate activity levels for **new prostate and renal cancer patients** to be discussed at SMDT, the assumption is that this will equate to all prostate and renal cancer patients being considered for specialist radical treatment (surgery/radiotherapy/brachytherapy as appropriate).
9. To estimate activity levels for **new bladder cancer patients** to be discussed at SMDT (muscle-invasive and high-risk superficial non-muscle invasive cancers), Ref 4 refers to 20%-25% of bladder cancer patients having muscle-invasive cancers. This

needs to be increased by 10%-20% for the high risk superficial non-muscle invasive cancers (figure endorsed by Ref 2). Hence a figure of 35% of bladder cancer incidence will be used.

References

Ref 1: Mr Vijay Sangar, Chair of the Specialised Urology Clinical Reference Group (meetings and e-mails, 2015)
Ref 2: London Cancer Case for Change (2011/12) – which is about the situation and the patient numbers in their locality of North and East London and West Essex
Ref 3: Improving Outcomes Guidance for Urological Cancers (2002)
Ref 4: Bladder Cancer: Diagnosis and Management NICE Guidelines (February 2015)

Specialised Urological Cancer Surgery Services in Essex

Itinerary for visit of the Expert Review Panel (ERP)
Monday 13th and Tuesday 14th June 2016.

Monday 13th June 3pm-5pm

Panel meeting at the Southend CCG offices.
The purpose of this meeting is to discuss the proposals, go through any specific questions and key lines of enquiry you may wish to discuss with the providers and appoint a Chair for the panel.

CCG Address: Belfairs Suite, Harcourt House, 5-15 Harcourt Avenue, Southend-on-Sea, Essex, SS2 6HT.

The CCG offices are 10 minutes' walk from Southend Victoria Station, note that trains from Liverpool St come into Southend Victoria.
For those coming by car, please note that there is no parking at the CCG so you will need to use public car parks nearby.

Southend Airport Premier Inn has been booked for overnight accommodation on the night of the 13th June.
Address: Premier Inn, Southend Airport, Thanet Grange, Princes Avenue, Southend on Sea SS2 6GB
Cars will be available to take panel members from the CCG to the Premier Inn after our meeting.

7.30pm dinner at the Premier Inn Restaurant.

Tuesday 14th June
7.30am – 830 am breakfast at the Premier Inn
8.45am checkout and leave for Southend Hospital

9.30am-12.30pm Southend University Hospital
2 hour meeting with team and 1 hour private panel meeting
Address: Prittlewell Chase, Westcliff-on-Sea,SS0 0RY.

Cars will be available to take panel members from Southend to Colchester

2pm-5pm Colchester Hospital University NHS Foundation Trust
2 hour meeting with team and 1 hour private meeting
Address:Turner Road, Colchester, CO4 5JL

Cars will be available to take panel members to Colchester Station after our meeting.

ESSEX SPECIALISED UROLOGY SERVICE REVIEW 14 06 2016

SUHFT ATTENDANCE AT MEETING

NAME	ROLE
SUE HARDY	CEO
JON FINDLAY	COO AND DEPUTY CEO
SAMPI MEHTA	CLINICAL LEAD AND CONSULTANT UROLOGIST
RICHARD LODGE	CONSULTANT UROLOGIST
PETE ACHER	CONSULTANT UROLOGIST
PETER PIETRZAK	CONSULTANT UROLOGIST
BEN DAWAM	CONSULTANT UROLOGIST
PANOS DIMOPOULOS	CONSULTANT UROLOGIST
MIKE SALTER	CLINICAL DIRECTOR OF SURGERY AND VASCULAR CONSULTANT
JANE MULREANY	ASSOCIATE DIRECTOR OF SURGERY
REBECCA BOYES	HEAD OF NURSING FOR SURGERY
JULIE OFFORD	GENERAL MANAGER
ANN FRENCH	ONCOLOGY CLINICAL NURSE SPECIALIST
KUMAR NAIR	UROLOGY WARD MANAGER
MAY CABER	UROLOGY OUTPATIENT SISTER
ADRIAN BUGGLE	ASSOCIATE DIRECTOR OF FINANCE
IMTIAZ AHMED	ONCOLOGY CONSULTANT
DR LIYANAGE	RADIOLOGIST
DR VENU	RADIOLOGIST
ROGER BASSETT	PATIENT REPRESENTATIVE

ESSEX SPECIALISED UROLOGY SERVICE REVIEW 14 06 2016

CHUFT ATTENDANCE AT MEETING

Name	**Position**
Nick Hulme	Chief Executive
Dr Angela Tillet	Medical Director
John Corr	Consultant Urologist FRCS, Cancer Lead
Sam Datta	Consultant Urologist FRCS, PgCME, Education & Training Lead
Prof. Bruce Sizer	Consultant Oncologist
Sean Whatling	Associate Director of Capacity Planning
Melanie Newnham	Deputy Service Manager
Maurice Newbolt	Pt Representative
Lucy Powell	Clinical Nurse Specialist
Gautam Banerjee	Head of Service, Urology, Ipswich Hospital Trust

Specialised Urology Service
Provider Evaluation Criteria

This document should be read in conjunction with the Urology Service Criteria (Prostate, Bladder, Renal) and the NHS England national Service Specification B14/S/a: Specialised kidney, bladder and prostate cancer services.

Information provided in this document will be used to assess the providers ability to meet the requirements of the specialised urology service, as detailed in the above documents.

The submitted service proposals will be assessed by an independent review panel.

Weighting

1. **Clinical Service and Quality (35%)**
2. **Workforce (15%)**
3. **Patient Access and Experience (20%)**
4. **Deliverability and Implementation (15%)**
5. **Service development (10%)**
6. **Finance (5%)**

1. Clinical Service and Quality (35%)

1.1 Specialist Multi-Disciplinary Team service model

Describe how you will ensure that the service will fully comply with requirements of the SMDT service model set out in the specification.

Your submission should include but not be limited to the following:

- How you will deliver a Specialist Multidisciplinary Team (SDMT) for kidney, bladder and prostate cancers and provide associated specialist care.
- How you will ensure your SMDT complies with all measures within the Manual for Cancer Services: Urology Measures, Version 1 and all subsequent versions.
- Details of how you will ensure that all specialist care and treatment is delivered under the care of a core member of the SMDT
- How you will ensure close collaborative working between SMDT members with particular reference to non-surgical oncology care and treatment.

1.2 Specialist Multi-Disciplinary Team service meeting

Describe how you will ensure that the SMDT has sufficient capability and capacity to perform its role.

Your submission should include but not be limited to the following:

- Given that this will be an SMDT covering kidney, bladder and prostate cancer, how you will ensure that sufficient time is allocated to discuss each case that meets criteria for referral.
- How you will ensure effective inclusion of all SMDT members in multi-disciplinary team decision making
- How you will ensure sufficient time and resource is available to SMDT members attending the MDT meeting.
- Confirm the full membership of the Specialist MDT.

1.3 Single service

Describe how you will deliver a single, integrated service to ensure equal access to high quality care for the population of Essex.

For a single SMDT serving the **whole population** in the specified geographical area your submission should include the following:

- Details of how a single referral point will be administered across the population of

Essex to ensure that where appropriate;

- cases are allocated dependent on clinical need
- referrals are managed by the clinical lead for the service
- equity is maintained for all patients

- How you will manage risk associated with variation in demand and ensure capacity is available to maintain relevant standards
- Your approach to organisational development in order to ensure a fully functioning team
- How you will ensure good communication between partners in the pathway e.g. for patients presenting at local A&E undergoing treatment at the cancer centre

1.4 Research and access to clinical trials

Describe your vision and approach to audit, research and access to clinical trials.

Your submission should include but not be limited to the following:

- Your approach to clinical trial recruitment and research
- Details of systems that will be in place to ensure that all patients who are referred to the SMDT are considered for entry in to a clinical trial and how they are supported to make an informed choice
- How you will collaborate with other organisations and agencies to maximise benefits of research and development.

1.5 Audit

Describe how you will assess and demonstrate continuous service improvement through audit.

Your submission should include but not be limited to the following:

- How the SMDT will ensure a single audit programme and clinical data collection process for the population of Essex
- How the SMDT(s) will ensure that audit results are used to improve outcomes of care and treatment.
- Details of how you will ensure prospective data capture and audit, including submission to national clinical audit programmes
- Details of your planned administrative arrangements for the service to ensure that recording of information is achieved to the specific standards outlined in the following standards:
    - Cancer Outcomes and Services Dataset (COSD)
    - Specialist Palliative Care Minimum Dataset
    - NHS Standard Contract reporting requirements
    - British Association of Urological Surgeons Dataset (BAUS)
    - Patient Reported Outcome Measures (PROMS)

1.6 Administration of the service

Indicate how you will ensure consistent delivery of service standards in relation to non-clinical services.

Your submission should include but not be limited to the following:

- How you will ensure that patients who meet criteria for onward referral will be referred in line with the agreed clinical pathway (this includes GP, local MDT, internal referrals and referrals on to the Supra network)
- How you will ensure that sufficient administrative resource is provided to support the service
- Details of how you will ensure delivery of cancer waiting time standards for all urology cancer patients as identified in 3.1 of NHS England's national service specification *B14/S/a: Specialised kidney, bladder and prostate cancer services.*

1.7 Management of emergency patients

Demonstrate how your service will support management of patients who present through an emergency route either at the specialist provider or local hospital.

Your submission should include but not be limited to the following:

- Details of how all surgeons will manage post op complications and contribute to the out of hours emergency urological on-call rota for the centre and as part of the single service for Essex
- How you will support patients who present as an emergency, wherever they present, including decision making and communication alert systems
- How you will ensure patients who present as emergencies have access to a clinical nurse specialist.

1.8 Treatment

Describe how the service will ensure that all patients who meet criteria for specialist treatment receive appropriate access.

Your submission should include but not be limited to the following:

- How you will ensure that all patients have access to joint consultation with the surgeon, oncologist and clinical nurse specialist to discuss treatment options
- Details of how you will ensure that the SMDT offers equal access for all patients to novel techniques within nationally agreed guidelines and delivered under the care of core members of the SMDT. This includes brachytherapy, robotic surgery, radio-frequency ablation and cryotherapy
- How you will ensure patients are managed as part of enhanced recovery pathways
- Please describe your intentions to provide access to robotic-assisted surgery (RAS) as part of the prostate pathway in line with the NHS England Clinical Commissioning Policy.

  Note: It is anticipated that we will commission a robotic prostatectomy service from a NICE compliant provider undertaking a minimum of 150 procedures per annum. Until this figure can be reached and the surgical minimum numbers maintained the centre is expected to form a sustainable relationship with a compliant provider of robotic services. Please describe interim operational arrangements to ensure that patients continue to have access to this technique.If access to RAS is from another centre provider, please set out the intended pathway.

1.9 Infrastructure

Describe how the service will meet infrastructure requirements set out in the specification.

Your submission should include but not be limited to the following:

- How your organisation will ensure that inpatients are cared for in an environment appropriate to their needs, which in most cases will be a designated urology ward area where the staff are experienced in the care of patients undergoing resectional surgery for urological cancer
- How you will ensure that all elective urological cancer surgery is supported by experienced theatre teams and anaesthetists.
- How you will ensure that sufficient critical care capacity will be available to manage this patient group
- Confirmation that all patients have access to on site critical care (level 3) beds

1.10 Interdependencies with other services

Indicate how the following services will be accessed by the SMDT:

- Named ward for the care of post-operative patients with appropriately trained staff
- Renal haemofiltration facility
- Arrangements for surgery to be undertaken in centres co-located with vascular and cardiothoracic surgery where appropriate, for example renal cancer cases with thrombus in the vena cava and/or heart
- In emergency situations, that the host hospital has access to relevant surgical expertise within 30 minutes, for example colorectal expertise.

1.11 Integration and communication
Describe how you will work in partnership with other providers to ensure delivery of an integrated, multi-disciplinary service. **The guiding principle here is that patients are cared for by healthcare professionals across the network collaborating throughout the care pathway, with as many elements as possible of that care pathway being delivered locally to the patient. By default, only surgery and immediate follow up should occur at the centre.** Your submission should include but not be limited to the following: • Details of your approach to working in co-operation with other NHS hospital trusts within the geographical boundary detailed in the specification which will continue to provide diagnostic/non-specialist care to their local population in line with existing arrangements • How you will ensure integration with health and social care providers local to the patient to help optimise any care delivered locally. • How you will manage patients in need of prolonged hospitalisation once specialist surgical care is no longer required • How you will ensure good governance and communication with primary care, referring teams, other specialist providers and with patients, including arrangements for transfer of clinical responsibility. This should include arrangements for patients who for clinical reasons are transferred to another site e.g. for cardiothoracic support. • Details of your approach to the multi-disciplinary care of patients and ensure effective integration with therapeutic disciplines. This should include how you propose to work in co-operation with the provider of radiotherapy and chemotherapy in line with existing agreed pathways.

2. Workforce (15%)

2.1 Access to specialist workforce

Describe how you will ensure provision of a specialist workforce as set out in the specification at point of mobilisation.

Your submission should include but not be limited to the following:

- Details of staffing arrangements that ensure provision of a specialist team workforce providing 24/7 continuity and sustainability of specialist care and why you believe this to be the optimal arrangement/number including specialist urological oncologists supported by middle grade cover.
- How you will demonstrate and maintain sufficient workload for each individual surgeon to maintain expertise, allow sub-specialisation and comply with national standards as a minimum.
- Details of how you will ensure that expertise is maintained within the Essex service so that patients have access to appropriate skills and experience, including management of recognised complications of elective and emergency urological surgery.
- How you will ensure sufficient management resource is provided to support the service.

2.2 Staffing structure

Submit a detailed staffing structure indicating professional group, roles, equivalent NHS grades, accountability, WTE numbers and reporting lines for both clinical and non-clinical staff. You must clearly identify which posts are to be recruited to. Please provide an operational management organisational structure chart in order to demonstrate the key operational management roles, supervision arrangements and responsibilities, reporting relationship and accountabilities.

2.3 Staff training

Provide details of how you will ensure all staff are adequately trained and competent to provide the service to a high standard. Where staff are yet to be appointed bidders need to demonstrate their processes and any previous successes of appointments to similar roles and training.

Your submission should include but not be limited to the following:

- What arrangements the organisation has in place for statutory and mandatory training, including role specific statutory and mandatory training.
- Details of how staff can access clinical supervision including the provision of a clinical supervision policy.

- Details of the organisation's learning and development policy.
- Details of how you as the centre will keep all network clinicians up to date with service developments.

2.4 Contingency arrangements

Describe, for all Clinical Staff, your proposed contingency arrangements to cover for planned and unplanned increases in workload and/or Staff absences.

2.5 Continuing professional development

Describe how you will manage and ensure that all clinical staff, including doctors, nurses and allied health professionals, meet the Continuing Professional Development (CPD) requirements of their professional and regulatory bodies.

Your submission should include but not be limited to the following:

- Details of the arrangements in place and a relevant CPD policy

3. Patient Access and Experience (20%)

3.1 Patient centred care

Please outline your proposals for ensuring patient access and support within the service.

Your submission should include but not be limited to the following:

- How you will ensure that all patients have access to an appropriately trained clinical nurse specialist and key worker to co-ordinate care and ensure continuity throughout their pathway
- How you will ensure that holistic needs assessment is undertaken and recorded at key points and that there are clear pathways to supportive care, primary care and specialist palliative care services.
- How you will ensure clear pathways are in place for sharing care plans with other care providers
- How effective communication will be maintained with patients at all stages of the pathway including care plans and end of treatment summaries
- How you will ensure the effective and efficient management of inter-trust transfers with regard to the patient's key worker.

3.2 Patient facilities and environment

Provide details of facilities and patient environment.

Your submission should include but not be limited to the following:

- How you will ensure that quiet areas are available in clinics and on or near ward areas where patients and relatives can receive significant news
- Details of facilities such as overnight accommodation for carers and relatives of patients travelling significant distances to the centre. Where charges are levied for such facilities, these should reflect a fair and affordable contribution to the cost of provision.

3.3 Follow-up and survivorship

Provide details of your approach to patient-centred care following treatment that promotes quality of life.

Your submission should include but not be limited to the following:

- How you will support patients living with and beyond cancer and your approach to patient centred follow-up in line with the National Cancer Survivorship Initiative.
- Details of patient access to support services such as erectile dysfunction, stoma and continence services
- How you will ensure treatment summaries are available to patients and care providers
- How you will involve oncology and other relevant services in the co-ordination of follow up post treatment.

3.4 Patient information

Describe how you will ensure information is available to patients according to their need.

Your submission should include but not be limited to the following:

- How you will offer patients information on all aspects of their clinical and non-clinical care and treatment, including resources other than written material
- How you will meet specific needs of patients including those with hearing loss, visual impairment, learning disabilities or who require communication aids and interpretation services

3.5 Patient engagement

Describe how you will ensure patient and carer engagement in the planning, involvement development and delivery of the service.

Your submission should include but not be limited to the following:

- Details of your proposals for service user, carer and public involvement in the planning and development of the service such as through surveys, focus groups and patient representatives
- Details of action plans to address the outcome of the National Cancer Patient Survey for urology and prostate services
- How you will obtain feedback on patients' experience across multiple organisations i.e. the whole pathway, ensure mechanisms are in place to resolve issues and continuously improve the patient's experience.

3.6 Accessible and responsive care

The SMDT will be required to provide specialist care and treatment across a large geographical area. You must describe how you will ensure the service is accessible and responsive to patient need.

Your submission should include but not be limited to the following:

- Details of how the SMDT will provide care as close to home as possible, including a surgical and non-surgical oncology outreach service in the patient's locality.
- Details of how the service will maximise ease of access for patients before and after surgery (for example, investigations required by the SMDT such as radiological imaging should be performed at the patient's local hospital to agreed protocols wherever possible).
- How you will ensure decisions are guided by patient choice
- Commissioners accept that patients may have to travel more than 60 minutes for specialist surgery however bidders must demonstrate how they will ensure that other services such as outpatient care are accessible and avoid the need to travel.

3.7 Equality: Practical

Briefly describe how you will deliver your service that is respectful and understands the needs of your patients by protected characteristics on the following issues:

Protected characteristics	1) Communication, information & accessibility	2) Sense of value and acceptance
Age		
Disability		

Gender reassignment		
Single/ Marriage /civil partnership		
Pregnancy & maternity		
Race		
Religion & belief		
Sex (M/F)		
Sexual orientation		
Other groups who face disadvantage and prejudice: Carers Homelessness Substance abuse Offenders Bodily weight control issues		

3.8 Equality: Compliance
Please give evidence of the following: • An Understanding of demographic demand for this service • How will you monitor satisfaction levels of your service across protected characteristics • How will you use this information to develop service provision

4. Deliverability and Implementation (15%)

4.1 Deliverability and implementation
Describe how you intend to deliver and implement the service for the duration of the contract. Your submission should include but not be limited to the following: • How you will guarantee consistent delivery of national cancer waiting times, and how the risks of delivery will be mitigated. Responses should include reference to the management of risks associated with inter-trust transfers. • You must provide a capacity plan that describes a detailed outline of clinic, bed, theatre and critical care provision and clearly reference both existing and planned new provision. • Details of your approach and assurance that sufficient organisation resource will be available to ensure service continuity for the duration of the contract, including any new service developments that are either within the specification or proposed within the bid provided. This should include managerial and administrative support.

4.2 Implementation plan

Please provide details of your implementation plan to demonstrate your capability and capacity to manage the transition process required to implement the new service in line with stated timelines.

The plan should include the following detail:

- Mobilisation/Transition plan: this plan should detail the key tasks and milestones the Service Provider will complete during the period up to service commencement date in order to deliver the service in accordance with the service specification requirements and contract and to achieve required performance targets.
- Operational plan: this plan should detail the key tasks and milestones that the Service Provider will complete to ensure continued delivery of a safe and effective service and achievement of performance targets.

The a brief outline of any issues from the list below should be included:

- Clinical (including CQC registration)
- IM&T
- Contracting
- Data capture and Reporting
- Operational delivery
- Communications including engagement with patients
- Service development and training
- Statutory Compliance (e.g. DPA, CQC)
- The plan must identify the resources within your organisation that will be responsible for governance and implementation
- Please explain what you consider will be critical to the successful implementation of this service and what are the critical components of your proposed service mobilisation plan and how do you propose to mitigate any risks?

4.3 Transfer of undertakings (TUPE)
Describe how you propose to deal with your responsibilities in respect of “TUPE” staff transfers (if applicable) and maintaining the principles of the Employment Act 2008. Describe how you will manage staff transition from TUPE transfer (if applicable) into the new organisation to the new structures identified.

5. Service Development (10%)

5.1 Service development
Describe how you will develop services in line with NHS England's service specification and the developing strategic direction and requirements for specialised services for the duration of the contract.

5.2 Response to service demand
Describe how you will respond to long term capacity requirements in terms of both facilities and workforce in line with anticipated trends in demand and increasing provision of services in alternative settings i.e. community settings.

5.3 Population
Please indicate the geographic area that relates to your submission, by Clinical Commissioning Group (CCG) and the anticipated activity associated with this population.
CCG List and anticipated activity

6. Finance (5%)

6.1 Cost of the service
Please detail your projected annual activity and charges for all elements of the service. We would expect your answer to clearly show how you will deliver these services in line with current national and local prices.

6.2 Compliance with national requirements on currencies and prices
Please confirm your acceptance that any activity recorded or charged for within the service will be compliant with national guidance as required by the General Conditions, Service Conditions and mandatory elements of the Particulars of the national NHS 2015/16 contract and any changes to the contract in subsequent years. This includes SC28 Information Requirements and SC36.3 Prices.

6.3 Use of Local prices
Please confirm your approach to the payment of activity under local prices, including critical care beds.

6.4 CEO/CCG Sign off
Please provide separate written evidence of executive sign off from: The Chief Executive Officer confirming support of this proposal and commitment to the provision of the future service. and The host CCG Accountable Officer confirming support for the proposal to provide an Essex wide service.
• CEO sign off • CCG sign off
Bidders Response Please include two letters of support as above.

6.5 Provider impact statement (if applicable)
Providers are expected to work with their local commissioners and produce an impact statement alerting the assessment panel of any negative impact on remaining services as a result of **not** providing the specialist urology service, or the effect on your current service as the result of any potential collaborative bid. This statement can be a consideration of any impact of the service reconfiguration on the current workforce and activity on you as a provider. • Please provide a written assessment of the impact on the organisation of the loss off or change in provider of the specialised surgical urology service

Appendix 8 – Panel Score SUHFT

Weighting

Clinical Service & Quality	35%
Workforce	15%
Patients Access & Experience	20%
Deliverability & Implementation	15%
Service Development	10%
Finance	5%

Panel Score %

1	2	3	4	5	Average
26%	34.5%	29%	33.25%	31%	30.75%
Not scored	15%	11%	15%	12%	13.6%
19.2%	20%	17%	19.6%	16%	18.36%
Not scored	15%	13%	15%	13%	14.2%
Not scored	8.3%	10%	10%	10%	9.66%
5%	5%	5%	5%	5%	5%
50.2%	97.8%	85%	97.85%	87%	83.57%

1.1 Specialist Multi-Disciplinary Team Service Model

Describe how you will ensure that the service will fully comply with requirements of the SMDT service model set out in the specification.

1 How will you deliver a Specialist Multidisciplinary Team (SMDT) for kidney, bladder and prostate cancers and provide associated specialist care?
2 How will you ensure your SMDT complies with all measures within the Manual for Cancer Services: Urology Measures, version 1 and all subsequent care?
3 Details of how you will ensure that all specialist care and treatment is delivered under the care of a core member of the SMDT
4 How will you ensure close collaborative working between SMDT members with particular reference to non-surgical oncology care and treatment?

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	4	Total	4	Total	4	Total	4	Total	3

Comments

- Presented a compliant inclusive outreach model recognising the full infrastructure of Essex, current staff across all providers and the need to utilise efficiency

1.2 Specialist Multi-Disciplinary Team Service Meeting

Describe how you will ensure that the SMDT has sufficient capability and capacity to perform its role

1. Given that this will be an SMDT covering kidney, bladder and prostate cancer, how you will ensure that sufficient time is allocated to discuss each case that meets criteria for referral?
2. How will you ensure effective inclusion of all SMDT members in multi-disciplinary team decision making?
3. How will you ensure sufficient time and resource is available to SMDT members attending the MDT meeting?
4. Confirm the full membership of the Specialist MDT

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	4	Total	3.5	Total	3	Total	4	Total	4

Comments

- An inclusive model incorporating all specialities recognised the need for more time in the sMDT but perhaps underestimated it. However, the Team come across as very open and supportive of each other and recognise the need to be fluid
- An improved plan to ensure adequate timing for sMDT required

1.3 Single Service

Describe how you will deliver a single, integrated service to ensure equal access to high quality care for the population of Essex.
For a single SMDT serving the whole population in the specified geographical area your submission should include the following:

1. Details of how a single referral point will be administered across the population of Essex to ensure that where appropriate:
    a. Cases are allocated dependent on clinical need
    b. Referrals are managed by the clinical lead for the service
    c. Equity is maintained for all patients
2. How will you manage risk associated with variation in demand and ensure capacity is available to maintain relevant standards
3. Your approach to organisational development in order to ensure a fully functioning team
4. How you will ensure good communication between partners in the pathway e.g. for patients presenting at local A&E undergoing treatment at the cancer centre

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	2	Total	4	Total	3	Total	3	Total	3

Comments

- They provided an excellent model utilising the same electronic record across all sites, the need to utilise other sites for non-cancer work to mitigate risks of waiting times
- The communication pathways for emergency care would need to be more precisely structures particularly with respect to ‘treat and transfer’ arrangements.

1.4 Research and access to clinical trials

Describe your vision and approach to audit, research and access to clinical trials.

1. Your approach to clinical trial recruitment and research
2. Details of systems that will be in place to ensure that all patients who are referred to the SMDT are considered for entry in to a clinical trial and how they are supported to make an informed choice
3. How you will collaborate with other organisations and agencies to maximise benefits of research and development

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	3	Total	3	Total	2	Total	3	Total	3

Comments

- Provided an evidence of collaboration plans for research and development to support bullet point 3

1.5 Audit

Describe how you will assess and demonstrate continuous service improvement through audit.

1. How the SMDT will ensure a single audit programme and clinical data collection process for the population of Essex
2. How the SMDT(s) will ensure that audit results are used to improve outcomes of care and treatment
3. Details of how you will ensure prospective data capture and audit, including submission to national clinical audit programmes
4. Details of your planned administrative arrangements for the service to ensure that recording of information is achieved to the specific standards outlined in the following standards:
    a. Cancer outcomes and services dataset (COSD)
    b. Specialist Palliative Care Minimum Dataset
    c. NHS Standard Contract reporting requirements
    d. British Association of Urological Surgeons Dataset (BAUS)
    e. Patient reported Outcome Measures (PROMS)

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	3	Total	4	Total	3	Total	4	Total	4

Comments

- Further outline clear mechanisms to support the contribution to national data sets- some rely on manual entry and then summary data checking from what is recorded for the institution

1.6 Administration of the service

Indicate how you will ensure consistent deliver of service standards in relation to non-clinical services.

1. How you will ensure that patients who meet criteria for onward referral will be referred in line with the agreed clinical pathway (this includes GP, local MDT, internal referrals and referrals on to the Supra network)
2. How you will ensure that sufficient administrative resources is provided to support the service
3. Details of how you will ensure delivery of cancer waiting time standards for all urology cancer patients as identified in 3.1 of NHS England's national service specification *B14/S/a: Specialised kidney, bladder and prostate cancer services*

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	1.5	Total	3	Total	2	Total	3	Total	3

Comments

- Demonstration of mechanisms ensuring LMDT patient requiring SMDT discussion are referred by all partners within Essex

1.7 Management of Emergency Patients

Demonstrate how your service will support management of patients who present through an emergency route either at the specialist provider or local hospital.

Details of how all surgeons will manage post op complications and contribute to the out of hours emergency urological on-call rota for the centre and as part of the single service for Essex

1. How you will support patients who present as an emergency, wherever they present, including decision making and communication alert systems
2. How you will ensure patients who present as emergencies have access to a clinical nurse specialist

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	2	Total	3	Total	3	Total	2	Total	3

Comments

- Communication pathways for emergency care would need to be more precisely structured particularly with respect to 'treat and transfer' arrangements.

1.8 Treatment

Describe how the service will ensure that all patients who meet criteria for specialist treatment receive appropriate access.

1. How you will ensure that all patients have access to joint consultation with the surgeon, oncologist and clinical nurse specialist to discuss treatment options.

2. Details of how you will ensure that the SMDT offers equal access for all patients to novel techniques within nationally agreed guidelines and delivered under the care of core members of the SMDT. This includes brachytherapy, robotic surgery, radio-frequency ablation and cryotherapy.
3. How you will ensure patients are manages as part of enhances recovery pathways
4. Please describe your intentions to provide access to robotic-assisted surgery (RAS) as part of the prostate pathway in line with the NHS England Clinical Commissioning Policy

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	2.5	Total	4	Total	4	Total	4	Total	4

Comments

- The team can see how to utilise ALL the resource available to deliver a service that will likely be beyond current requirements.

1.9 Infrastructure

Describe how the service will meet infrastructure requirements set out in the specification.

1. How your organisation will ensure that inpatients are cared for in an environment appropriate to their needs, which in most cases will be a designated urology ward area where staff are experienced in the care of patients undergoing resectional surgery for urological cancer.
2. How you will ensure that all elective urological cancer surgery is supported by experienced theatre teams and anaesthetists
3. How you will ensure that sufficient critical care capacity will be available to manage this patient group
4. Confirmation that all patients have access to on site critical care (level 3) beds

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	4	Total	4	Total	4	Total	4	Total	3

Comments

- The use of Level I HDU needs clarification
- The team can see how to utilise all the resources available to deliver a service that will likely be beyond current requirements

1.10 Interdependencies with other services

Indicate how the following services will be accessed by the SMDT:

1. Named ward for the care of post-operative patients with appropriately trained staff
2. Renal haemofiltration facility
3. Arrangements for surgery to be undertaken in centres, co-located with vascular and cardiothoracic surgery where

appropriate, for example renal cancer cases with thrombus in the in the vena caca and /or heart

4. In emergency situations, that the host hospital has access to relevant surgical expertise within 30 minutes, e.g colorectal expertise

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	3	Total	4	Total	4	Total	4	Total	4

Comments

- Collocated with gynae oncology and pelvic cancer team support.

1.11 Integration and communication

Describe how you will work in partnership with other providers to ensure delivery of an integrated, multi-disciplinary service.

1. Details of your approach to working in co-operation with other NHS hospital trusts within the geographical boundary detailed in the specification which will continue to provide diagnostic / non-specialist care to their local population in line with existing arrangements
2. How you will ensure integration with health and social care providers local to the patient to help optimise any care delivered locally
3. How you will manage patients in need of prolonged hospitalisation once specialist care is no longer required
4. How you will ensure good governance and communication with primary care, referring teams, other specialist providers and with patients, including arrangements for transfer of clinical responsibility. This should include arrangements for patients who for clinical reasons are transferred to another site e.g. for cardiothoracic support.
5. Details of your approach to the multi-disciplinary care of patients and ensure effective integration with therapeutic disciplines. This should include how you propose to work in c-operation with the provider of radiotherapy and chemotherapy in line with existing agreed pathways.

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	2	Total	5	Total	3	Total	5	Total	5

Comments

- Increased consideration of transfer to a more local hospital for patients requiring prolonged hospitalisation once specialist care is no longer required
- Greater details of interactions with diagnostic and non-specialist care teams

2.1 Access to specialist workforce

Describe how you will ensure provision of a specialist workforce as set out in the specification at point of mobilisations.

1. Details of staffing arrangements that ensure provision of a specialist team workforce providing 24/7 continuity and sustainability of specialist care and why you believe this to be the optimal arrangement / number including specialist urological oncologists supported by middle grade cover.
2. How you will demonstrate and maintain sufficient workload for each individual surgeon to maintain expertise, allow sub-specialisation and comply with national standards as a minimum
3. Details of how you will ensure that expertise is maintained within the Essex services so that patients have access to appropriate skills and expertise, including management of recognised complications of elective and emergency urological surgery.
4. How you will ensure sufficient management resource is provided to support the service

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	-	Total	4	Total	2	Total	4	Total	4

Comments

- The teams shows clear evidence of ability to take the urology service beyond the current IOG
- More precise details regarding out of hours cover accommodating subspecialisation and incorporation of additional surgeons currently working elsewhere

2.2 Staffing Structure

Submit a detailed staffing structure indicating professional group, roles, equivalent NHS grades, accountability, WTE numbers and reporting lines for both clinical and non-clinical staff. You must clearly identify which posts are to be recruited to. Please provide an operational management organisational structure chart in order t demonstrate the key operational management roles, supervision arrangements and responsibilities, reporting relationship and accountabilities.

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	-	Total	1	Total	1	Total	1	Total	1

Comments

- Needs more details of interactions with diagnostic and non-specialist care teams.

2.3 Staff Training

Provide details of how you will ensure all staff are adequately trained and competent to provide the service to a high standards.

Where staff are yet to be appointed bidders need to demonstrate their processes and any previous successes of appointments to similar roles and training.

1. What arrangement the organisation has in place for statutory and mandatory training, including role specific statutory and mandatory training
2. Details of how staff can access clinical supervision including the provision of a clinical supervision policy
3. Details of the organisation's learning and development policy
4. Details of how you as the centre will keep all network clinicians up to date with service developments

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	-	Total	4	Total	3	Total	4	Total	3

Comments

- Greater detail on how the broader organisational arrangements for these points meet the needs of a specialist cancer centre

2.4 Contingency Arrangements

Describe, for all clinical staff, your proposal contingency arrangements to cover for planned and unplanned increases in workload and / or staff absences.

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	-	Total	1	Total	1	Total	1	Total	0

Comments

- Needs more precise details regarding out of hours cover accommodating subspecialisation and incorporation of additional surgeons currently working elsewhere

2.5 Continuing professional development

Describe how you will manage and ensure that all clinical staff, including doctors, nurses and allied health professionals, meet the Continuing Professional Development (CPD) requirement of their professional and regulatory bodies.

1. Details of the arrangements in place and a relevant CPD policy

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	-	Total	1	Total	1	Total	1	Total	1

Comments

- Showed a good model of outreach care encompassing all areas, inclusion of all current teams plus potential need to expand.

3.1 Patient Centred Care

Please outline your proposals for ensuring patient access and support within the service.

1. How you will ensure that all patients have access to an appropriately trained clinical nurse specialist and key workers to co-ordinate care and ensure continuity throughout their pathway
2. How you will ensure that holistic needs assessment is undertaken and recorded at key points and that there are clear pathways to supportive care, primary care and specialist palliative care services
3. How you will ensure clear pathways are in place for sharing care plans with other care providers
4. How effective communication will be maintained with patients at all stages of the pathway including care plans and end of treatment summaries
5. How you will ensure the effective and efficient management of inter-trust transfers with regard to the patient's key worker

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	5	Total	5	Total	5	Total	5	Total	5

Comments

- The CNSs are pivotal in this area and showed themselves to be of a very high practising standard. This was also evidenced by a good team ethos

3.2 Patient facilities and environment

Provide details of facilities and patient environment.

1. How you will ensure that quiet areas are available in clinics and on or near ward areas where patients and relatives can receive significant news
2. Details of facilities such as overnight accommodation for carers and relatives of patients travelling significant distances to the centre. Where charges are levied for such facilitates, these should reflect a fair and affordable contribution to the cost of provision.

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	2	Total	2	Total	2	Total	2	Total	2

Comments

- The team were able to demonstrate how accommodation, already in place, can be utilised. Excellent facilities for family members traveling local distance and reasonable prices

3.3 Follow-up and survivorship

Provide details of your approach to patient-centred care following treatment that promotes quality of life.

1. How you will support patients living with and beyond cancer and your approach to patient centred follow-up in line with the

National Cancer Survivorship Initiative.
2. Details of patient access to support services such as erectile dysfunction, stoma and continence services.
3. You will ensure treatment summaries are available to patients and care providers.
4. How you will involve oncology and other relevant services in the co-ordination of follow up post treatment

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	4	Total	4	Total	3	Total	4	Total	4

Comments
- Especially good community set up which will be utilised within the current system and be expanded
- Greater articulation of how services available at Southend will be provided across the sector
- Describe arrangements beyond Southend and how local providers are collectively engaged for activities that for geographical reasons need to be located elsewhere

3.4 Patient Information

Describe how you will ensure information is available to patients according to their need.
1. How you will offer patients information on all aspects of their clinical and non-clinical care and treatment, including resources other than written material.
2. How you will meet specific needs of patients including those with hearing loss, visual impairment, learning disabilities or who require communication aids and interpretation services.

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	2	Total	2	Total	2	Total	2	Total	2

Comments
- patients have consultations with the various clinicians involved in their care: Surgeons, Oncologists, CNSs, ED Nurses, and Stoma Nurses

3.5 patient engagement

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	2	Total	3	Total	2	Total	2	Total	3

Comments
- Provision of the details are needed for all 3 points regarding patients from beyond Southend as much of what was provided seemed essentially internally focussed

3.6 Accessible and responsive care

The SMDT will be required to provide specialist care and treatment across a large geographical area. You must describe how you will ensure the service is accessible and responsive to patient need

1. Details of how the SMDT will provide care as close to home as possible, including a surgical and non-surgical oncology outreach service in the patient's locality
2. Details of how the service will maximise ease of access for patients before and after surgery (for example, investigations required by the SMDT such as radiological imaging should be performed at the patient's local hospital to agreed protocols wherever possible)
3. How you will ensure decision are guided by patient choice
4. Commissioners accept that patients may have to travel more than 60 minutes for specialist surgery however bidders must demonstrate how they will ensure that other services such as outpatient care are accessible and avoid the need to travel.

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	4	Total	4	Total	3	Total	4	Total	4

Comments

- Demonstrates a good model of outreach care encompassing all areas, inclusion of all current teams plus potential need to expand

3.7 Equality : Practical

Briefly describe how you will deliver your service that is respectful and understands the needs of your patients by protected characteristics on the following issues:
Age, disability, gender reassignment, single / married / civil partnership,
Pregnancy & Maternity, race, religion and belief, Sex, sexual orientation, other groups who face disadvantage and prejudice : carers, homelessness, substance abuse, offenders, bodily weight control issues

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	1	Total	1	Total	1	Total	1	Total	1

Comments

- Formal assessment to be completed as part of the NHS England assurance process

3.8 Equality : compliance

Please give evidence of the following:

1. An understanding of demographic demand for this service
2. How you will monitor satisfaction levels of your service across protected characteristics
3. How will you use this information to develop service provision

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	3	Total	3	Total	2	Total	3	Total	3

Comments
- Formal assessment to be completed as part of the NHS England assurance process

4.1 Deliverability and Implementation

Describe how you intend to deliver and implement the service for the duration of the contract.

1. How you will guarantee consistent delivery of national cancer waiting times, and how the risks of delivery will be mitigated. Responses should include reference to the management of risks associated with inter-trust transfer.
2. You must provide a capacity plan that describes a detailed outline of clinic, bed, theatre and critical care provision and clearly reference both existing and planned new provision
3. Details of your approach and assurance that sufficient organisation resource will be available to ensure service continuity for the duration of the contract, including nay new service developments that are either within the specification or proposed within the bid provided. This should include managerial and administrative support.

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	-	Total	3	Total	3	Total	3	Total	3

Comments
- They were able to communicate a very succinct plan which instilled confidence in their ability to mobilise and transform
- Team members present were able to show true dedication to this project
- Greater detail relating to transition of services currently provided at Colchester including details of service transition

4.2 Implementation plan

Please provide details of your implementation plan to demonstrate your capability and capacity to manage the transition process to implement the new service in line with stated timelines.

The plan should include the following detail:

1. Mobilisation / transition plan: this plan should detail the key tasks and milestones the service provider will complete during the period up to service commencement date in order to deliver the service in accordance with the service specification

requirements and contract and to achieve required performance targets.

2. Operational plan: this should detail the key tasks and milestones that he Service Provider will complete to ensure continued delivery of a safe and effective service and achievement of performance targets, to include:

Clinical (including CQC registration), IM&T, Contracting, data capture and reporting, operational delivery, communications including engagement with patients, service development and training, statutory compliance.

3. The plan must identify the resources within your organisation that will be responsible for governance and implementation
4. Please explain what you consider will be critical to the successful implementation of this service and what are the critical components of your proposed service mobilisation plan and how you propose to mitigate any risks?

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	-	Total	4	Total	3	Total	4	Total	4

Comments

- Someone already in place to oversee the implementation
- The Southend team showed true understanding of the needs for the entire population and presented an inclusive outreach model this was encompassed in their mobilisation and capacity plans.

4.3 Transfer of undertakings

Describe how you propose to deal with your responsibility in respect of 2TUPE2 staff transfers (if applicable) and maintaining the principles of the Employment Act 2008.

Describe how you will manage staff transition from TUPE transfer into the new organisation to the new structures identified.

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	-	Total	1	Total	1	Total	1	Total	1

Comments

- Discussed and needs further detail.

5.1 Service development

Describe how you will develop services in line with NHS England's service specification and the developing strategic direction and requirements for specialised services for the duration of the contract

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	-	Total	0.5	Total	1	Total	1	Total	1

Comments

- Did not demonstrate how the cancer strategy might be incorporated into the development

5.2 Response to service demand

Describe how you will respond to long term capacity requirements in terms of both facilities and workforce in line with anticipated trends in demands and increasing provision of services in alternative settings i.e. community settings.

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	-	Total	1	Total	1	Total	1	Total	1

Comments

- showed true understanding of the needs for the entire population and presented an inclusive outreach model that showed very clearly they had thought about everyone and all sites.

5.3 Population

Please indicate the geographic area that relates to your submission, by CCG and the anticipated activity associated with this population.
CCG list and anticipated activity

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	-	Total	1	Total	1	Total	1	Total	1

Comments

- It was apparent that populations this Team were able to serve would be significantly higher than that for Colchester, hence this model is likely to provide a more equitable provision for Essex.

Appendix 9 – Panel Score Colchester

Weighting

Clinical Service & Quality	35%
Workforce	15%
Patients Access & Experience	20%
Deliverability & Implementation	15%
Service Development	10%
Finance	5%

Panel Score %

1	2	3	4	5	Average
23%	21%	22%	14.7%	28%	21.74%
Not scored	9%	10%	6.75%	12%	9.43%
19.2%	17.5%	15%	10.8%	16%	15.7%
Not scored	7.5%	8%	3.75%	12%	7.8%
Not scored	6.67%	10%	6.6%	10%	8.31%
5%	5%	5%	5%	5%	5%
47%	67%	70%	47.6%	83%	62.92%

1.1 Specialist Multi-Disciplinary Team Service Model

Describe how you will ensure that the service will fully comply with requirements of the SMDT service model set out in the specification.

1 How will you deliver a Specialist Multidisciplinary Team (SMDT) for kidney, bladder and prostate cancers and provide associated specialist care?
2 How will you ensure your SMDT complies with all measures within the Manual for Cancer Services: Urology Measures, version 1 and all subsequent care?
3 Details of how you will ensure that all specialist care and treatment is delivered under the care of a core member of the SMDT
4 How will you ensure close collaborative working between SMDT members with particular reference to non-surgical oncology care and treatment?

Assessor 1		**Assessor 2**		**Assessor 3**		**Assessor 4**		**Assessor 5**	
Total	2	Total	2	Total	4	Total	1	Total	3

Comments

- The Team were able to show what the definition of an MDT and how the current set up functions – which seems effective, but they were unable to demonstrate a model for integrating other services – this was relatively poor, and did not demonstrate inclusiveness of all specialties across multiple sites.

- Better descriptions of the roles of urologists and oncologists outside the Trust. This should include the mechanisms by which urological surgeons are incorporated and effectively included in the MDT

1.2 Specialist Multi-Disciplinary Team Service Meeting

Describe how you will ensure that the SMDT has sufficient capability and capacity to perform its role

1. Given that this will be an SMDT covering kidney, bladder and prostate cancer, how you will ensure that sufficient time is allocated to discuss each case that meets criteria for referral?
2. How will you ensure effective inclusion of all SMDT members in multi-disciplinary team decision making?
3. How will you ensure sufficient time and resource is available to SMDT members attending the MDT meeting?
4. Confirm the full membership of the Specialist MDT

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	4	Total	2	Total	2	Total	2	Total	4

Comments

- The Team should think more about the time line for the MDT accounting for the increased size.

1.3 Single Service

Describe how you will deliver a single, integrated service to ensure equal access to high quality care for the population of Essex. For a single SMDT serving the whole population in the specified geographical area:

1. Details of how a single referral point will be administered across the population of Essex to ensure that where appropriate:
    a. Cases are allocated dependent on clinical need
    b. Referrals are managed by the clinical lead for the service
    c. Equity is maintained for all patients
2. How will you manage risk associated with variation in demand and ensure capacity is available to maintain relevant standards
3. Your approach to organisational development in order to ensure a fully functioning team
4. How you will ensure good communication between partners in the pathway e.g. for patients presenting at local A&E undergoing treatment at the cancer centre

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	2	Total	1	Total	1	Total	1	Total	3

Comments

- The Team need an inclusive rather than exclusive approach. It seemed to lack the need for multispecialty members from all of Essex.
- Detail beyond what was provided in the documentation and presentation on how the 'single service' will be operational for the entire population is needed

1.4 Research and access to clinical trials

Describe your vision and approach to audit, research and access to clinical trials.

1. Your approach to clinical trial recruitment and research
2. Details of systems that will be in place to ensure that all patients who are referred to the SMDT are considered for entry in to a clinical trial and how they are supported to make an informed choice
3. How you will collaborate with other organisations and agencies to maximise benefits of research and development

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	3	Total	3	Total	2	Total	3	Total	3

Comments

- good focus on research and access to clinical trials. Clinical trials flagged up at the MDT.
- Better arrangements need to be considered for surgical trials and need to be outlined.

1.5 Audit

Describe how you will assess and demonstrate continuous service improvement through audit.

1. How the SMDT will ensure a single audit programme and clinical data collection process for the population of Essex
2. How the SMDT(s) will ensure that audit results are used to improve outcomes of care and treatment
3. Details of how you will ensure prospective data capture and audit, including submission to national clinical audit programmes
4. Details of your planned administrative arrangements for the service to ensure that recording of information is achieved to the specific standards outlined in the following standards:
    a. Cancer outcomes and services dataset (COSD)
    b. Specialist Palliative Care Minimum Dataset
    c. NHS Standard Contract reporting requirements

d. British Association of Urological Surgeons Dataset (BAUS)
e. Patient reported Outcome Measures (PROMS)

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	3	Total	1	Total	1	Total	4	Total	3

Comments

- Concrete proposals for data capture and analysis across the sector and a clear description of systemic approaches will help to drive service improvement
- Details is needed on specifics and evidence to support review of audit outcomes in relation to COSD, BAUS and PROM's data.

1.6 Administration of the service

Indicate how you will ensure consistent deliver of service standards in relation to non-clinical services.

1. How you will ensure that patients who meet criteria for onward referral will be referred in line with the agreed clinical pathway (this includes GP, local MDT, internal referrals and referrals on to the Supra network)
2. How you will ensure that sufficient administrative resources is provided to support the service
3. Details of how you will ensure delivery of cancer waiting time standards for all urology cancer patients as identified in 3.1 of NHS England's national service specification *B14/S/a: Specialised kidney, bladder and prostate cancer services*

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	3	Total	2.5	Total	1	Total	2	Total	3

Comments

- Greater clarity regarding administrative resources to provide oversight of referral pathways particularly from LMDTs to SMDTs to reduce the expectation of local providers ie non-specialist urology services.

1.7 Management of Emergency Patients

Demonstrate how your service will support management of patients who present through an emergency route either at the specialist provider or local hospital.

1. Details of how all surgeons will manage post op complications and contribute to the out of hours emergency urological on-call rota for the centre and as part of the single service for Essex
2. How you will support patients who present as an emergency, wherever they present, including decision making and communication alert systems
3. How you will ensure patients who present as emergencies have access to a clinical nurse specialist

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	2	Total	1	Total	1	Total	0	Total	3

Comments

- The management of emergency situations out of hours would need to be clarified. More precise detail of the appropriate level of decision making and access to the centre would be required.
- The CNS network in Essex seems to be of a very high standard and could be utilised further in this part of the service.

1.8 Treatment

Describe how the service will ensure that all patients who meet criteria for specialist treatment receive appropriate access.

1. How you will ensure that all patients have access to joint consultation with the surgeon, oncologist and clinical nurse specialist to discuss treatment options.
2. Details of how you will ensure that the SMDT offers equal access for all patients to novel techniques within nationally agreed guidelines and delivered under the care of core members of the SMDT. This includes brachytherapy, robotic surgery, radio-frequency ablation and cryotherapy.
3. How you will ensure patients are manages as part of enhances recovery pathways
4. Please describe your intentions to provide access to robotic-assisted surgery (RAS) as part of the prostate pathway in line with the NHS England Clinical Commissioning Policy

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	3	Total	3	Total	3	Total	1	Total	4

Comments

- Although JOC appeared central to workings it seemed to exclude certain areas of Essex within this function, it was not clear how these clinics would run for southern areas.
- Clinic arrangements are required that provide joint consultations at local centres particularly in relation to the varying needs of tumour types.

1.9 Infrastructure

Describe how the service will meet infrastructure requirements set out in the specification.

1. How your organisation will ensure that inpatients are cared for in an environment appropriate to their needs, which in most cases will be a designated urology ward area where staff are experienced in the care of patients undergoing resectional surgery for urological cancer.
2. How you will ensure that all elective urological cancer surgery is supported by experienced theatre teams and

anaesthetists
3. How you will ensure that sufficient critical care capacity will be available to manage this patient group
4. Confirmation that all patients have access to on site critical care (level 3) beds

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	2.5	Total	3	Total	4	Total	1	Total	3

Comments

- The Team need to provide more robust evidence on how new workload would be serviced within the current infrastructure.
- Greater detail regarding interactions with other Trusts and providers within Essex required. Current arrangements with MEHT used as example but no detail concerning how others would be incorporated or involved.

1.10 Interdependencies with other services

Indicate how the following services will be accessed by the SMDT:

1. Named ward for the care of post-operative patients with appropriately trained staff
2. Renal haemofiltration facility
3. Arrangements for surgery to be undertaken in centres, co-located with vascular and cardiothoracic surgery where appropriate, for example renal cancer cases with thrombus in the in the vena caca and /or heart
4. In emergency situations, that the host hospital has access to relevant surgical expertise within 30 minutes, e.g colorectal expertise

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	2	Total	3.5	Total	4	Total	1	Total	4

Comments

- There was lack of insight into how the new service would allow existing non-urological services within Essex to function safely, e.g. gynaecology, Pelvic cancer teams

1.11 Integration and communication

Describe how you will work in partnership with other providers to ensure delivery of an integrated, multi-disciplinary service.

1. Details of your approach to working in co-operation with other NHS hospital trusts within the geographical boundary detailed in the specification which will continue to provide diagnostic / non-specialist care to their local population in line with existing arrangements
2. How you will ensure integration with health and social care providers local to the patient to help optimise any care

delivered locally

3. How you will manage patients in need of prolonged hospitalisation once specialist care is no longer required
4. How you will ensure good governance and communication with primary care, referring teams, other specialist providers and with patients, including arrangements for transfer of clinical responsibility. This should include arrangements for patients who for clinical reasons are transferred to another site e.g. for cardiothoracic support.
5. Details of your approach to the multi-disciplinary care of patients and ensure effective integration with therapeutic disciplines. This should include how you propose to work in c-operation with the provider of radiotherapy and chemotherapy in line with existing agreed pathways.

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	1.5	Total	3.5	Total	3	Total	2	Total	4

Comments

- Need to demonstrate how the future will work not just describe todays service.
- need to see that they and social care are working together to provide the necessary care to the patient across the health and social care spectrum.
- Would prefer to see a positive process for handover of clinical care.

2.1 Access to specialist workforce

Describe how you will ensure provision of a specialist workforce as set out in the specification at point of mobilisations.

1. Details of staffing arrangements that ensure provision of a specialist team workforce providing 24/7 continuity and sustainability of specialist care and why you believe this to be the optimal arrangement / number including specialist urological oncologists supported by middle grade cover.
2. How you will demonstrate and maintain sufficient workload for each individual surgeon to maintain expertise, allow sub-specialisation and comply with national standards as a minimum
3. Details of how you will ensure that expertise is maintained within the Essex services so that patients have access to appropriate skills and expertise, including management of recognised complications of elective and emergency urological surgery.
4. How you will ensure sufficient management resource is provided to support the service

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	-	Total	2	Total	1	Total	1	Total	4

Comments

- Further work on inclusion of other surgeons and how they integrate into the model is required. The Team seemed to feel that they would take on the additional work as they currently stand, which does not seem feasible. This itself would impact on the ability to provide a safe and sustainable service.

2.2 Staffing Structure

Submit a detailed staffing structure indicating professional group, roles, equivalent NHS grades, accountability, WTE numbers and reporting lines for both clinical and non-clinical staff. You must clearly identify which posts are to be recruited to. Please provide an operational management organisational structure chart in order t demonstrate the key operational management roles, supervision arrangements and responsibilities, reporting relationship and accountabilities.

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	-	Total	1	Total	1	Total	1	Total	1

Comments

- Further work on inclusion of other surgeons and how they integrate into the model is required

2.3 Staff Training

Provide details of how you will ensure all staff are adequately trained and competent to provide the service to a high standards. Where staff are yet to be appointed bidders need to demonstrate their processes and any previous successes of appointments to similar roles and training.

1. What arrangement the organisation has in place for statutory and mandatory training, including role specific statutory and mandatory training
2. Details of how staff can access clinical supervision including the provision of a clinical supervision policy
3. Details of the organisation's learning and development policy
4. Details of how you as the centre will keep all network clinicians up to date with service developments

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	-	Total	3	Total	3	Total	2	Total	4

Comments

- There was limited focus on service development and keeping clinicians across the network up to date.

2.4 Contingency Arrangements

Describe, for all clinical staff, your proposal contingency arrangements to cover for planned and unplanned increases in workload and / or staff absences.

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	-	Total	0	Total	1	Total	0	Total	0

Comments

- Given that exclusivity of the model, there was little scope to answer this adequately, e.g what if a specialist surgeon from Southend become suddenly unwell. It seemed they had not really factored in southend clinicians or anyone else, working as specialists within the new service.

2.5 Continuing professional development

Describe how you will manage and ensure that all clinical staff, including doctors, nurses and allied health professionals, meet the Continuing Professional Development (CPD) requirement of their professional and regulatory bodies.

1. Details of the arrangements in place and a relevant CPD policy

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	-	Total	1	Total	1	Total	1	Total	1

Comments

Operational measures need to be outlined to ensure surgeons maintain sufficient workload as service evolves (eg joint operating, levels of subspecialisation).

3.1 Patient Centred Care

Please outline your proposals for ensuring patient access and support within the service.

1. How you will ensure that all patients have access to an appropriately trained clinical nurse specialist and key workers to co-ordinate care and ensure continuity throughout their pathway
2. How you will ensure that holistic needs assessment is undertaken and recorded at key points and that there are clear pathways to supportive care, primary care and specialist palliative care services
3. How you will ensure clear pathways are in place for sharing care plans with other care providers
4. How effective communication will be maintained with patients at all stages of the pathway including care plans and end of treatment summaries

5. How you will ensure the effective and efficient management of inter-trust transfers with regard to the patient's key worker

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	5	Total	5	Total	5	Total	2	Total	5

Comments
- Strong clinical Nurse presence for patients

3.2 Patient facilities and environment

Provide details of facilities and patient environment.

1. How you will ensure that quiet areas are available in clinics and on or near ward areas where patients and relatives can receive significant news
2. Details of facilities such as overnight accommodation for carers and relatives of patients travelling significant distances to the centre. Where charges are levied for such facilitates, these should reflect a fair and affordable contribution to the cost of provision.

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	2	Total	1	Total	2	Total	0	Total	1

Comments
- Accommodation very expensive and is just a local hotel, not fully thought out. Patient input into this might have provided better solution.

3.3 Follow-up and survivorship

Provide details of your approach to patient-centred care following treatment that promotes quality of life.

1. How you will support patients living with and beyond cancer and your approach to patient centred follow-up in line with the National Cancer Survivorship Initiative.
2. Details of patient access to support services such as erectile dysfunction, stoma and continence services.
3. You will ensure treatment summaries are available to patients and care providers.
4. How you will involve oncology and other relevant services in the co-ordination of follow up post treatment

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	4	Total	3.5	Total	3	Total	1	Total	4

Comments

- Telephone follow ups were not very clear, sometimes nurse or on duty consultant
- Further evidence on how follow up with/without oncology could be undertaken across the area of Essex is required e.g for how long, where, when, hospital, community GP, nurse led or not.

3.4 Patient Information

Describe how you will ensure information is available to patients according to their need.

1. How you will offer patients information on all aspects of their clinical and non-clinical care and treatment, including resources other than written material.
2. How you will meet specific needs of patients including those with hearing loss, visual impairment, learning disabilities or who require communication aids and interpretation services.

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	2	Total	2	Total	2	Total	2	Total	2

Comments

- Patient information good and comprehensive.

3.5 Patient engagement

Describe how you will ensure patient and carer engagement in the planning, involvement, development and delivery of the service.

1. How you will offer patients information on all aspects of their clinical and non-clinical care and treatment, including resources other than written material.
2. Details of action plans to address the outcome of the National Cancer Patient Survey for urology and prostate services
3. How you will obtain feedback on patients' experience across multiple organisations i.e

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	2	Total	3	Total	2	Total	2	Total	3

Comments

- No action plans or details of actions were presented.

3.6 Accessible and responsive care

The SMDT will be required to provide specialist care and treatment across a large geographical area. You must describe how

you will ensure the service is accessible and responsive to patient need.

1. Details of how the SMDT will provide care as close to home as possible, including a surgical and non-surgical oncology outreach service in the patient's locality
2. Details of how the service will maximise ease of access for patients before and after surgery (for example, investigations required by the SMDT such as radiological imaging should be performed at the patient's local hospital to agreed protocols wherever possible)
3. How you will ensure decision are guided by patient choice
4. Commissioners accept that patients may have to travel more than 60 minutes for specialist surgery however bidders must demonstrate how they will ensure that other services such as outpatient care are accessible and avoid the need to travel.

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	4	Total	3	Total	2	Total	3	Total	4

Comments

- The team did not show how the services for the south of Essex would function
- Consideration of populations beyond Colchester and MEHT need to be addressed, particularly for the south of Essex.

3.7 Equality: Practical

Briefly describe how you will deliver your service that is respectful and understands the needs of your patients by protected characteristics on the following issues:
Age, disability, gender reassignment, single / married / civil partnership,
Pregnancy & Maternity, race, religion and belief, Sex, sexual orientation, other groups who face disadvantage and prejudice : carers, homelessness, substance abuse, offenders, bodily weight control issues

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	1	Total	1	Total	1	Total	1	Total	1

Comments

- Formal assessment to be completed as part of the NHS England assurance process

3.8 Equality: compliance

Please give evidence of the following:

1. An understanding of demographic demand for this service
2. How you will monitor satisfaction levels of your service across protected characteristics
3. How will you use this information to develop service provision?

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	3	Total	2.5	Total	1	Total	2	Total	3
Comments ○ Formal assessment to be completed as part of the NHS England assurance process									

4.1 Deliverability and Implementation

Describe how you intend to deliver and implement the service for the duration of the contract.

1. How you will guarantee consistent delivery of national cancer waiting times, and how the risks of delivery will be mitigated. Responses should include reference to the management of risks associated with inter-trust transfer.
2. You must provide a capacity plan that describes a detailed outline of clinic, bed, theatre and critical care provision and clearly reference both existing and planned new provision
3. Details of your approach and assurance that sufficient organisation resource will be available to ensure service continuity for the duration of the contract, including nay new service developments that are either within the specification or proposed within the bid provided. This should include managerial and administrative support.
4.

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	-	Total	2	Total	2	Total	1	Total	2
Comments ○ The Team did not clarify how cancer waiting time issues will be mitigated with the extra workload, given that recruitment seemed out with the requirement of staff to service the needs of the population ○ More detail on inter-trust interactions regarding delays/late referral as these are a major source of pathway delay									

4.2 Implementation plan

Please provide details of your implementation plan to demonstrate your capability and capacity to manage the transition process to implement the new service in line with stated timelines.

1. Mobilisation / transition plan: this plan should detail the key tasks and milestones the service provider will complete during the period up to service commencement date in order to deliver the service in accordance with the service specification

requirements and contract and to achieve required performance targets.

2. Operational plan: this should detail the key tasks and milestones that he Service Provider will complete to ensure continued delivery of a safe and effective service and achievement of performance targets, to include:

Clinical (including CQC registration), IM&T, Contracting, data capture and reporting, operational delivery, communications including engagement with patients, service development and training, statutory compliance.

3. The plan must identify the resources within your organisation that will be responsible for governance and implementation
4. Please explain what you consider will be critical to the successful implementation of this service and what are the critical components of your proposed service mobilisation plan and how you propose to mitigate any risks?

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	-	Total	2	Total	2	Total	1	Total	4

Comments

- No clear plan for long-term development of the service. responsibility for implementation was not clear

4.3 Transfer of undertakings

Describe how you propose to deal with your responsibility in respect of 2TUPE2 staff transfers (if applicable) and maintaining the principles of the Employment Act 2008.
Describe how you will manage staff transition from TUPE transfer into the new organisation to the new structures identified.

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	-	Total	0	Total	0	Total	0	Total	1

Comments

- Definite arrangements are needed to include urologists from Southend as there has been no consideration of TUPE arrangements to manage changes.

5.1 Service development

Describe how you will develop services in line with NHS England's service specification and the developing strategic direction and requirements for specialised services for the duration of the contract

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	-	Total	0.5	Total	1	Total	1	Total	1

Comments

- There needs to be more about developing and innovating the service rather than relying on what is already present. Some areas of the current service are good, there is always a better way of doing things.
- There needs to be a greater emphasis on how the team can deliver the specification and cancer strategy.

5.2 Response to service demand

Describe how you will respond to long term capacity requirements in terms of both facilities and workforce in line with anticipated trends in demands and increasing provision of services in alternative settings i.e. community settings.

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	-	Total	0.5	Total	1	Total	0	Total	1

Comments

- Needs greater understanding of the demographic demand for the service and potential movement of patients beyond Essex with emphasis on measures to maintain a critical mass to justify a specialist centre in the future

5.3 Population

Please indicate the geographic area that relates to your submission, by CCG and the anticipated activity associated with this population.

CCG list and anticipated activity

Assessor 1		Assessor 2		Assessor 3		Assessor 4		Assessor 5	
Total	-	Total	1	Total	1	Total	1	Total	1

Comments

- The team presented what seemed to be an exclusive system/model rather than an inclusive one, and did not fully anticipate the wider service need.