The Future of Specialist Care for Patients with Gynaecological Cancer

A Report for the Bath & North East Somerset Health Overview and Scrutiny Committee

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INTRODUCTION

1. In 1999 the NHS Improving Outcomes Guidance (IOG) for gynaecological cancers was published by the Department of Health. The IOG is designed to ensure the very best outcomes for women with gynaecological cancers and sets out recommendations for the provision of specialist services for the diagnosis and treatment of such cancers.

2. The guidance specifically emphasises the benefits of ensuring that clinicians work in multi-disciplinary teams that deal with large enough caseloads to deliver high quality services and the centralisation of the most complex gynaecological cancer surgery in specialist centres.

3. The IOG standards for centralisation cover specialist treatments only. Diagnostics, surgery for less complex cancers, chemotherapy, radiotherapy and palliative care should continue to be provided locally.

4. In 2004 the national Cancer Action Team called for action plans from all cancer networks setting out plans for delivering IOG compliant services. This included compliance with the gynaecological cancer IOG. Avon, Somerset and Wiltshire (ASW) Cancer Services Network carried out a review of local gynaecological cancer services but the review was only partially implemented because of concerns raised about the review process and outcomes.

5. In 2008 a further review into specialist gynaecological cancer services was initiated with NHS B&NES taking the lead and co-ordination role on behalf of six local Primary Care Trusts (B&NES, Bristol, North Somerset, Somerset, South Gloucestershire and Wiltshire).

6. This latest review resulted in the ASW Cancer Services Network and local Primary Care Trusts (PCTs) agreeing that the best option for specialist gynaecological cancer surgery services in the Avon catchment area would involve the centralisation of such services in Bristol.

7. This conclusion is not based on the desire to comply with government guidance simply for the sake of it, but on the strongly held clinical belief that the establishment of a single centre for specialist gynaecological cancer surgery is best clinical practice.

8. It is also the strongly held view of the ASW Cancer Services Network, local PCTs and local clinicians that the centralisation of these specialist services will:

   - Help save more lives and offer faster recovery rates for local women
   - Ensure that services are sustainable well into the future
   - Help local clinicians contribute to cancer research and treatment development
- Have a positive impact on the continuous professional development of doctors and nurses and help us attract the brightest and best clinical trainees
- Facilitate better multi-disciplinary team working and better use of resources
- Ensure we keep pace with national standards of best practice

9. The proposed change to services will mean that around 35 women each year from Bath and North East Somerset will receive complex surgery for rare cancers in Bristol instead of Bath. All diagnostics and aftercare will take place in Bath as at present ensuring that routine and follow-up care is provided as close as possible to patients’ homes. In a typical case the changes will affect a patient for approximately one week over a five year treatment programme.

**Complex surgery for rare cancers - the current service model**

10. Treatment for gynaecological cancer usually involves some combination of surgery, radiotherapy and chemotherapy and the care pathway - including follow up - is typically five years. Chemotherapy and radiotherapy require frequent trips to hospital and surgery usually requires one hospital stay of around five days.

11. Treatment can be separated into surgery for more straightforward and common gynaecological cancers, and complex surgery for more advanced, rarer and complex gynaecological cancers. The Royal United Hospital, Bath (RUH) and University Hospitals Bristol NHS Foundation Trust (UHB) currently both provide a range of gynaecological cancer services including both types of surgery.

12. The RUH service operates with a catchment population of less than half a million. The IOG recommended catchment population is 1 million. It also operates without the two gynae-oncology subspecialists recommended in a regular peer review by ASW Cancer Services Network. It is led by a single subspecialist consultant gynae-oncological surgeon.

13. The UHB service operates with a catchment population slightly below the 1 million recommended by the IOG and employs three subspecialist consultant gynae-oncological surgeons and a specialist trainee.

14. Both services are run by excellent professionals, achieve good outcomes and are well supported by patients and the public. However, neither site is compliant with the IOG and the current arrangement is not sustainable in the long term.

15. The two services – as currently provided – are good, but could be better. Cancer services across England are using best practice research to make changes that raise the bar for patients. We believe it is essential that women in Bath and North East Somerset benefit from such service improvements.
16. The evidence suggests that centralising expertise and resources for complex surgery can improve long term outcomes and survival rates for women with advanced, rare and complex gynaecological cancers and it is the only way to ensure compliance with the widely acknowledged best practice contained in the IOG. Implementing the proposed model of care outlined in this document will help us reach our aspiration to match the highest survival rates and best standards of care in Europe.
THE PROPOSAL

17. We are proposing to:

- Concentrate complex surgery for rare gynaecological cancers at the University Hospitals Bristol NHS Foundation Trust (UHB)
- Keep less specialist gynaecological cancer surgery at the Royal United Hospital Bath NHS Trust (RUH)
- Keep all other services (including outpatients, diagnostics, chemotherapy, radiotherapy and aftercare) as close as possible to where patients live

18. These proposals are subject to a number of conditions including the following:

- Augmented care should be provided on the wards at St Michael’s Hospital, Bristol before any changes in patient flows are made. This will significantly reduce reliance upon critical care facilities at the Bristol Royal Infirmary.
- Patients will not be transferred for planned surgery from St Michael’s Hospital to the Bristol Royal Infirmary in order to maintain theatre lists.
- Should the ongoing review of pathology services at UHB identify any issues with the service, these will be rectified before the transfer of services from the RUH is implemented.
- UHB will ensure that all staff including surgeons will have a formal contractual arrangement with UHB.
- UHB will collect and provide outcomes data for the service commissioners and these will be monitored over the short and long term to ensure continuous service improvement.

19. This service model proposed has been developed by local clinicians with input from patients and the public. It has taken into account national guidance and local circumstances and has been reviewed by an independent external clinical panel of national gynaecological cancer experts.

20. The proposed model of care involves developing a specialist gynaecology cancer centre for the West of England at St Michael’s Hospital, Bristol, run by UHB. This centre will work closely with the gynaecological cancer surgical unit at the RUH.

21. The specialist gynaecology cancer centre at UHB will:

- Treat intermediate and higher risk cervical cancer cases (approximately 90 per cent of cases)
- Treat intermediate and higher risk endometrial cancer cases (approximately 45 per cent of cases)
- Treat all ovarian, vulval and vaginal cancers
22. The gynaecological cancer surgical unit at RUH will:
   - Treat lower risk cervical cancers (approximately 10 per cent of cases)
   - Treat lower risk endometrial cancers (approximately 55 per cent of cases)
   - Manage the long term care of all gynaecological cancer patients in its catchment area.

23. This model of care will provide people living in the four Avon PCT areas and parts of Wiltshire and Somerset with a service which fully complies with national clinical best practice guidance.

**PATIENT IMPACT**

24. Across Bath and North East Somerset approximately 70 women a year need surgery for gynaecological cancer (including those needing surgery for recurrent cancers). Approximately 35 of these women will require surgery for less complex cancers (unit level surgery) and approximately 35 women will require more specialist surgery (centre level surgery).

25. Under these new proposals patients with suspected gynaecological cancer will continue to be referred to their local hospital for assessment and diagnosis as is currently the case. Where specialist surgery is recommended it will be provided at UHB by a multi-disciplinary team including specialist staff from the RUH.

26. This means that each year approximately 35 women who would have been treated in Bath will now travel for specialist surgery in Bristol. The remainder of their care including assessment, diagnostics, chemotherapy, radiotherapy and follow up appointments will take place in Bath thus ensuring that all treatment – with the possible exception of the specialist operation itself - is available as close to home as possible.

27. An average hospital stay for gynaecological cancer surgery is around five days. The proposed changes will therefore affect patients for less than one week over a typical five year treatment programme.

**Impact on other services**

28. The proposals contained in this document focus exclusively on specialist surgery for gynaecological cancer. They do not impact on any other aspects of gynaecological surgery or gynaecological cancer services provided at the RUH.

29. When services are moved from one hospital to another it is natural for people to question whether that decision somehow marks the start of a wider migration of services.
30. In this case the issues that triggered these proposed changes are only relevant to a tiny number of patients and have no implications for other services. The RUH undertakes more than 35,000 operations each year; this proposal affects fewer than 100 of these operations (35 from Bath and North East Somerset plus about 50 from Wiltshire). That is less than a quarter of 1% of RUH operations.

31. NHS B&NES has undertaken an Impact Assessment which is appended to this document at Appendix two. Throughout the review stakeholders have expressed a range of views on the proposals and these views have been fully considered by the Steering Group. Key issues raised by stakeholders include service access, travel times and the possible need for critical care in Bristol. These issues are addressed later in this document.

THE BENEFITS

32. The main benefits of the proposals detailed in this paper are as follows:

Improving patient outcomes for local women

33. The services we are currently offering are good, but we aspire to offer even better services. Over time we aim to match the very best standards in Europe. The scientific and professional evidence shows that centralising the most specialist surgery in higher volume centres can improve outcomes, including long term survival, and post operative mortality.

Supporting our clinicians in cancer research and development

34. Creating a centre of excellence for the treatment of complex gynaecological cancers provides an important pool of patient data for randomised controlled trials. In time the proposed changes will help ensure that local patients can access the most innovative treatments that have previously only been offered in larger, more specialist hospitals.

Offering an excellent training ground to attract the best doctors

35. As training for clinical specialties becomes more specialised, centres must prove they can offer access to a sufficient volume of patients to offer trainees a diverse and challenging learning experience. Current patient volumes in Bristol and Bath are not sufficient for us to be certain that both centres will be attractive to surgical trainees in an increasingly tough and competitive training environment.
Supporting ongoing learning and development

36. The model of care will allow our surgeons, clinical oncologists, specialist nurses and other clinicians to ‘sub-specialise’, developing greater experience and expertise in the treatment of gynaecological cancer.

A simpler, clearer structure for multi-disciplinary team working

37. Research has shown that effective multi-disciplinary team working is a crucial factor in improving the quality of cancer services. The proposed model of care outlines a clear division of the roles and responsibilities which will help clinicians manage every patient’s care to the same high standards, with less duplication of effort, better record-keeping and closer monitoring.

More robust staffing arrangements

38. Staffing rotas for surgical lists is a complex process. The larger surgical team based in Bristol will be more resilient to these challenges because if one surgeon becomes unavailable, there are two others who may be able to cover. There is, of course, only one subspecialist consultant gynae-oncological surgeon based at Bath.

Compliance with IOG clinical best practice guidance on specialist services

39. Centralising expertise and resources for complex gynaecological surgery in a single, specialist centre at UHB is the best option to achieve compliance with the IOG. The national evidence is that this is the best way to improve long term outcomes and survival rates for women with advanced, rare and complex gynaecological cancers.

Compliance with national policy and clinical best practice guidance on care closer to home

40. The proposed model of care ensures that localised care is available for patients who do not need Centre level care and for those who have already been treated at the UHB Centre. RUH will continue to deliver a substantial service to meet the diagnostic, routine care and follow-up for the women affected by these proposals close to their own homes.
THE EVIDENCE

41. There is a considerable body of clinical evidence that supports the proposals made in this document but NHS B&NES has not simply relied upon research conducted elsewhere, we have also examined, reviewed, considered and appraised the various options that could be applicable locally.

42. It is also important to note that this paper is set in the context of a report published earlier this month (December 2009) by the Cancer Czar, Prof. Mike Richards. The report – Prof. Richards’ second annual report for the Cancer Reform Strategy – revealed significant differences in one-year cancer survival rates depending on where patients live. Prof. Richards’ report emphasises the importance that both he and the Department of Health attach to IOGs as a mechanism for improving outcomes.

43. While the report shows that cancer mortality rates are declining it also indicates that the NHS needs to do more if it is to move closer to the best survival rates to be found elsewhere in Europe.

The clinical evidence

44. It is in the nature of clinical evidence that it is often contested by different clinicians. It is by testing the evidence for different approaches that medicine advances. But when a consensus begins to emerge it is important that it be recognised.

45. The IOG for gynaecological cancers, published in 1999 was based on a review of the evidence called “Management of gynaecological cancers”. The review and the proposed model of care was endorsed by an advisory group of national experts. The review concluded, among other things, that long term outcomes for this group of cancers were better in centres treating higher volumes of patients. This policy direction has been confirmed in the latest version of the Manual for Cancer’s Peer Review Standards which was again endorsed by a national expert group on the basis of their experience and their understanding of the evidence.

46. Two outcomes of care in particular have been studied in relation to the size of a cancer service:

- longer term survival after diagnosis (from 2 to 5 years) and
- complications around the time of operation

47. Improved outcomes have been repeatedly shown for various cancers in higher volume centres in several countries. In most cases this research is done by comparing outcome in low and high volume hospitals. Most studies of gynaecological cancers have also found better outcomes in higher volume
centres. For a list of the key policy documents and peer reviewed clinical papers please see appendix one.

48. Clinical experts have tried to determine why outcomes are better in higher volume hospitals and the reason seems to involve greater sub-specialisation among surgeons and other clinicians in higher volume units. This enables them to develop greater expertise with uncommon procedures and find innovative ways of treating their patients.

49. The research leads to a number of clear conclusions:

- There is a positive relationship between better outcomes for women with gynaecological cancers and larger treatment centres.
- The chance for surgeons to develop greater expertise in specific surgical procedures appears to be at the heart of this relationship.
- The benefit arising from treatment in a larger centre is greatest for patients needing highly skilled, largely surgical treatment. But the less intensive aspects of care – including follow-up care – can still best be delivered effectively in local settings.

**Reviewing the options**

50. In addition to examining the scientific evidence concerning the centralisation of specialist gynaecological cancer services we have also conducted an options review designed to explore alternative solutions. This review was conducted in three stages:

*Stage 1 - Developing the service model*

51. The service model was developed by local clinicians and service users taking into account the specification set out in the IOG and more recent clinical developments.

*Stage 2 - Confirming the options to the considered*

52. Some service users urged the Steering Group to consider a two site option, with specialist surgery provided at both RUH and UHB. Such a model was also specifically raised by the B&NES OSC and was raised at the initial stakeholder event when NHS B&NES gave a commitment to work with the Cancer Action Team to confirm the constraints and freedoms.

53. As part of the review process, NHS B&NES wrote to the Cancer Action Team to ask whether a two site option with specialist surgery performed across both sites by one specialist MDT would be viewed as compliant with the IOG. The Cancer Action Team said that such a two site cancer centre would not be compliant. This position was supported by the Gynaecological Cancer Peer Review Standards which were revised and reissued in November 2008.
54. The Steering Group took the view that it would be preferable to exclude any model of care that would not be seen by the Cancer Action Team as sustainable, deliverable or compliant.

Stage 3 – Appraising the options

55. RUH and UHB developed proposals against the agreed service specification and the review team commissioned a travel analysis prepared by the South West Public Health Observatory and feedback from an expert clinical panel.

56. The steering group - including five service user representatives, six PCT representatives and representatives from RUH and UHB - met to review the respective proposals against previously agreed criteria. These criteria included:

- Quality
- Best practice
- Patient access
- Impact on other services
- Research and education
- Deliverability and
- Value for money

57. Despite considerable discussion the Steering Group was unable to reach a majority recommendation on the location of the centralised service and asked PCT commissioners to conduct a due diligence exercise, review both proposals against the agreed criteria and then recommend a preferred site for the centre.

58. PCT commissioners undertook the required review and unanimously recommended that the service be centralised at UHB.

59. The principle arguments in favour of centralising at UHB were that:

- Consolidating the service at Bristol would affect fewer people (patients and staff) than consolidation in Bath
- Bristol is better placed to deliver the service because the increase in capacity required there is relatively small with fewer challenges to delivery

60. The recommendation was presented to the Avon, Somerset and Wiltshire Cancer Services Board on 25 September 2009 and the Board supported the recommendation.
ENGAGEMENT

61. As with any change that affects the way patients receive care, the PCT has gone to considerable lengths to ensure that patients’ needs and views are considered carefully.

Stakeholder launch event

62. The review was launched with a stakeholder event in September 2008 to which Avon, Somerset and Wiltshire area Local Involvement Networks (LINks), Overview and Scrutiny Committee representatives, service user groups, public and patient representatives and Trust clinicians and leaders were invited to discuss the review, ask any questions about the process and sign up to be involved.

63. The launch was followed by regular briefings to stakeholders, updates and review paperwork published on PCT websites and briefings to local and joint Overview and Scrutiny Committees.

Creating a service user group

64. The PCT asked six LINks - Bath and North East Somerset, Bristol, South Gloucestershire, Somerset, North Somerset and Wiltshire - along with the service user groups at RUH, UHB and the ASW Cancer Services Network to nominate representatives for a service user group.

65. The group’s role was to co-ordinate service user input on behalf of their referring organisation, to act as a ‘voice’ for local people and patients, to review clinical proposals and to provide feedback to inform the decisions taken by the project steering group. The service user group was chaired by an external person, recommended by Bath and North East Somerset LINk and supported by external facilitation from two organisations including the Centre for Public Scrutiny.

66. The PCT arranged for the group to meet with clinicians from the RUH and UHB and the clinical advisory group – the clinicians from the ASW Cancer Services Network who developed the proposed model of care. The service user group was also consulted on the design of a public survey and provided input throughout the engagement communication programme.

Patient representation on the review steering group

67. Five representatives from the service user group were asked to join the Steering Group which led the project, alongside lead clinicians and Medical Directors, to ensure that the views of those who use and work in the services were put right at the heart of decision-making.
68. The representatives from the Service User Group were voting members of the Steering Group and all other members of the Service User Group were invited to attend the final meeting of the Steering Group as observers.

Public survey

69. A questionnaire to gather views on the proposed service changes was made available to patients and the public in outpatients departments at the RUH and UHB. The questionnaire was also publicised in the media and various newsletters and online. The survey was published on the RUH and UHB websites, trailed in local media and on relevant websites. Take up of the survey was light and responses centred on Banes residents. Feedback received indicated two areas of concern:

- the impact of services leaving the RUH
- the affect on access of services moving to Bristol

A full schedule of engagement communication methods

70. Local people were kept informed about the development of proposals through a range of communication methods, including press releases, articles published in the local authority magazine council connect (delivered to all households in Bath and North East Somerset) the PCT’s health and wellbeing newsletter, articles in the PCT’s regular e-newsletter to all stakeholders and a BBC Points West programme.

Key themes from stakeholder feedback

71. A range of views was expressed during the engagement period. All views expressed were considered by the Steering Group during the review process. A selection of views reported and fed back at the final Steering Group meeting included:

- “We request and expect the highest possible quality service to be specified”
- “What is important is what is best for the majority of patients and the patient experience for the majority of patients”
- “If I was a patient my priority would be to be alive”
- “My personal view would be to support a one site option on the basis that a specialist site would offer more options to all patients”
- “I found the evidence pack comprehensive and easy to understand”
- “NHS B&NES is threatening to decommission and move to a location that will cause women physical and psychological harm for no demonstrable or quantifiable benefit”.

72. The majority of stakeholders are not seeking formal consultation but strongly believe that the time has come to move on, confirm the decision,
implement the proposed model of care and communicate widely with all patients and potential patients. The Impact Assessment expresses the views of stakeholders quite clearly and suggests that if the commissioners have not yet completely succeeded in communicating the compelling reasons for change then this should be their next challenge.

73. For the public, travel times and the associated impact on patients and carers were the key issues of concern. A patient survey conducted as part of the review found that most patients travel by car to the hospital. Average journey times for B&NES patients were calculated independently by the South West Public Health Observatory who found that, on average, the patient journey to RUH took 13 minutes. For the 35 patients who would – under these proposals – need to travel to UHB the additional journey time would, on average, amount to 16 minutes making a total, average journey time of 29 minutes.

74. A recent Ipsos MORI survey of 2,846 residents in the South West asked how much time people were prepared to spend travelling by car from home to different types of NHS services. This survey found that if they needed highly complex surgery or specialist treatment they would be prepared to travel for quite long periods of time if that meant they could get the best possible treatment. Across the South West as a whole people were willing to travel for more than 77 minutes, on average, for complex or specialist treatment. B&NES residents were actually prepared to travel even longer, for an average of 82 minutes.

75. UHB has indicated that for patients who are seriously unwell the trust can offer overnight accommodation in hospital side rooms for carers or family members. The hospital has also developed arrangements for overnight accommodation with local hotels.

76. As part of our implementation programme, we will work with the RUH and UHB to ensure patients are aware of the transport support available, including support for patients with medical needs as well as financial hardship.

CLINICAL SUPPORT

77. Local and national clinicians with wide ranging experience of specialist cancer care were closely involved in the development and assessment of the proposals described in this document including clinicians at RUH and UHB, the GP chair of NHS B&NES Professional Executive Committee and clinical members of ASW Cancer Services Network gynaecological cancer site specialist group.

78. The development of the model of care has been clinician-led and has been subject to assessment and review by an External Clinical Panel comprising the following nationally and internationally acknowledged cancer specialists:

- Andy Nordin, national clinical lead for Gynaecological Cancer
• Professor John Green, secretary of the British Gynaecological Cancer Society
• Professor David Luesley, president the British Gynaecological Cancer Society
• Juliette Sim from the Gynaecological Oncology Nurse Forum

79. The Expert Clinical Panel has indicated that it considers the proposed model of care to be safe and sustainable. The panel has made a number of recommendations that have been adopted by the service commissioners including the provision of augmented care (intensive nursing support). NHS B&NES has confirmed that, in line with this advice from the Expert Clinical Panel, services will not be transferred until augmented care is in place on the wards at UHB.

80. The proposed model of care is supported by clinicians at UHB and the Medical Director at the RUH has said that RUH, “recognises that a single larger centre for specialised cancer services has potential advantages in allowing the development of sub-specialisation and increased research and development opportunities.”

FINANCE

81. Specialist surgical services are paid for by Primary Care Trusts at a fixed national tariff, a set price for each procedure including the ward stay. Since the RUH and the UHB both charge the tariff price, there is no cost implication involved in the surgical aspect of these proposals.

82. UHB will be using part of its operating surplus to provide a new augmented care service at St Michael’s Hospital as part of these proposals at a cost of approximately £400,000.

83. Certainly these proposals are not designed to save money but rather to improve outcomes for patients and to ensure the longer term sustainability of the specialist gynaecological cancer service.

CONCLUSION

84. NHS B&NES believes that specialist gynaecological cancer services for Avon, Somerset and parts of Wiltshire should be concentrated at UHB in order to ensure the best possible care and the best possible outcomes for local women. Other key points that we would urge the OSC to bear in mind when considering this paper include:

• The concentration of specialist services in specialist centres would allow us to keep pace with national clinical guidelines designed to deliver best practice and best outcomes.
• Concentrating specialist surgery will go hand-in-hand with delivering routine care and follow-up care close to where patients live.
• These proposals have been developed by local clinicians with significant patient and public input and have been subject to thorough, independent review.
• Importantly these proposals have been carefully considered during a wide-ranging engagement programme involving services users, staff, clinicians and the public.
• The scientific/professional evidence supports proposals to concentrate complex cancer surgery in specialist centres.
• These proposals are designed to ensure specialist gynaecological cancer services are safe and sustainable into the future. Our aspiration is to match the highest survival rates and best standards of gynaecological cancer care in Europe.
• These proposals will affect very few women in Bath and North East Somerset - about 35 women a year.
• These proposals are not driven by any sense of cost saving. The new proposed service will actually cost more money not less.

IMPACT OF THE CHANGES - NEXT STEPS

85. NHS B&NES does not believe the proposed changes constitute a substantial variation in local services based on the numbers involved. They will affect just 35 women a year from B&NES and involve a change of service location for just one week in a typical five year care pathway. In terms of overall activity at the RUH, the move will affect fewer than 100 surgical episodes (including the 35 from within B&NES) and this amounts to less than a quarter of 1% of the RUH surgical workload.

86. The RUH Medical Director has said, “this change does not amount to a substantial variation in the service we provide here at the RUH” and the trust does not envisage any loss of beds or staff at the trust. The pre-operative diagnostics and work-up and the follow-up care of all patients will continue at the RUH as will services for patients with other gynaecological cancers.

87. Following a year-long engagement process, incorporating public and patient questionnaires as well as a service user group, NHS B&NES does not believe there are further insights to be gained from additional public consultation. There should, however, be a programme of communication for patients, public and staff to explain the proposals and the benefits that could come from having a nearby specialist gynaecological cancer centre.

88. This programme would involve the dissemination of information about:-

• The service changes and new patient pathways
• Travel and access arrangements along with accommodation arrangements
• Who to contact for support and advice

89. Communication methods would include:-

• A series of meetings with the Health and Wellbeing Network, the local GP Forum and patient groups to ensure patients and carers understand the new care pathway and receive best advice
• Media initiatives and advertisements in local newspapers and online
• New patient information leaflets
• Leaflets and posters in outpatient departments and cancer information centres
• Information for all stakeholders available via the RUH website
• An explanatory article in “Council Connect” delivered to all households in B&NES

90. The approach described above is informed by discussions with patient and public bodies including B&NES LINk and is supported by key stakeholders and NHS B&NES.

RECOMMENDATION

91. The Healthier Communities Overview and Scrutiny Panel are asked to consider the findings of this report and the impact assessment attached at Appendix 2. The panel is asked to support the recommendation that the proposed change does not constitute a substantial variation of service. The Panel is asked to support the suggested approach to further public communications and to comment on the details of that model.