*Clinical Senate*
*Yorkshire and the Humber*

*"An independent source of strategic clinical advice for Yorkshire and the Humber"*

# Clinical Senate Review

# of

# Pancreatic Cancer Services

# for

# Specialised Commissioning

# Yorkshire and the Humber

Final Version

December 2016

Clinical Senate Reviews are designed to ensure that proposals for large scale change and reconfiguration are sound and evidence-based, in the best interest of patients and will improve the quality, safety and sustainability of care.

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Yorkshire and the Humber Clinical Senate
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## Version Control

| Document Version | Date | Comments | Drafted by |
|---|---|---|---|
| Version 0.1 | 28th Sept 2016 | Based on Working Group and Council discussion | Joanne Poole |
| Version 0.2 | 5th October | Following Working Group feedback | Joanne Poole |
| Version 0.3 | 7th October | With further working group comment included | Joanne Poole |
| Version 0.4 | 22nd November | Amended following Council discussion | Joanne Poole |
| Version 0.5 | 13th December | Amended following commissioner comment | Joanne Poole |
| Final Version | 22nd December 2016 | | Joanne Poole |

# 1. Chair's Foreword

1.1 The Senate thanks the specialised commissioners for the opportunity to work with them on their review of specialised pancreatic cancer services. In this review the Senate has considered the clinical appropriateness of the current clinical model and the risks, issues and opportunities of any changes to this model. The Senate has not advised on what the future service model may look like as this is out of the scope of the question asked.

1.2 We recognise that Yorkshire and the Humber specialised pancreatic cancer service currently benefits from the support of three very talented teams of providers providing a good service. As always, our advice is independent to the providers and focuses on the long term sustainability and safety of the service. Trying to achieve what is best overall for service users is our overriding priority.

## 2. Summary of Key Recommendations

2.1 The Improving Outcomes Guidance (1991)[1] is the leading guidance for the organisation of specialised pancreatic cancer services. The Senate supports the Improving Outcomes Guidance (IOG) messages including that a central service that does not draw upon the minimum population of 2 – 4 million will in the longer term struggle to sustain its excellence of service.

2.2 The Senate advises that the population base is a critical factor and therefore a 3 centre model for specialised pancreatic cancer services within Yorkshire and the Humber is not clinically appropriate. The Senate would welcome the opportunity to work with commissioners further to advise on the proposed location of the centres in the future model. The Senate recommends that the opportunities to improve the service are by delivering the IOG recommendations and by ensuring that there are robust pathways in place, in compliance with this guidance.

2.3 As they develop the options for the future model of service, commissioners are recommended to make best use of the 3 passionate and excellent teams currently providing the service and maximise the opportunities for collaboration in the new service model and to keep as much of the patient pathway as local as possible.

[1] Guidance on commissioning cancer services: improving outcomes in upper gastro-intestinal cancers the manual (2001). Available via: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/publications/PublicationsPolicyAndGuidance/DH_4010025

# 3. Background

### Clinical Area

3.1 In most parts of the UK pancreatic services are organised as a series of pancreatic centres in hub hospitals, each fed by a number of peripheral hospitals. Hub hospitals set regional protocols with the intention for all patients to be discussed at a central Multi-Disciplinary Team (MDT). Surgery, interventional radiology and interventional endoscopy are all performed in the hubs. These hubs, or centres, have been arranged around populations of 2 – 4 million in order to comply with the national guidance[2].

3.2 This population minimum has been developed nationally to ensure that each centre has a sufficient number of cases annually to maintain the expertise of the staff and that the centres can employ sufficient numbers of staff to run safe rotas. It is expected that within each centre at least 80 – 100 pancreatic resections and 150 liver resections (75 major) would be carried out.

3.3 Specialised pancreatic cancer services within Yorkshire and the Humber are currently delivered in 3 centres:

- Sheffield Teaching Hospitals NHS Foundation Trust
- Hull and East Yorkshire NHS Foundation Trust
- Leeds Teaching Hospitals NHS Trust

3.4 Specialised commissioners assessed these services against the nationally mandated service specification[3] and found that only one is compliant with the required population minimum. This evaluation was also supported from the outputs of the Pancreatic Improving Outcomes Group (IOG) and peer reviews which noted that services within the Yorkshire and the Humber region were not delivered to the required standard.

3.5 Specialised commissioners have therefore commenced a project designed to review and evaluate the current service delivery and commission a service delivery model for the provision of specialised pancreatic cancer services. This model will best meet the needs of patients and the public within Yorkshire and the Humber, delivered by providers who are compliant with the national service specification.

3.6 Non specialised pancreatic cancer services are excluded from the scope of this review but the implications of any proposed changes on these services will need to be taken into account.

[2] Guidance on commissioning cancer services: improving outcomes in upper gastro-intestinal cancers the manual (2001).
[3] A02/S/b 2013/14 NHS Standard Contract for Cancer: Pancreatic (Adult).

**Role of the Senate**

3.7 Specialised commissioners are in the initial stages of their review, having completed:

- A gap analysis (based on the service specification review, the IOG reports and the peer review reports)
- One to one meetings with the trust teams to gain an understanding of their views of the service.

3.8 At this point in the project, the Senate was asked to review the self-assessments and supporting evidence and advise:

> *Is the current service model for pancreatic cancer clinically appropriate?*
>
> *Are there opportunities to improve the service and its compliance with the national service specification and what risks, issues, opportunities or concerns does the Senate advise the commissioner to consider in the development of the options for the future service.*

3.9 It is anticipated that this is the first stage of the Senate involvement and that specialised commissioners will consult with the Senate again when they have developed an option appraisal paper with recommendations about the future commissioning of the specialised pancreatic cancer services within Yorkshire and the Humber. The Senate advice provided in this review will help inform those next stages of the commissioner assessment.

**Process of the Review**

3.10 The Senate received the request for review on the 9th September 2016 and the associated evidence was received week commencing 12th September. The Working Group was appointed by the 13th September and the Terms of Reference were agreed on 15th September.

3.11 The Senate Working Group held a teleconference to aid their discussions on 19th September and a discussion was arranged with the commissioners for the 26th September. The report was drafted by the Working Group following these discussions and the final draft was provided to the commissioners for comment on the 7th October 2016. The report and commissioner comments will be provided to the Senate Council for final ratification on the 17th November 2016.

## 4. Evidence Base

4.1 In considering this review, the panel has drawn upon the Guidance on commissioning cancer services; improving outcomes in upper gastro intestinal cancers, the manual[4] and the more recent National Peer Review manual[5]. More recent evidence on the impact of increasing hospital volume and lower mortality on pancreatic surgery is referenced below.

## 5. Recommendations

5.1 The recommendations from the Senate focus on the specific questions asked by commissioners:

**Is the current service model for pancreatic cancer clinically appropriate?**

5.2 The Improving Outcomes Guidance (1991)[6] is the leading guidance for the organisation of specialised pancreatic cancer services. Over the last 15 years there is evidence[7][8][9][10] that mortality rates for pancreatic cancer are slowly decreasing and

[4] Guidance on commissioning cancer services: improving outcomes in upper gastro-intestinal cancers the manual (2001).

[5] National Peer Review Programme. Manual for Cancer Services, Hepato-Pancreato-Biliary Cancer Measures, version 1, July 2013. Julia Hill, NHS England Gateway No 10790 –January 2014

[6] Guidance on commissioning cancer services: improving outcomes in upper gastro-intestinal cancers the manual (2001).

[7] Ann Surg. 2016 Apr;263(4):664-72. doi: 10.1097/SLA.0000000000001437.Effect of Hospital Volume on Surgical Outcomes After Pancreaticoduodenectomy: A Systematic Review and Meta-analysis.Hata T[1], Motoi F, Ishida M, Naitoh T, Katayose Y, Egawa S, Unno M.

[8] Br J Surg. 2014 Jul;101(8):1000-5. doi: 10.1002/bjs.9468. Epub 2014 May 20.**Impact of centralization of pancreatic cancer surgery on resection rates and survival.**Gooiker GA[1], Lemmens VE, Besselink MG, Busch OR, Bonsing BA, Molenaar IQ, Tollenaar RA, de Hingh IH, Wouters MW.

[9] Br J Surg. 2014 Apr;101(5):523-9. doi: 10.1002/bjs.9420. Epub 2014 Feb 24.**Impact of hospital volume on hospital mortality, length of stay and total costs after pancreaticoduodenectomy.**Yoshioka R[1], Yasunaga H, Hasegawa K, Horiguchi H, Fushimi K, Aoki T, Sakamoto Y, Sugawara Y, Kokudo N.

[10] Ann Surg. 2016 Apr;263(4):727-32. doi: 10.1097/SLA.0000000000001490. **Surgeon Volume and Cancer Esophagectomy, Gastrectomy, and Pancreatectomy: A Population-based Study in England.** Mamidanna R[1], Ni Z, Anderson O, Spiegelhalter SD, Bottle A, Aylin P, Faiz O, Hanna GB.

survival rates increasing. Clinical expert opinion is that this is due in part to greater centralisation of the service in line with the recommendations of the IOG. The Senate supports the IOG strategic messages.

5.3 A critical factor within the IOG is that for the central unit to work effectively it needs a population of 2 – 4 million to sustain the full range of services. Currently, only the Leeds service has a population that meets this minimum and both the Hull and Sheffield services fall below this minimum.

5.4 The Senate acknowledges the experience, energy and passion of the three teams and the good outcomes of these services currently, when compared to national benchmark data. However, the Senate endorses the messages within the IOG that a central service that does not draw upon this minimum population will, in the longer term, struggle to sustain its excellence of service and this may lead, in time, to poorer outcomes, lower resection rates for tumours and failure to offer a holistic service to patients.

5.5 The Senate advises that the population base is a critical factor and therefore a 3 centre model for specialised pancreatic cancer services within Yorkshire and the Humber is not clinically appropriate. A clinically appropriate model for this service would be one that is compliant with the IOG recommendations, including that of the population minimum.

5.6 The Senate recognises that any reduction in the number of centres will impact on associated services and this needs to be considered in the next phase of the work. Commissioners need to ensure that they understand the complexity of the surgical and non-surgical treatments that are provided across the geography and the impact of any changes on the associated support services of radiology and gastroenterology.

5.7 The Senate panel discussed the discrepancies between the catchment population and the resection rate. This is most evident when considering the Hull service. Their catchment population is 1.2 million and yet their resection rate is equivalent to a centre with a much larger population. This may, in part, be due to the flow of patients to the Hull service from Lincolnshire and commissioners are advised to consider these population flows in more detail. Currently, there is no clear explanation of this discrepancy and no way to evaluate whether higher activity is likely to be maintained or whether it is appropriate. The Senate therefore, still has concerns about the longer term sustainability of this service. The converse is that the Leeds service has a higher population but apparently a lower resection rate. There is no explanation of this and commissioners need to have confidence that all potentially operable patients are being offered the treatment.

5.8 The Senate also discussed the co-location of the full range of hepatobiliary (HpB) services, including liver surgery. The benefit of this approach is that patients are offered all the treatment options by a highly skilled team with a single multi-disciplinary team (MDT) to discuss the complexities. There is the potential that when these services are separate, not all clinicians involved in the care of the patient are part of the MDT which can lead to decisions being made on the basis of limited

diagnostic information. This can be overcome by clear pathways but there are benefits to this model of service which the commissioners will wish to consider.

**Are there opportunities to improve the service and its compliance with the national service specification?**

5.9 The Senate agreed that the opportunities to improve the service are by delivering the IOG recommendations and by ensuring that there are robust pathways in place in compliance with this guidance. In view of the inconsistency in the data, the Senate advises that the principle objective is to achieve a sustainable high quality service in the long term.

**What risks, issues, opportunities or concerns does the Senate advise the commissioner to consider in the development of the options for the future service?**

5.10 The Senate agrees that the risks arise by not following the IOG recommendations, resulting in services that are likely to struggle with their sustainability in the longer term, with the potential of:

- Increased complications and poorer outcomes leading to increased mortality
- Non-compliant MDTs
- Lower resection rates
- Failure to comply with peer review

5.11 The Senate discussed a number of risks associated with a smaller centre which can be summarised as:

- A risk that the centres will in time not tackle the more complex cases due to the impact this may have on mortality rates across a small cohort of patients. This can result in centres offering different selection criteria on borderline cases
- A risk that the centres will be unable to offer the full range of supporting services of interventional radiology and diagnosis with endoscopic retrograde cholangiopancreatography (ERCP) and endoscopic ultrasound. These supporting services feed into the narrative of the complexity of patients that a centre feels confident to manage. In time, the centre may struggle to offer the same level of service to those patients with more complex needs
- A risk that the centres will struggle to recruit and particularly to attract more experienced staff, and it is these staff that can lead to a more comprehensive, effective and efficient service for patients
- A risk that the centres will not be able to support as much clinical research due to the smaller critical mass of patients, leading to less start up trials and less patients entered into trials

5.12 Commissioners have the opportunity to re model the service in line with the IOG recommendations but to do so in a way that uses the experience of the 3 teams and allows collaboration. There are options to include the expertise of the teams within a bigger specialised multi-disciplinary team (SMDT) to help maintain expertise and these opportunities will need to be explored in the network options referred to by

commissioners. Commissioners need to ensure that their proposals for the new model keep travel to the central hub at a minimum and sustain as much of the patient pathway locally as possible. Commissioners will need to ensure that any remodelling is supported by adequate capital investment for the supporting services for pancreatic surgery including intensive care.

**Additional comments from the Senate**

5.13 The evidence supplied raised a number of questions in Senate discussion which we would recommend are addressed by commissioners in order to inform the preferred option in the next stage of work. The commissioners are advised to:

i. Undertake further work to understand the demographics of the disease and its higher prevalence in the East Yorkshire area in order to better understand the scale of service provision
ii. Undertake further work to understand why Yorkshire and the Humber has a higher proportion of patients presenting through A&E. Commissioners will need to be clear on what access those patients have to the specialised service and how effective this pathway is
iii. Understand critical care capacity and the impact of their proposals on this service
iv. Have more detailed analysis and understanding of the activity. The Senate questioned the low resection rate in Leeds for example, and questioned the accuracy of this
v. Request further information from the trusts on how the MDTs are working in terms of how often they are held, attendance and patient selection, for example, including referral criteria and the criteria for patient fast track. There is a lack of clarity in the information provided about the SMDT and MDT and how these fit together. It is difficult to comprehend the flow of the 3 services from the information provided
vi. Develop more detailed information on the diagnostic and supporting services including:
    - the endoscopic ultrasound (EUS) waiting times
    - the endoscopic availability
    - the endosonographers waiting list
    - the endoscopic retrograde cholangiopancreatography (ERCP) waiting list
    - the access to chemotherapy and radiotherapy
    - the waiting times for CT
    - the waiting times for liver biopsy
    - the waiting times for interventional radiology
    - the waiting times for PET scanning

5.14 The peer review information from 2014 raised a number of concerns with the 3 services, including the Leeds pathway for local chemotherapy, histopathology, MDT quoracy and the quality of patient information, for example. The trust self-assessments provided are helpful but they also require evidence to support the statements to give assurance that progress has been made to address the peer review concerns. Commissioners need to consider more than just the volume of the

service and need a comprehensive understanding of the quality of the service and the actions taken to address the criticisms of the peer review.

5.15 With regard to primary care, it is noted that in the summary of the clinical workshop discussions it highlights the need to better educate GPs in possible presentations of pancreatic cancer. The service specification[11] states symptomatic patients *"can be referred direct from primary care. To avoid delay in making the diagnosis, appropriate investigations including endoscopic ultrasound (EUS), computerised tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET) are usually performed by the specialist MDT"* and that GPs would refer via the 2 week wait system.

5.16 However, the most recent NICE guidance[12] states:

- Refer people using a suspected cancer referral pathway (for an appointment within 2 weeks) for pancreatic cancer if they are aged 40 and over and have jaundice
- Consider an urgent direct access CT scan (to be performed within 2 weeks) or an urgent ultrasound scan if CT is not available, to assess for pancreatic cancer in people aged 60 and over with weight loss and any of the following:
    - Diarrhoea
    - Back pain
    - Abdominal pain
    - Nausea
    - Vomiting
    - Constipation
    - New onset diabetes

5.17 This would suggest that GPs are going to be requesting a significantly higher volume of abdominal CTs prior to any referral unless the 2 week wait criteria are fulfilled. In further development of the service, local referral pathways need to be very clear on this to avoid confusion and delay.

5.18 The service specification[13] also states on page 10, the importance of sharing the holistic needs assessment with the MDT. All the trusts will need to share this with primary care, which is not the current practice. Consideration as to how this will best be achieved, including implications for information sharing with the current primary care and secondary care IT systems, needs to be considered.

5.19 Patient engagement will be an important part of the future development of the proposals and the local active cancer patient groups will prove helpful to commissioners in accessing those patients, as will the Yorkshire Cancer Patient Forum website. Commissioners will need to consider how to address the equality and health inequalities in the next stage of their work, particularly due to the increased incidence of this disease linked with deprivation and age and the challenges of the rural geography.

[11] A02/S/b 2013/14 NHS Standard Contract for Cancer: Pancreatic (Adult). Page 12
[12] Suspected Cancer: Recognition and Referral. Nice Guideline (NG12) published date June 2015
[13] A02/S/b 2013/14 NHS Standard Contract for Cancer: Pancreatic (Adult). Page 10

## 6. Summary and Conclusions

6.1 The Senate advises that a 3 centre model for specialised pancreatic cancer services within Yorkshire and the Humber is not clinically appropriate. The Senate has not made comment on the proposed location of the centres in the future model as this is out of the scope of the question asked. At this early stage of work, commissioners have not yet assembled all the information that would lead to an assessment on the quality, capacity, detailed outcomes, relationship and support between referring and specialist units. Our understanding is that this will be developed in the future modelling. The Senate advice, however, is that the issue of population is so fundamental that we have confidence in saying that the current model needs to change.

6.2 Commissioners are recommended to make best use of the excellent teams currently providing the service and maximise the opportunities for collaboration in the new service model.

# APPENDICES

## Appendix 1

# LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

Council Members

Professor Chris Welsh, Senate Chair

Assembly Members

Peter Allen, Public Representative

Co-opted Members

Professor Peter Hoskin, Consultant Clinical Oncologist, East and North Hertfordshire NHS Trust

Dr Richard Charnley, HPB Consultant, Aintree Hospitals NHS Foundation Trust

Mr Raaj Praseedom, Consultant HPB Transplant Surgeon, Addenbrooke's Hospital

Dr Jayapal Ramesh, Gastrointestinal and Liver Services, Royal Liverpool & Broadgreen University Hospital

Mr Saboor Khan, Consultant Hepatobiliary Pancreatic and General Surgeon, University Hospitals Coventry & Warwickshire NHS Trust

Kerry Pape, Macmillan Lead Cancer Nurse, Queens Hospital

Rob Gornall, Clinical Director – Cancer, West Midlands Clinical Networks & Senate

Karen McAdam, Consultant Medical Oncologist, Peterborough & Stamford Hospitals NHS Foundation Trust

Dawn Elliott, UGI Clinical Nurse Specialist, Northumbria Healthcare

## Appendix 2

# PANEL MEMBERS' DECLARATION OF INTERESTS

| Name | Title | Organisation | Date of Declaration | Reason for Declaration | Date of Response | Proposed way of Managing Conflict |
|---|---|---|---|---|---|---|
| Dr Caroline Hibbert | Joint Medical Director, Surgery Health Group | Hull & East Yorkshire Hospitals NHS Foundation Trust | At Senate Council meeting on 21.9.16 | Medical Director at the Trust whose cancer service provision is under review | 21.9.16 at the Senate Council meeting | To manage this conflict of interest we will need to ensure that Caroline does not take part in any Council or sub group discussions as they relate to this matter |

## Appendix 3

CLINICAL REVIEW

# TERMS OF REFERENCE

**TITLE:**

**Pancreatic Cancer Services Review**

**Specialised Commissioning Yorkshire and the Humber**

**V0.1**

**Sponsoring Organisation:** Yorkshire and the Humber Specialised Commissioning, NHS England (North)

**Terms of reference agreed by:** Chris Welsh on behalf of Yorkshire and the Humber Clinical Senate and Sharon Hodgson on behalf of Specialised Commissioners

**Date:** 11th September

## 1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: Chris Welsh, Senate Chair

Citizen Representative: Peter Allen

Clinical Senate Review Team Members:

| | | |
|---|---|---|
| Prof Peter Hoskin | Consultant Clinical Oncologist | East & North Hertfordshire NHS Trust |
| Dr Richard Charnley | HPB Consultant | Aintree Hospitals NHS Foundation Trust |
| Mr Raaj Praseedom | Consultant HPB-Transplant Surgeon | Addenbrooke's Hospital, Cambridge University Hospitals Foundation NHS Trust |
| Dr Jayapal Ramesh | Gastrointestinal & Liver Services | Royal Liverpool & Broadgreen University Hospital |
| Mr Saboor Khan | Consultant Hepatobiliary Pancreatic and General Surgeon | University Hospitals Coventry and Warwickshire NHS Trust |
| Kerry Pape | Macmillan Lead Cancer Nurse | Queens Hospital Burton |
| Rob Gornall | Clinical Director – Cancer, West Midlands Clinical Senate | West Midlands |
| Dr Karen McAdam | Consultant Medical Oncologist | Peterborough & Stamford Hospitals NHS Foundation Trust |
| Dawn Elliott | UGI Clinical Nurse Specialist | Northumbria Healthcare NHS Foundation Trust |

## 2. AIMS AND OBJECTIVES OF THE REVIEW

**Question:**

*Is the current service model for pancreatic cancer clinically appropriate?*

*Are there opportunities to improve the service and its compliance with the national service specification and what risks, issues, opportunities or concerns does the Senate advise the commissioner to consider in the development of the options for the future service.*

**Objectives of the clinical review (from the information provided by the commissioning sponsor)**

*The objective of the overall project is for commissioners to review and evaluate the current service delivery against the national service specification and to develop recommendations based on the evidence from these reviews for a model of service that is compliant with the national standards and best meets the needs of patients within Yorkshire and the Humber.*

*The Senate is being consulted following the evaluation of the current model so as commissioners can consider their advice in their development of the recommendations for the future service model. The Senate may be consulted at a later stage to advise on the preferred option.*

**Scope of the review**

The review is to consider Specialised Pancreatic Cancer services within Yorkshire and the Humber. Non specialised pancreatic cancer services are excluded but the Senate will need to consider the impact of this review upon any associated services.

## 3. TIMELINE AND KEY PROCESSES

**Receive the Topic Request form:** 9th September

**Agree the Terms of Reference:** 15th September

**Receive the evidence and distribute to review team**: w/c 12th September

**Teleconferences:** w/c 19th September

**Draft report submitted to commissioners**: 3rd October

**Senate Council ratification**; 17th November meeting

**Final report agreed**: 21st November

**Publication of the report on the website**: end of November

## 4. REPORTING ARRANGEMENTS

The clinical review team will report to the Senate Council who will agree the report and be accountable for the advice contained in the final report. The report will be given to the sponsoring commissioner and a process for the handling of the report and the publication of the findings will be agreed.

## 5. EVIDENCE TO BE CONSIDERED

The review will consider the following key evidence:

- The criteria required to meet the NHS England Pancreatic Service specification and embedded documents for the 3 provider Trusts
- The Public Health England information on the epidemiology within Yorkshire and the Humber
- the Project Initiation Document v0.5
- the clinical workshop notes 07/06/16

The review team will review the evidence within these documents and supplement their understanding with a clinical discussion.

## 6. REPORT

The draft clinical senate report will be made available to the sponsoring organisation for fact checking prior to publication. Comments/ correction must be received within 10 working days.

The report will not be amended if further evidence is submitted at a later date. Submission of later evidence will result in a second report being published by the Senate rather than the amendment of the original report.

The draft final report will require formal ratification by the Senate Council prior to publication.

## 7. COMMUNICATION AND MEDIA HANDLING

The final report will be disseminated to the commissioning sponsor, provider, NHS England (if this is an assurance report) and made available on the senate website. Publication will be agreed with the commissioning sponsor.

## 8. EVALUATION

The Senate will ask the commissioning sponsor to complete a short evaluation to assess the impact of the Senate advice. This will be emailed to the commissioning lead 3 months following the publication of the report.

## 9. RESOURCES

The Yorkshire and the Humber clinical senate will provide administrative support to the clinical review team, including setting up the meetings and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

## 10. ACCOUNTABILITY AND GOVERNANCE

The clinical review team is part of the Yorkshire and the Humber Clinical Senate accountability and governance structure.

The Yorkshire and the Humber clinical senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

## 11. FUNCTIONS, RESPONSIBILITIES AND ROLES

The **sponsoring organisation** will

i. provide the clinical review panel with agreed evidence. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance. The sponsoring organisation will provide any other additional background information requested by the clinical review team.
ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.
iii. undertake not to attempt to unduly influence any members of the clinical review team during the review.
iv. submit the final report to NHS England for inclusion in its formal service change assurance process if applicable
v. complete the evaluation form issued by the Senate 3 months after the publication of the Senate report.

**Clinical senate council** and the **sponsoring organisation** will:

i. agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

**Clinical senate council** will:

i. appoint a clinical review team, this may be formed by members of the senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
ii. endorse the terms of reference, timetable and methodology for the review
iii. consider the review recommendations and report (and may wish to make further recommendations)
iv. provide suitable support to the team and
v. submit the final report to the sponsoring organisation

**Clinical review team** will:

i. undertake its review in line the methodology agreed in the terms of reference
ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
iii. submit the draft report to clinical senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
iv. keep accurate notes of meetings.

**Clinical review team members** will undertake to:

i. commit fully to the review and attend all briefings, meetings, interviews, and panels etc. that are part of the review (as defined in methodology).
ii. contribute fully to the process and review report
iii. ensure that the report accurately represents the consensus of opinion of the clinical review team
iv. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the clinical senate manager, any conflict of interest prior to the start of the review and /or materialise during the review.

**END**

## Appendix 4

# BACKGROUND INFORMATION

The evidence received for this review is listed below

1. Criteria Required to Meet Pancreatic Service Specification for Hull & East Yorkshire Hospitals Trust (HEYHT)
2. Criteria Required to Meet Pancreatic Service Specification for Leeds Teaching Hospitals Trust (LTHT)
3. Criteria Required to Meet Pancreatic Service Specification for Sheffield Teaching Hospitals Trust (STHT)
4. Elements of Service – guidelines used
5. Leeds Pancreatic Peer Review Report
6. Referral Pathway (LTHT)
7. Pancreatic Cancer Individual Surgical Workload, Leeds Cancer Centre
8. Yorkshire Cancer Network – Cancer Pathway
9. Clinical Workshop Notes v07.06.16
10. Equality Impact Assessment v1
11. Pancreatic Cancer Project Plan
12. Pancreatic Cancer Review Terms of Reference v3
13. Peer Review Analysis May 2016 v2
14. Epidemiology of Pancreatic Cancer, Public Health England
15. Public and Patient Engagement Plan
16. Evolution of HPB Surgery
17. Guidance for the Care of a Person in Last Hours to Days of Life
18. Pancreatic Chemotherapy Guidelines
19. Pancreatic Cancer Waiting Times Performance (STHT)
20. Radiotherapy Handbook – Pancreas
21. Upper GI Guidelines
22. Clinical Pathway for UGI/HPB Patients in Clinical Distress