Our Ref:
Your Ref:

NHS England – North (Yorkshire and the Humber)
Oak House
Moorhead Way
Bramley
Rotherham
S66 1YY

Sharon Hodgson
Local Services Specialist
Programme of Care - Cancer and Blood
NHS England

26th May 2017

Dear Sharon

Thank you for inviting the Senate to work with you on reviewing the proposal for a 2 centre (3 operating site) model for the delivery of pancreatic cancer surgery services in Yorkshire and the Humber. We previously worked with you on the Case for Change for this service and our published report is available on our website.

The question which you asked us to consider for this review is:

Does the Senate consider the proposal for a 2 centre, 3 operating site model for pancreatic cancer services in Yorkshire and the Humber to be a sustainable option? What will be required to enable this model to deliver high quality pancreatic services and ensure the 3 centres work collaboratively to improve early diagnosis and outcomes?

In reviewing this proposal we developed an Expert Working Group using the same Clinical Experts as worked with us previously and their details can be found in the Terms of Reference for this review which are included as Appendix A to this letter. Our advice was ratified through our Senate Council and any conflicts of interest of the Council members and their management of them is listed in Appendix B.

The Terms of Reference at Appendix A also lists the documentation we were provided for this review. The Working Group developed its advice through review of the documentation and discussion via email and teleconference. Many members of our Working Group had a very helpful conversation with you on 3rd April to discuss our advice prior to finalising this letter.

In our consideration of the question, we have continued to focus on providing impartial clinical advice on the long term sustainability of the services. I hope that this letter provides a balanced clinical overview on the proposed configuration of the services and assists commissioners in moving forward to achieve the changes required.

The Evidence Base

The evidence base underlying our advice is detailed in our previous report and is not repeated within this letter. One of the key considerations of the Senate in this review was whether the proposal for a 2 centre (3 operating site model) is compliant with the Improving Outcomes Guidance[1] which is the leading guidance for the organisation of Specialised Pancreatic Cancer Services.

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

Senate Advice and Recommendations

Compliance with the IOG

1. The IOG implies 1 surgical site for hepato-pancreato–biliary (HPB) services centralised to draw from 2-4 million population and this has been the direction of travel over the last 15 years. The IOG guidance is there to reduce surgical mortality with good surgical outcomes and to achieve:
   - maximised resection rates
   - increased expertise to carry out complex resections such as pancreatectomy with vascular resections and after neo-adjuvant therapy
   - low surgical mortality, (currently 30 day mortality in the UK is 4%)

2. There is varying interpretation locally as to whether the proposed solution for Yorkshire and the Humber will deliver the benefits of the centralised model or leave this region as an outlier in the provision of this service. What is clear is that this model can only be considered as compliant if the Hull and Sheffield services were to be truly integrated and both sites act as part of one team, with one multi-disciplinary team (MDT), one on call rota, a single point of contact for the service with one Trust managing the pathway across 2 sites, and one Trust as lead provider.

3. The documentation references the West Midlands model and states that there is the intention to replicate and learn from their approach. The proposal in the West Midlands is to amalgamate the Coventry and Birmingham pancreatic surgery and liver services in to 1 service delivered across 2 sites. Work has been ongoing on this proposal for over 2 years but it remains in the early stages.

4. At this point in time our understanding of the proposed West Midlands model is that there will be:

- a joint governance structure
- a joint single MDT
- a single point of access
- a single surgical / intervention waiting list
- cross site working for surgeons with the intention to propagate the cross site working to other specialities and for future joint appointments
- complex cases performed specifically at Birmingham, with mutual agreement by named surgeons, and all surgeons will be encouraged to expand and develop their expertise. All other cases will be allocated based on waiting time, resources and geography moving in time to a shared surgical rota
- patients will have equal access to all therapies and research trials.

5. At a meeting to discuss the West Midlands proposals on the 7th April our understanding is that it was agreed to pause the developments due to concerns that the proposal did not comply with the IOG. A decision was made to put a briefing document to NHS England Specialist Commissioning to detail the complexities.

6. The Senate recommends caution in replicating a model which is not yet established and where agreement is not yet reached that this is compliant with the IOG. Aside from this proposed model, the rest of the country has realigned its services to a centralised model. In discussion, the Expert Working Group referenced their experiences in East Anglia with a centralised service at Cambridge University Hospitals NHS Foundation Trust; North London, with a centralised service at the Royal Free London NHS Foundation Trust and the Middlesbrough/ North Tees/ Newcastle region with a centralised service at the Freeman Hospital in Newcastle. The results of pancreatic cancer disease in the UK are improving with surgical mortality reducing (referenced in our previous report). Clinical expert opinion is that this is due in part to greater centralisation of the service in line with the recommendations of the IOG.

7. Commissioners are also recommended to note that there are differences between the West Midlands model and the Yorkshire and Humber proposal. Most notably these are that in West Midlands the service serves a bigger population and the two centres are closer in geography (30 miles as compared to 90 miles in Yorkshire and the Humber) making cross site working easier to achieve. The proposals also span both liver services and pancreatic work.

8. We recommend that commissioners review the perceived advantages of the split site model, set out in the documentation, and ask the commissioners to consider the following points in reference to these.

The Perceived Advantages of the Model

The proposed model ensures there is no detrimental impact on co-dependent services and the centres are able to continue to provide the wider HPB service

9. There is the argument that if the pancreatic resection service is removed from a large teaching hospital, this shall have inevitable knock on effect on all aspects of care for pancreatic patients We realise this is a real concern for the current centres. We ask commissioners to consider whether they are convinced that the removal of the surgical service will destabilise the service for benign disease. This has not been shown to be the case in other areas of the country. The East Anglia region is an example where it took 9 years to centralise the pancreatic surgical service from 4 sites to 1 site. The hospitals at Norwich and Ipswich are large hospitals which no longer perform pancreatic surgery and their non-surgical services continue to be provided with an excellent working relationship with the surgical service in Cambridge. The Norwich Hospital is a university hospital with a medical school on site. In cases of acute pancreatitis, the non-surgical site seeks an opinion from colleagues in Cambridge and the case is usually treated by a radiologist at the non-surgical site.

10. Commissioners need to consider that the existing services for the remaining non operated 80% of the pancreatic cancer patients are dealt with in the non-surgical centre which will have opportunity for significant and improved focus to services such as
    - its diagnostic service
    - fast track jaundice service (one stop clinic for jaundice with Liver Function Tests, Ultrasound Scan and CT scans in one day)
    - pre-operative and post-operative oncological management
    - improved access to palliative care and
    - long term follow up

11. We also discussed the ability of the non-surgical service to be active in clinical trials and provided examples in Middlesbrough and Carlisle services where these non-surgical sites are very active in submitting patients to oncology clinical trials.

The importance of providing good patient access over a very wide geography

12. Commissioners need to consider whether the advantages for the geography are enough to overcome the risks of the split site model and the resultant dilution of the workforce. Commissioners are concerned that removal of the service from Hull would have a detrimental impact on the population served by the Hull service where there are pockets of deprivation and a higher incidence of pancreatic disease. The patient perspective document provided, and comments from our own patient members, has questioned whether these patients would have the willingness, means and ability to access a service 90 miles away.

13. The Senate recommends that commissioners further consider that only 20% of the pancreatic cancer patients would have to travel to the surgical site, which in this case really means patient numbers going for surgery from peripheral hospitals per year would be less than 50 a year. It needs to be made clear in discussion with patients that the efficient and rapid diagnosis, aftercare including non-surgical oncology and palliative care will be maintained and embellished at the three sites in Yorkshire and the Humber.

14. In Tyneside, Teesside and West Cumbria patients do travel long distances to access the surgical service at Newcastle and the distances being discussed in Yorkshire and the Humber are not new. There are other examples of centralised pathways in Yorkshire and the Humber where patients have understood the benefit of receiving a specialist service in a place of expertise and accepted that. What is important in making this system work for the patient is the efficiency of the communication between the teams, maintaining excellent clinical relationships between the teams and the importance of maintaining the remaining pathway in the non-surgical centre.

The benefits brought by an innovative model in terms of teaching / research / training / developing new pathways and joint appointments

15. The Senate understands that this could be the evolution of a new service if managed well however the information provided in support of this model is lacking in detail. We advise commissioners to be cautious at this stage and fully consider a 2 surgical site model before there is an acceptance that the proposed model is the best way forward for the Yorkshire and the Humber population.

The Concerns with the Model

16. If commissioners wish to explore this proposed model further the Senate recommends that much more detail is provided to be assured of the ability for both sites to act as part of one team, with one MDT, one on call rota, a single point of contact for the service and one Trust as lead provider.

17. Despite good intentions the Senate is concerned that this approach will essentially maintain three 'centres' despite attempts at joint working, resulting in the continuation of a non-compliant service albeit with a different name or proposed structure. There are other examples in the country of attempts at ‘joint’ working, which did not succeed, where both sites

were deficient in the required population. These examples are across both Gastro-oesophageal and HPB disciplines. The proposed joint service, therefore, has to be truly inclusive and imaginative. If it is done in a superficial manner but actually the practice does not change, the two organisations and commissioners would then have to address the same issue at a later date.

18. Within the documentation provided, the lack of detail leads to the following questions:

    a) Leadership, governance, experience and resources are of equal importance to resection rates. The governance and oversight structure for the day to day running of the service is not clear. Discussion with commissioners suggested that the commissioned service would be with Sheffield who will have oversight of the service but this detail is not included in the proposal.

    b) There is sparse detail on the joint working arrangements leading to concerns about the safety of the model, particularly consultant on call arrangements. The documentation leads to questions about how the emergency on call will be provided and whether it is the intention to maintain a full rota of hpb surgeons and hpb interventional radiologists across both sites. We have emphasised the importance of there being 1 truly integrated team.

    c) We were not clear from this proposal how members of staff in the wider MDT will feel part of one centre and how across two operating sites the team would perform the volume of surgery the IOG expects. This includes for example the palliative care team, the dieticians and the specialist nurses who are integral members of the team.

    d) The proposals also do not include the detail of the number of anticipated surgical resection numbers at the two sites and whether cases would be allocated regardless of complexity. This level of detail needs to be included.

    e) We also have questions about how patients find their way through that pathway and how patient preference will be taken into account. There are risks with this model that the person presenting the patient at the MDT will not understand that patient's pathway and that information is not effectively shared across sites. There needs to be clarity on the how and what of the communication.

    f) We also recommend that there is specific mention of the availability, sharing and development of specialist services at the two sites (e.g. spy glass ERCP / interventional EUS / specialist radiology), as well as more specific information about encouraging local expertise in referring units. Commissioners need to ensure that the full range of supporting services will be available at both sites and available to all patients.

Other Points

19. From the information provided it is also not clear what overarching structure there will be in Yorkshire and the Humber to bring a closer working relationship between Leeds and the Sheffield/Hull service to drive up consistency of standards across Yorkshire and the Humber. We recommend that this is considered and made clear.

20. In our telephone call we discussed the impact of new treatments including neoadjuvant and the potential impact on resection rates, however, we advised commissioners to maintain their focus on ensuring compliance with the IOG.

In Summary

At this time we advise careful consideration to adopting the suggested model. Commissioners must ensure that its remodelled service is IOG compliant and we suggest that the worked examples of a centralised service from the North and East of the country should influence the Yorkshire and the Humber solution more so than the as yet unestablished model in the West Midlands.

In discussion with commissioners, members of the panel invited commissioners and clinicians from Yorkshire and the Humber to visit the centralised service model in East Anglia, see the workings of the centralised MDT and meet with clinicians from the non-surgical sites. This invitation was welcomed.

Our clinical experts also offered assistance to the Yorkshire and the Humber teams in working through the detail of the reconfigured service.

I hope that this advice assists you in your discussions for this service and we would be very happy to work with you further as the detail develops.

Yours sincerely

Chris Welsh
Senate Chair
Yorkshire and the Humber

Clinical Senate
Yorkshire and the Humber

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

Appendix - A

CLINICAL REVIEW

TERMS OF REFERENCE

TITLE:

Pancreatic Cancer Services Review – Part 2

Specialised Commissioning Yorkshire and the Humber

Version 0.2

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: 7th March 2017

---

1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: Chris Welsh, Senate Chair

Citizen Representative: Peter Allen and Sandy Gillan

Clinical Senate Review Team Members:

Prof Peter Hoskin	Consultant Clinical Oncologist	East & North Hertfordshire NHS Trust
Mr Richard Charnley	Consultant HPB Surgeon	Freeman Hospital, Newcastle upon Tyne.
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:

Does the Senate consider the proposal for a 2 centre, 3 operating site model for pancreatic cancer services in Yorkshire and the Humber to be a sustainable option? What will be required to enable this model to deliver high quality pancreatic services and ensure the 3 centres work collaboratively to improve early diagnosis and outcomes?

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

To advise the commissioners on:

- Whether their preferred option is sustainable.
- What supporting structures are needed to ensure this model delivers high quality care

Scope of the review

The Senate is not being asked to review all the options and state our preferred option. The focus of the review is to advise commissioners on what is required to ensure that their preferred option delivers a high quality service and improves early diagnosis and outcomes

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: 3rd March 2017

Agree the Terms of Reference: 10th March 2017

Receive the evidence and distribute to review team: 10th March 2017

Teleconferences: Working Group teleconference during w/c 20th March 2017 and with commissioners w/c 27th March 2017. Additional teleconference with commissioners held 3rd April

Draft report submitted to commissioners: Letter submitted 21st April 2017

Senate Council ratification; 18th May meeting 2017

Final report agreed: end May 2017

Publication of the report on the website: to be agreed with commissioners but not later than July 2017

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:

- Pancreatic Clinical Workshop Summary
- Pancreatic Services Review – outline proposal from Sheffield and Hull
- Patient Perspective
- Specialised Pancreatic Cancer Services in Leeds

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 in the form of Chair's letter. This will be made available to the sponsoring organisation for fact checking prior to publication. Comments/ correction must be received within 10 working days.
The letter will not be amended if further evidence is submitted at a later date. Submission of later evidence will result in a second letter being published by the Senate rather than the amendment of the original letter.
The draft final letter will require formal ratification by the Senate Council prior to publication.

7. COMMUNICATION AND MEDIA HANDLING

The final letter 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 contribute to a Case Study summary with opportunity to assess the impact of the Senate advice. This will be emailed to the commissioning lead 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 - B

CONFLICTS OF INTEREST

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 in March 2017	Medical Director at the Trust whose cancer service provision is under review	At the March Senate Council meeting	To manage this conflict of interest we will ensure that Caroline does not take part in any Council or sub group discussions as they relate to this matter