NHS
Yorkshire and the Humber
Clinical Senate

Free and full independent and impartial clinical advice

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Via email to:

5th March 2019

Kevin Peters
Senior Supplier Manager
Specialised Commissioning Team (Yorkshire & Humber)

Dear Kevin

Senate Review of Clinical Haematology Services in Hull and North Lincolnshire

Thank you for the opportunity to review your proposals for the reconfiguration of clinical haematology services provided by Hull and East Yorkshire NHS Hospitals Trust (HEYHT) and Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (NLAG).

The objectives of the clinical review are to provide you with independent clinical oversight of the proposed model and for this advice to form part of your submission to Stage 2 of the NHS England assurance process. The members of the clinical review panel who reviewed the proposals through email and teleconference discussion are listed within the Terms of Reference enclosed with this letter.

The questions you asked us to consider are:

- *Can the Clinical Senate advise if they agree that the proposed clinical model is in line with best practice/provides the best solution to patients given the workforce challenges.*
- *Can the Clinical Senate identify any clinical concerns that they may have about the proposed model?*

The Senate panel received the documentation (listed in the Terms of Reference) on the 31st August. There was no advance notice of the request and therefore appointment of the panel commenced following receipt of the documentation and was completed on 20th September. The panel reviewed the documentation and compiled a list of questions to discuss with the commissioning lead on 9th October. There was considerable delay in organising a response to those questions which stalled the progress of the review. Our discussion on 13th December with commissioning and clinical colleagues was very helpful and enabled the panel to develop their advice.

I hope this letter provides a constructive summary of our comments and advice.

General Comments

The Senate panel recognises that this reconfiguration is driven by the unfilled Consultant Haematologist (CH) vacancies in NLAG and the recognition that for the foreseeable future there is no realistic prospect of recruiting a substantive CH to this Trust. This has led to the need to make immediate changes to ensure that the service is safe and effective.

The focus of the service proposals are the provision of chemotherapy services for haemato-oncology patients. Due to the rarity and complexity of clinical haematology services the chemotherapy delivery is directly commissioned by NHS England Specialist Commissioning services. Inpatient and outpatient clinical haematology, however, is commissioned directly with CCGs, with a small amount commissioned by NHS England. The complexity of the commissioning model is reflected in the business case provided and the Senate advises that there is a lack of clarity in identifying the relationship between the haematology service and the wider oncology service. These questions were largely addressed in discussion, but remain confusing in the paperwork and we recommend that this is set out clearly to provide the clinical coherence needed.

Our more detailed comments on the model are provided in response to each question:

- **Can the Clinical Senate advise if they agree that the proposed clinical model is in line with best practice/provides the best solution to patients given the workforce challenges**

The Senate recognises that the NLAG Trust cannot continue to provide a service without partnership with another provider. We agree that the proposed clinical hub and spoke model is in line with established practice and has the potential to provide a good solution to patients, if there is the ability to retain a comprehensive outpatient service and day case chemotherapy at NLAG.

There are 3 options set out in the business case. The Senate does not support the do nothing option (option 1) due to the medical staffing issues and the risk to patient safety. Option 2, the hub and spoke model, has our support. There are significant factors to overcome in achieving the hub and spoke model put forward in option 2 including recruitment to posts to achieve the medical model, agreement on managing certain conditions from other specialties, commissioner and secondary care agreement to a single site in Northern Lincolnshire, a strong governance structure and of course patient agreement.

The Senate cannot comment on Option 3, the STP regional hub and spoke model, as there is no supporting information on the York service. Due to the lack of supporting information commissioners will wish to note that option does not present as a fully considered option. It might prove to be the best option but we do not have sufficient evidence to evaluate this. We advise that this model should be developed in more detail if it is to remain within the paper. Commissioners need also to note that the table 5 weighting is different to the weighting applied in table 6 which brings into question the scoring of the 3 options.

The Senate struggled to understand the service proposals solely from the paperwork provided particularly the impact on the wider haematology services and the proposed outpatient and day unit services which will remain at NLAG. A number of questions therefore arose from our reading of the proposals which were addressed in discussion and our understanding of the intended model based on those discussions is set out below.

Understanding the intended NLAG sites for this model and services to be retained at NLAG.

NLAG is referred to as both plural and singular in the paperwork. Currently both outpatients and day treatment is delivered on both sites but in the new model you have confirmed that the intention is that there will be a haematology outpatient clinic and day unit treatment offered on a single site on NLAG under the umbrella of a Hull service (as a spoke from the hub in Hull). The proposals received by the Senate describe the intention for 'limited outpatient services' to continue and in discussion you have confirmed that treatment that can be delivered safely in an outpatient and day centre basis at NLAG will be provided there. This includes maintenance treatments and treatments for palliative care. If admission is required the patient will be admitted to Hull and then repatriated to NLAG for outpatient chemotherapy. This model will therefore be a multi-site delivery of chemotherapy but managed by Hull. This is discussed further in the governance section. The proposals need to make clear whether they include paediatric haematology provision.

We understand that due to the immediate safety issues with the NLAG service more activity has been removed from NLAG and transferred to Hull than is intended with the longer-term model. Simpler chemotherapy regimens, which have been removed currently to reduce pressure on the NLAG service, will return to NLAG with the single site model. These include those regimens listed on page 12 of the business case.

The success of this intended model is dependent upon the ability of NLAG to agree how they move to a single site for this service. We are unclear on how developed those discussions are.

Understanding the impact of this model on the non-cancer haematology service. The business case is written from a cancer perspective without reference to general haematology services. As there is a significant amount of haematology liaison work within the hospital, important for orthopaedics and stroke services for example, in addition to the haematology malignancies, the Senate panel were concerned to understand the strategy for the management of this work. With regard to the laboratory haematology service, in terms of who is reviewing the results, films, abnormal coagulation for example and advising for NLAG, you confirmed that the laboratory haematology service is currently provided entirely by the networked Pathlinks service. If required then the proposed model with Hull could potentially extend to cover laboratory haematology but at present this is not how the NLAG service is structured. Your view therefore was that this proposal will not impact on the laboratory haematology service.

The Senate panel also questioned the impact of these proposals on the general haematology/ non-malignant consultative provision for the rest of NLAG (including for example transfusions for GI bleeds and the complex scenario of AIHA)**.** In discussion it was confirmed that non-malignant clinical haematology would be covered using the same hub and spoke model as malignant work. For haematology problems such as the AIHA example then telephone discussion followed by either transfer or local review at the next appropriate opportunity would be the solution. For GI bleeds and DOAC issues patients do not get admitted under haematology but go to a specialty appropriate to their clinical problem. Haematology provide advice and support for the clotting problem and your proposal is that this can be done remotely regardless of where the patient is admitted or where the haematologist is physically located and therefore these services can continue to be provided safely on the NLAG site. Commissioners need to seek agreement from other specialties on this approach. We are unclear how developed those discussions are.

Health Education England (HEE), who are represented on our Senate Council, have advised that they are concerned about haematology provision in NLAG, particularly the ability to provide blood products and would urge the Trusts to look at employing clinical scientists for this role.

The proposed consultant and middle grade medical cover at the NLAG site. In discussion you confirmed that your aim is to provide consultant cover at NLAG 5 days a week by clinicians from Hull who provide the service on the NLAG site. This is dependent on recruitment and the final model that can realistically be supported. Your current estimates are that you will need to recruit an additional 3 CH to provide a 5 day presence in NLAG. The proposed job plan is that the newly recruited Consultants would work 4 days a week in the cancer centre in Hull and 1 day a week on the NLAG site. Due to the challenges of recruitment your view is that should the recruitment not be possible an alternative model is to provide cover and support in NLAG through locally based Clinical Nurse Specialist Teams who have ready access to haematology medical staff (Consultant and Middle Grade) in Hull for advice and support. You cited the example where the Hull team previously ran services in Scarborough with onsite staff for 2 days in the week but provided telephone support all day, every day of the year. We understand that there is currently a good Clinical Nurse Specialist model in place at Grimsby. You acknowledged the risk that with the temporary measures put in place (removing activity from NLAG) the nurses will feel deskilled but you have already put processes in place for the CNS to spent time in Hull and integrate with the wider Hull team.

Your proposal for onsite middle grade haematology cover is for it to run along a similar visiting service model to the consultants. An alternative model would be to rotate middle grade specialty doctors from the Hull centre to the NLAG site for a longer period of time to provide continuity and onsite service – again this would be very dependent on clinical need, resource and the ability to fill posts. We have been advised by HEE that they would not support unsupervised middle grades in haematology working in NLAG to provide a service. This model of provision has failed in oncology in other Trusts for both in and out patient work. Junior doctors must work with clear supervision at all times. HEE would support an outreached service to the trust from neighbouring trusts (such as Hull) but junior doctors would need to be accompanied by a consultant and not work in isolation with remote supervision. In discussion you have confirmed that your proposals would not leave a junior doctor unsupervised.

With nurse led delivery one of the concerns of the Senate panel was the challenge of managing the ill health of patients following the chemotherapy in terms of how will that patient will be managed and where will they access support. The availability of medical advice is key to managing both the complications from chemotherapy or if the patient presents for chemotherapy and is unwell and requires an assessment of whether they are fit enough to receive treatment. In discussion you confirmed that you have set up a Cancer Assessment Unit which is working very effectively. If a haemato-oncology patient suffers difficulty following their chemotherapy they will be able to call the assessment unit which is the single point of contact for all patients in the Hull and NLAG network. This will take them through to nurse led triage and then directed on to the relevant service. If admission is required this would be to Hull and if assessment and e.g. IV fluids are required then this could be provided in the normal day time hours of operation at the NLAG site. This process also provides access to medical decisions regarding the management of unwell patients attending the day ward.

Understanding the inpatient and outpatient activity at NLAG. The Senate noted the high activity recorded in NLAG for both inpatient and outpatient activity and questioned whether this was correct. In discussion we were informed that there is a substantial amount of outpatient activity assigned to haematology rather than its correct service e.g. gastro hepatology. This is due to historical differences in patient pathways which is skewing the activity figures for haematology outpatient activity in NLAG. It is not clear to the panel if NLAG have started to have the discussions with other specialties regarding this model. We recommend that commissioners work with GPs to address this issue to ensure scarce consultant haematology expertise can be focussed on specialist work.

Inpatient activity in NLAG is also recorded in the business case as higher than in Hull. You confirmed that your understanding is that this is due to the differences in recording attendances and the example we discussed is that 1 cycle of RCHOP at Scunthorpe will be recorded as 3 attendances rather than 1 at Hull. The new diagnosis data from the Regional Haematology Network supports this conclusion as it states that in 2016 in Hull there were 386 new cancer diagnoses and in NLAG there were 274. The inpatient activity issues therefore are not about the volume of patients; it is that each patient is creating more episodes of care.

Understanding the governance arrangements. At the moment there is a governance framework within each Trust and each site is accountable to its own internal governance processes. We are in agreement that this would have to change with the adoption of the hub and spoke model to ensure equality of care. We recommend that you focus on the clinical governance required as the success and safety of this model requires criteria and protocols across multiple specialities and Trusts including the ambulance services. We recommend that there is a single governance framework for this service with training, peer review and a single MDT for example all led by Hull and that the NLAG service is seen as an outreach post of the Hull service. We understand that the single MDT structure is already in place The role of the accountable clinician is very important in this model due to patients being cared for in satellite sites.

Discussions with transport services. Our understanding is that NLAG have commenced discussions with NHS transport but we are not aware of the outcomes of those discussions. Commissioners need to ensure that patient transport will be easily accessible in a timely manner between all existing sites and Hull.

The cost of travel can be a significant issue for primary carers with significant distances between some areas of Northern Lincolnshire and Hull and solutions to this need to be considered.

Commissioners also need to involve and discuss the proposals with ambulance services.

Engagement with the public. Engagement with the public has been undertaken by NLAG in October and November 2017 to promote the transfer of the 6 regimens to Hull. An update on Haemato-Oncology service was published in July 2018 (and is available on the webpages of the Humber, Coast and Vale STP Acute Services Review.) We understand that further engagement may be undertaken as part of the wider piece of work underway in Humber Coast and Vale looking at the acute services. If the public engagement is tied into that wider work it has the advantage of connecting this to the wider picture of service change. We are all agreed that the message to the public needs to be about ensuring the provision of services that are safe and sustainable.

- **Can the Clinical Senate identify any clinical concerns that they may have about the proposed model?**

The Senate's clinical concerns with this model have been discussed in the earlier section and can be summarised as:

- The ability to provide sufficient medical cover at NLAG to enable a comprehensive outpatient service and day case chemotherapy service to be delivered on the NLAG site;
- The ability to reconfigure the current NLAG service on to a single NLAG site;
- The strong single clinical governance framework required to ensure the Hull/NLAG service operates as a single service;
- The agreement to manage certain conditions from other specialties to enable the consultant haematology expertise to be focussed on specialist work;
- The ability to maintain the wider non-cancer haematology service at NLAG.

Conclusion

The Senate recognises that the NLAG Trust cannot continue to provide a service without partnership with another provider. We agree that the proposed clinical hub and spoke model is in line with established practice and has the potential to provide a good solution to patients, if there is the ability to retain a comprehensive outpatient service and day case chemotherapy at NLAG.

We recommend that the relationship between these proposals for the oncology service and the wider haematology service are made much clearer and that going forward you focus on addressing the clinical concerns that we have highlighted. These are particularly the medical model and the clinical governance framework, and we recommend that the NLAG Trust and commissioners accelerate their discussions to develop the service on to a single site and their discussions with other specialties with regard to this haematology service.

We hope our comments are helpful to you.

Yours sincerely

Chris Welsh
Senate Chair
NHS England – North (Yorkshire and the Humber)

NHS
Yorkshire and the Humber
Clinical Senate

CLINICAL REVIEW

TERMS OF REFERENCE

TITLE: Clinical Haematology Services in Hull and North Lincolnshire

Sponsoring Organisation: NHS England Specialised Commissioning

Terms of reference agreed by: Kevin Peters, Senior Supplier Manager and Joanne Poole, Senate Manager

1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: Dr Steve Ollerton, GP and Clinical Leader, Greater Huddersfield CCG

Citizen Representative: David Ita and Tony Alcock

Clinical Senate Review Team Members:
Dr Rod Johnson
Consultant Haematologist, Leeds Cancer Centre, St James University Hospital

Michelle Kwok-Williams
Consultant in Clinical Oncology, Leeds Cancer Centre, St James University Hospital

Sue Morgan
Teenage Cancer Trust Nurse Consultant, Leeds Teaching Hospitals NHS Trust

Gail Jones
Haemato-oncology Service Lead, Newcastle University Hospital

Fiona Clark
Consultant Haematologist, University Hospitals Birmingham

Tina Dutt, Consultant Haematologist and Honorary Clinical Lecturer, Roald Dahl Haemostasis and Thrombosis Centre, Royal Liverpool University Hospital

2. AIMS AND OBJECTIVES OF THE REVIEW

Question:
Can the Clinical Senate

- advise if the review panel agree that the proposed clinical model is in line with best practice / provides the best solution to patients given the workforce challenges?
- identify any clinical concerns that the Senate may have about the proposed model?

Objectives of the clinical review (from the information provided by the commissioning sponsor): The purpose of the service review is to provide independent clinical oversight on the proposed model of care for chemotherapy services for haematology cancers in Northern Lincolnshire and to ensure that high quality service provision is maintained and delivered for the population. The Senate advice will form part of the evidence provided by commissioners to the NHS England assurance panel.

Scope of the review: The Clinical Senate will answer the above questions based on the information provided in the documentation and the clinical panel will supplement their understanding of the model through discussion with commissioners.

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: 31st August 2018

Agree the Terms of Reference: September 2018

Receive the evidence and distribute to review team: Distributed to the panel on 20th September

Teleconferences: Panel discussions held on 28th September and 5th October. Discussion with commissioners and clinical leads held on 13th December

Style of Report: Chair's letter

Draft letter submitted to commissioners: 10th January

Commissioner Comments Received: within 10 working days of the draft letter being received

Senate Council ratification; January 2019 meeting

Final report agreed: end January 2019

Publication of the letter on the website: To be confirmed with commissioners

4. REPORTING ARRANGEMENTS

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

5. EVIDENCE TO BE CONSIDERED

The review will consider the following key evidence:

- Project brief,
- HCV chemo logic model,
- Visio-NLaG six regimen referral pathway v2,
- HCV chemotherapy PID v0,
- Equality and Health Inequalities Service review,
- Chemotherapy – patient and public participation form v2,
- Final OSC HCV haem onc brief,
- Humber Acute Services Review Comms and Engagement Plan final,
- S Sawyer letter and S Sawyer Enc – haemato oncology action plan

6. REPORT

The draft clinical senate letter 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. 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.

9. 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.

10. 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

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