Liver Metastases Information Event on 11 July 2011

The aim of this document

The aim of this Q&A document is to capture and reflect the main themes and concerns of those who attended the Liver Metastases Information event in Cambridge on 11 July; this document is not therefore, verbatim record of the event.

The questions and issues raised have been grouped into themes and some questions joined together where there was overlap. This helps to highlight the key areas of challenge and concern that will now be taken forward by the project team.

Session Introduction

The event was introduced by Carole Theobald, Director of Commissioning from the East of England Specialised Commissioning Group (SCG). The first presentation was a brief introduction to the project by Dr Rory Harvey, Medical Director of the Anglia Cancer Network (ACN) who set out the background and its aims and objectives.

The aim of the ACN is to achieve an increase in the number of patients accessing this surgery as there is an unacceptable variation in numbers of people currently treated. Pam Evans from East of England SCG then explained the process and timescales of designation of a single surgical centre.

Presentations

Both presentations can be found by clicking


Liver Information Day Rory Slides.ppt


Designation process and Timetable - Liver

Question and Answer session – key issues raised & responses given

Questions relating to the IOG guidelines

Q1. The process is being driven by the IOG Guideline which states that a population base of two million is required to run the service. You want to drive people towards a service so that they can improve; this is the wrong way round when good services already exist.

Response

Our aim is to develop a high quality, IOG-compliant centre with volumes and personnel that will be sustainable over the long term. The review team will look at the service proposal of any interested party and assess whether they meet the criteria.

If potential services within the Anglia Cancer Network (ACN) boundaries do not meet the criteria and are not mature enough to be developed there is a potential that we could divert all our patients to a service outside of the network. However we believe that there

are providers within the region who offer high quality services and will be able to meet the required specified standards.

Q2. Would you offer the work to a provider outside the IOG guidelines?

Response
The remit is to commission an IOG compliant service and the SCG will only designate an IOG compliant service. Our broader remit is not just what is happening now but what our services will look like in five years time and about transforming the services for this group of patients.

Q3. Why are you prejudiced against a solution outside the region when you have already said that Peterborough has three times the resection referral rate than other areas?

Response
All options will be considered, so long as the result is an IOG compliant service.

Q4. Why do you feel that you are mandated to only commission an IOG compliant service?

Response
This has to be driven by clinical guidelines and we would be remiss if we didn't commission an IOG compliant service. There is an expectation that the SCG will commission services, on behalf of it's constituent PCTs which are IOG compliant.

Q5. Who made the decision on having an IOG compliant service?

Response
The IOG provides quality measures and a clinical basis for commissioning/providing services and is the best available guideline at this time. The Secretary of State for the Department of Health is responsible for approving NICE guidelines.

Q6. When did the SCG Board make a decision about having an IOG compliant service for liver metastases?

Response
The principles of commissioning IOG compliant services has always been supported by the SCG Board, as it is believed that IOG compliant services ensure improved outcomes.

This particular IOG was discussed at both the January and March Board meetings in 2011 where the approach for taking this forward was agreed.

Q7. Why was the decision to go for an IOG compliant service only made in January 2011, when the paper came out in 2008?

Response
As a network we have to deliver IOG compliant services and we have to prioritise the order in which they are implemented. As the SCG commission this service the project was in their work plan too and needed to be agreed by the SCG Board.

Q8. New guidance has come out in April, how has this affected the process?

Response
It has not changed it. The new guidance still reinforces implementation of the IOG.

Q9. The service specification incorporates areas outside of the IOG. Has this been agreed by the board?

Response
The service specification has been sent to all PCTs for their comments and the Board will be made aware of any contentious issues. The service specification has followed all normal sign off processes within the SCG. The IOG is about liver metastases resection for colorectal cancer patients, but the network does not see any reason to exclude patients with other primaries.

Q10. Is it the view of SCG that they can only commission an IOG service even if that service is worse than what is currently being delivered?

Response
The SCG does not believe that commissioning an IOG compliant service would worsen patient outcomes.

Q11. Has the SCG ever commissioned a non IOG compliant service?

Response
Not that we are aware of, although there is a programme of work which is being prioritised to ensure compliance. We are aware that there have been some nationally agreed exceptions.

Q12. Under peer review, units have to have more than one surgeon?

Response
Yes they do, an IOG compliant service needs to be sustainable.

Q13. Could there be one SMDT and surgeons based on two surgical sites?

Response
This is not what is described in the IOG.

Questions relating to the External Review Team

Q14. Will there be a Terms of Reference for the external review team?

Response
Yes the review team will be measuring the service proposals received against the service specification requirements.

Q15. Will the review team be asked come up with the best option to deliver the service specification?

Response
No they are being asked to tell us which providers will be able to deliver the service specification.

Q16. Under this service specification there is no way that the review team could suggest a unit outside the region to undertake the work.

Response
It may be that no units within the network are suitable to deliver up to 180 resections a year and therefore we would have to look outside the network to the required capacity.

Q17. Why have you chosen London and SE Coast to be on the review team and not some one from respected clinical bodies?

Response
The people referred to in this context are external SCG commissioning representatives of the panel not the external clinical representatives on the panel.

It was generally agreed that AUGIS would be an appropriate source of advisors for the clinical review team.

Questions relating to the service specification

Q18. The service specification does not show how equity of access will be improved through the interworking between colorectal and liver resection MDTs, how will the local MDTs work with MDTs within the network?

Response
Within the Liver Resection SMDT, there are liver resection surgeons who are responsible for the links to the Colorectal Local MDTs. We have agreed to add more into the service specification to make this clearer.

Q19. Who wrote the service specification?

Response
The project team wrote the service specification.

Q20. Who wrote the evidence based section from the service specification?

Response
It was written in accordance with the IOG.

Questions relating to a low volume centres

Q21. What is the definition of a low volume centre?

Response
We have no definition of a low volume unit but none of the three current providers within the network go above 100. The results around volume are linear and the more you do the better the outcomes.

Q22. What about high quality and low volume services?

Response
The issues that would need to be considered would be around sustainability, particularly 24/7 hour cover, if there was no access during holidays many patients would continue not to get access to the service.

Q23. You have two low volume centres providing services that are above the national average, will the board not consider having two centres?

Response
We have listened to your comments today and will reflect on these. However we want to commission an IOG compliant service.

Questions relating to the quality of service and outcome data

Q24. How do you mean you want to improve the quality of the services?

Response
We want all patients to get equal access to the surgical service and we believe that the IOG assures a minimum level of quality standards.

Q25. If you decide to have the service in Cambridge and the PCTs don't send their patients there as they can get a better service elsewhere – what happens then?

Response
The SCG Board is representative of all PCTs in the east of England and decisions will be binding on SCG commissioned services, where agreed by the SCG Board.

Q26. Will current outcome data from across the country be considered in the review?

Response
You will have an opportunity to provide evidence of your current outcomes in your service proposal. We will be commissioning on what the services will look like in the future including over the next 5 years.

Q27. How are you going to measure the outcomes?

Response
There is a detailed range of metrics within the service specification against which the service will be monitored.

Q28. Have the outcomes improved for pancreatic after moving to a single centre?

Response
The centralisation is only 10 months old, which is not enough time to generate outcome data for pancreatic.

Questions around geographical access

Q29. The issue of travel times from Norfolk was raised as a concern and the impact of patient choice in terms of the proposed changes to the established pathways to ensure an IOG compliant service.

Response
The SCG and ACN have experienced this issue before and we recognise the need of a good communication plan which incorporates the needs of providers, HOSCS and patients.

Q30. Will geographical access equity appear in the service specification?

Response
No but it will be considered in any consultation/engagement undertaken.

Questions around access to the new service and increase in numbers

Q31. How is one surgical site going to increase the numbers of patients receiving treatment?

Response
Through strengthened referral processes and improved patient information. If one centre is unable to meet the capacity requirements then we would need to consider commissioning additional capacity from another designated centre outside of the network.

Q32. How much notice will you take from the consensus of opinion of the CRNSSG specialist group if they want to keep the current referral pathway?

Response
There is evidence to suggest that all patients that should be accessing the service are not getting access, this suggests that the current referral pathways are not effective for this group of patients.

Q33. Can we have some further info on detailed working on why we are not doing enough resections?

Response
Yes, Rory Harvey agreed to send some data to those present.

Question around the destabilising of other services

Q34. If it is decided that Norwich is chosen will you take into account that it may destabilise the liver team in Cambridge?

Response
Impact on services is a factor and our process will be completely open and transparent. This issue would not be part of remit of the expert review. Contractual issues will have to be taken into consideration if other services were to be decommissioned. Impact assessments would be part of any subsequent consultation. In a previous consultation for pancreatic services we sought advice of the impact on other services and expert feedback found that it would have no impact on those services.

Comments

The Peterborough colorectal team do not wish to change the long established referral route to Leicester for patients with colorectal liver metastases.