East Anglia Area team – Specialised Commissioning
Assessment Criteria and Scoring for Review of Proposals to Host the Anglia Cancer Network Area Liver Resection Service

External Review Panel Criteria and Scoring for AngCN Liver Resection Service May 2013

Scoring for each (lowest overall score = best fit with criteria) **2=Added Value, 4= Meets Criteria, 6= Risk, 8= Significant Risk**

Criteria Weighting (if required)
Again the lower the score the more important the criteria 1=essential 2=developmental

Ref	Criteria	Weighting
1	CEO Sign-Off	1
2	Commissioner Sign-Off	1
3	Fully Costed Implementation Plan 1	2
4	Fully Costed Implementation Plan 2	2
5	Cancer Performance and Developments within the Trust	1
6	Clinical Outcomes	1
7	Future Impact on Trust Services	2
8	Guiding Principle	1
9	Accessibility/Acceptability	1
10	Responsibility for the Patient	1
11	Diagnostics	1
12	Liver Resection Specialist MDT	1
13	Surgery	1
14	Oncology and Follow-up Agreements	1
15	Research	1
16	Data Collection	1
17	Operational Model	2
18	Operational Policy	1
19	Service Audit	1

Cambridge University Hospitals NHS Foundation Trust – results of panel consensus scoring 22.05.13

Ref	Criteria	Weighting	Score	Weighted score	Panel Comments
1	**CEO Sign-Off** Trust Chief Executive agreement to and sign off of the service proposal. This must be in the form of a letter signed by the Chief Executive of the Trust confirming support of the proposal and commitment to the provision of the future service.	1	4	4	
2	**Commissioner Sign-Off** Host Local Commissioner agreement to and sign off of the service proposal. This must be in the form of a letter signed by the Local Commissioner Chief Executive and state support of the trust proposal for the delivery of a network wide service.	1	4	4	
3	**Fully Costed Implementation Plan (Finance Director view)** Assessment of the financial planning model for consistency, feasibility and cost-neutrality	2	4	8	
4 **4.1** **4.2** **4.3** **4.4**	**Fully Costed Implementation Plan (External Panel view)** Fully costed implementation plan detailing phased delivery of the activity plan and service model described in the service criteria. Service commencement in June 2014. Timescales provided for recruitment to key posts and detail of any additional facilities required. Proposal and associated documentation clearly showing a resource plan that meets the expected demand: • SMDT personnel, equipment, and videoconferencing facilities to accommodate between 738 and 923 referrals per annum;	2	4	8	

	• Theatre space, staff, ITU and HDU facilities to accommodate up to 185 liver resections per annum				
5 **5.1** **5.2** **5.3** **5.4**	**Cancer Performance and Developments within the Trust** Information provided that demonstrates any recent developments in cancer services within the Trust and their integration with other Trust services. Peer review reports. Current waiting times performance for the Trust and any associated action plans for underperformance. Areas of outstanding good practice, along with any key challenges to the development of cancer services.	1	4	4	
6.1 **6.2** **6.3**	**Clinical Outcomes** Data made available. Data sources identified. Taking all the data as a whole (current activity levels, 30 day mortality, survival rates and re-admission rates), do you have clinical confidence in the service?	1	4	4	
7	**Future Impact on Trust Services** Assessment of the impact of the Trust losing their liver resection service on members of the local population who access the Trust for other services.	2	2	4	Clear demonstration that collocated services would suffer if surgery for colorectal liver metastases were removed.
8	**Guiding Principle** Does the proposal and associated operational policy demonstrate that they have internalised the guiding principle that patients are cared for by healthcare professionals across the Network collaborating throughout the care pathway, with as many elements as possible of that care pathway delivered locally to the patient. By default, only surgery and immediate follow up should occur at the centre (unless the centre is also	1	4	4	

	the patient's local Trust)				
9 **9.1** **9.2** **9.3** **9.4**	**Accessibility/Acceptability** Liver resection service to be accessible regardless of age, disability, race, culture, religious belief, sexual orientation or income levels? The service shall describe how patients will access the centre from wherever they live across the Network. The service shall demonstrate flexibility for visiting families and carers. Information shall be provided on local accommodation, car parking, public transport, social support, benefits, and facilities within the centre. Patients and their families/carers shall be provided with written information about liver metastases and its treatment.	1	4	4	Whilst this criteria was met transport issues do need addressing
10	**Responsibility for the Patient** Clarity on who is responsible for the patient at any point in their pathway.	1	6	6	The plan to continue as now. There was little evidence that the team had thought through the leadership of the provision of a regional centre
11	**Diagnostics** The centre must demonstrate within their SMDT Operational Policy how it will coordinate the transfer and analysis of scans and test results from referring Trusts.	1	4	4	
12 **12.1** **12.2**	**Liver Resection Specialist MDT** The liver resection specialist MDT shall be hosted by the same Trust that provides the liver resection surgical service. Either the liver resection specialist is a stand-alone specialist MDT with the following core membership:: • two or more hepato-biliary surgeons; • histopathologist; • imaging specialist; • nurse specialist; • an oncologist (clinical or medical) who takes	1	2	2	The review team concluded that collocation of the metastatic liver resection service with the pancreatic service led to a depth and breadth of skills and services that would ensure a fully comprehensive service.

	responsibility for chemotherapy given in combination with metastatectomy; • MDT co-ordinator/secretary; • an NHS-employed member of the core or extended team nominated as having specific responsibility for users' issues; • a member of the core team nominated as the person responsible for ensuring recruitment into clinical trials and other well designed studies Or the liver resection specialist MDT is combined with the pancreatic specialist MDT, with the following core membership: • physician gastroenterologist; • clinical oncologist; • medical oncologist (where the responsibility for chemotherapy is not undertaken by the clinical oncologist core member); • dietician; • histopathologist; • imaging specialist; • HPB nurse specialist; • a core member of the specialist palliative care team; • MDT co-ordinator/secretary; • an NHS-employed member of the core or extended team should be nominated as having specific responsibility for users' issues and information for patients and carers; • a member of the core team nominated as the person responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the MDT; • at least one of the core team radiologists should be an interventional radiologist; • there should be a core team member trained in endoscopic ultrasonography.				

12.3 **12.4** **12.5**	The liver resection specialist MDT shall be a video-conferenced MDT giving all referring Trusts and clinicians the opportunity to participate fully in the discussion of their patients. The provider must ensure that the video-conferenced liver resection specialist MDT is broadcast using up to date video-conferencing equipment that is under a maintenance contract If the liver resection specialist MDT decision is to treat the patient at the surgical centre • a key worker shall be identified for the patient and their name recorded in the patient notes; • the follow-up team shall be decided based on clinical/geographical need and patient choice.				
13 **13.1** **13.2**	**Surgery** The surgical centre shall also have the capability to deliver radiofrequency ablation treatment for patients, if this cannot be provided locally. The provider shall ensure that there is an emergency care specialist surgical service available with 24/7 cover and access to expert opinion for both patients and clinicians. The emergency care pathway shall be defined within the SMDT Operational Policy.	1	2	2	The review team concluded that collocation of the metastatic liver resection service with the pancreatic service led to a depth and breadth of skills and services that would ensure a fully comprehensive service.
14	**Oncology and Follow-up Agreements** Assessment of the processes and policies for deciding on location of oncology and follow-up, given the guiding principle of maintaining diagnostics and treatments as local as possible to the patient.	1	4	4	
15	**Research** Evidence of a positive culture of research within the organisation and an assessment of how this is implemented	1	4	4	

	for patient benefit. This should include leadership arrangements for research and the arrangements for promoting access to high quality clinical trials.				
16	**Data Collection** Datasets for collection are up to date (Cancer Outcomes Services Dataset) and relevant to the Specialist MDT organisation chosen	1	4	4	
17	**Operational Model** The operational model shall demonstrate how communication, joint learning and joint working amongst clinicians across the Network will be achieved.	2	6	12	The review team found evidence of a lack of communication between the centre and the referring local MDTs
18	**Operational Policy** Does the operational policy comprehensively cover all that was required of it: • Name of Organisation; • Type of MDT and the organisational support for MDT working; • Clinical Leadership of the service and how this will develop to ensure appropriate clinical engagement in the patient pathway across the network, ensuring a standardised approach is achieved and maintained; • Membership of the core MDT*; • Extended membership of the MDT; • Clinical expertise available*; • Clinical facilities available*; • Proposed working with the Colorectal NSSG and other relevant SSGs, MDTs and cross cutting groups. Demonstration of how system wide priorities for improvement will be identified and agreed; • Referral arrangements into the MDT (including an MDT referral template) and policy for clinical responsibility for patients at different points in their pathway; • The Model of Care and operation of the MDT and the	1	2	2	Clear documented processes added value to the MDT working.

	role of local services in the following: ▪ Pre-diagnostics ▪ Diagnostics ▪ Pre-treatment ▪ Treatment ▪ Emergency care ▪ Follow-up ▪ Supportive care • Communication to referrers and how the MDT will manage whole system relationships, sharing information between all constituent organisations and clinicians in order to manage patients across their care pathway; ▪ Key Worker policy ▪ Emergency cover arrangements* ▪ Re-referral arrangements • Service User information policy which outlines how patients will be communicated with and provided with informed choice throughout their pathway; • Service User feedback policy which will describe how patient experience data will be used to improve and develop working practice within the Trust and in the wider Network of care; • Patient access, transport and accommodation information, ensuring these are considered across the whole Network area; • Plans for data collection and audit; • Evidence of a positive culture of research within the organisation and an assessment of how this is implemented for patient benefit. This should include leadership arrangements for research and the arrangements for promoting access to high quality clinical trials; • Description of video-conferencing equipment – make, model, year of installation and duration of current maintenance contract.				

	*where posts need to be appointed to or facilities increased a clear recruitment/development plan needs to be available to meet the implementation date.				
19	**Service Audit** Is it clear from the proposal and associated documentation how the Trust will audit its service, both clinically and from a patient experience perspective?	1	4	4	
	Totals		72	88	