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To provide every patient with the care we want for those we love the most

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

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Mr Tony Goldson
Chairman
Cambridgeshire, Norfolk & Suffolk
Joint Health Scrutiny Committee

By e-mail: theresa.harden@suffolk.gov.uk

Our Ref: AD/JPG/vr/LA.11.090

15 November 2013

Dear Mr Goldson

Call for Evidence – Liver Resection Services

I write further to Ms Harden's e-mail of 24 October 2013, and thank you for inviting us to comment on the proposal to implement a single surgical centre for patients with liver metastases within the Anglia Cancer Network. We believe that there is an opportunity to improve the services available to patients in this region and I hope that the comments in this letter will be accepted in the constructive spirit in which they are offered.

I enclose a copy of my letter of 30 January 2013 to the Specialist Commissioning Group, which sets out this Trust's position. I would re-iterate the message of that letter, that this is an opportunity for creative leadership, implementing international best practice in a way that is sensitive to the circumstances and demographics of our local population and region, rather than imposing a 'one-size fits all' solution. Our concerns in this regard were detailed by our Medical Director in his letter to Sir Bruce Keogh on 3 November 2011 (copy attached for your information).

Before going further, I should make three preliminary points:

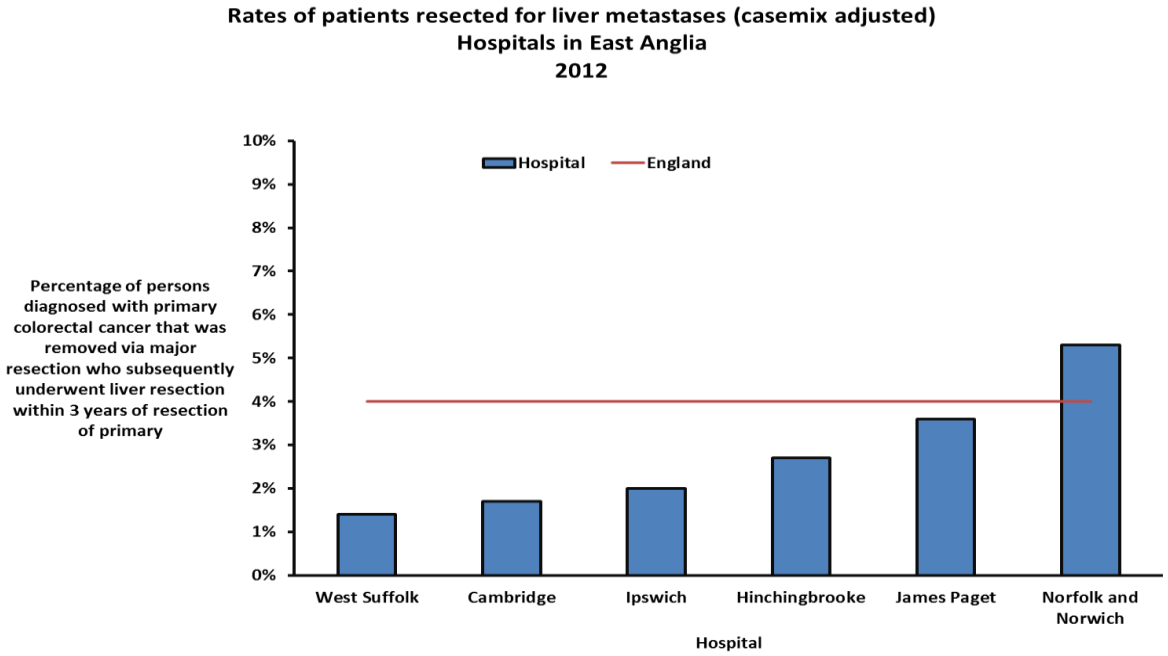
(i) We believe that there are circumstances in which consolidation of clinical services to larger units can be to the benefit of patients and the wider health service. I think it is agreed by all parties that the previous arrangement of three surgical centres in the Network was not best for patients and some reorganisation was required;

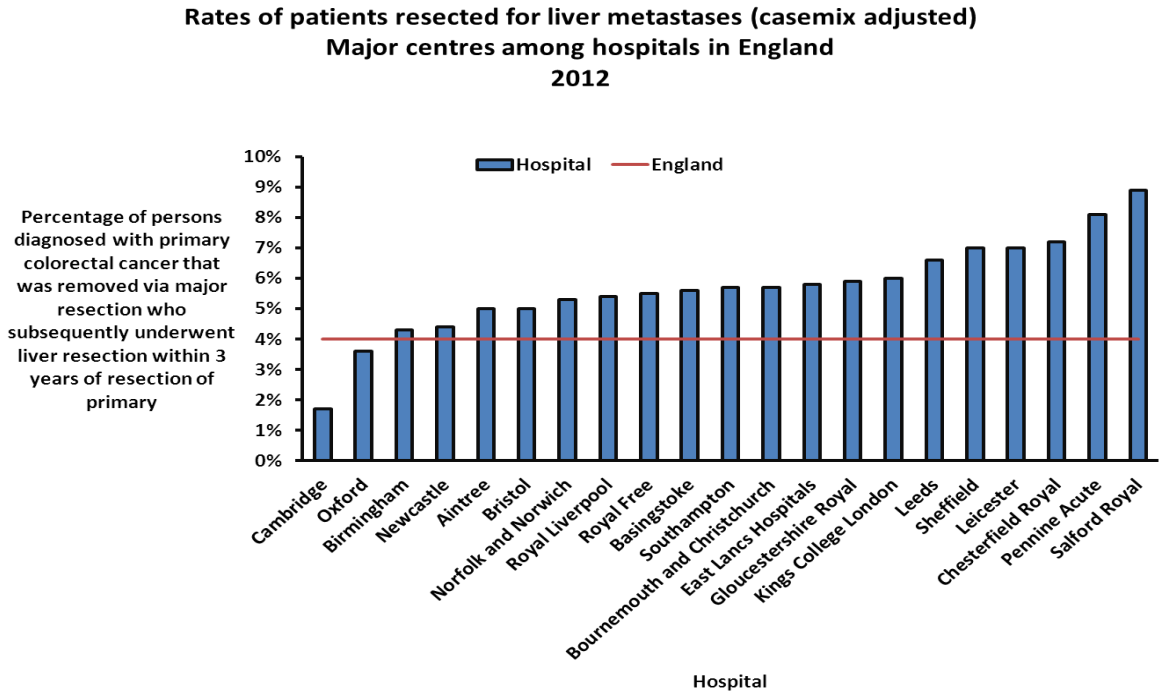
(ii) If surgery for liver metastases is to be centralised to a single hospital within our region it would be logical, all other things being equal, for this to be in the same location as liver transplant services (i.e. Addenbrookes Hospital);

(iii) This Trust has however consistently proposed an alternative model, because we believe that patients would be best served by the establishment of a single liver MDT to oversee and support two surgical centres in the Network. We believe that this proposal would build on existing strengths and promote consistency in best practice

across the region whilst benefitting patients/families through the provision of expert care as locally as possible.

The declared purpose of the proposed reorganisation is to increase the percentage of patients with liver metastases who are offered surgery, in order to increase their chances of survival. It is therefore striking that the proposed reorganisation involves diverting patients away from the only hospital in the Network exceeding the national average resection rate, as summarised in the graphs below, taken from the papers provided to your meeting of 25 September 2013 (Agenda Item 7 – Evidence Set 5). This may be a case of the best of intentions having unintended consequences but it may prove difficult to explain to clinicians and the public.





Cross-organisational MDT arrangements typically involve a 'host' hospital supporting clinicians in a number of 'satellite' hospitals in caring for patients with cancer. Data from the National Cancer Intelligence Network suggests that the proposal as currently formulated will require all cases of liver metastases to be referred to an MDT service generating some of the lowest resection rates in the country in its satellite hospitals.

The papers provided to your meeting of 25 September 2013 also show that the decision to move to a single surgical centre was based on a report prepared for the National Cancer Action Team (NCAT) (Agenda Item 7 – Evidence Set 4). We provided comments on a draft version of that report and a copy of my letter of 27 November 2012 is attached for your information. Unfortunately, the NCAT report was flawed not least through reference to incorrect or out-of date data. The report provided to you was apparently uncorrected despite our comments.

Based on figures provided by the Anglia Cancer Network there are enough patients in this region who require surgery for liver metastases to support two 'high volume' surgical centres, both meeting the international best-practice minimum centre volume threshold (see page 2 of my letter of 27 November 2012). We believe that this proposal remains the best option, in the best interests of patients.

Whatever the outcome to this process, we believe that there must be adequate safeguards in place in future to ensure that:

- MDT arrangements function collaboratively so that no further 'satellite' hospitals develop the low resection rates of some historically in the Network;
- as much care as possible is provided in hospitals local to where patients live. Even though surgery may be centralised to one or two centres, as far as possible those centres should offer support to local clinicians and hospitals in offering investigation, primary surgery and follow-up care to patients in their local hospital.

These are difficult matters and again I hope that my comments will be accepted in the constructive spirit in which they are offered, so that collectively we can achieve the best outcomes for our patients with cancer.

If you require any further information, please let me know.

Yours sincerely

Anna Dugdale
Chief Executive

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Our Ref: AD/JPG/vr/LA.11.090

30 January 2013

Dear Catherine,

I am writing as requested to confirm my support for this Trust's Proposal to provide a Metastatic Liver Resection Service and our commitment to future provision of this Service.

You will see that our Proposal is based on a single surgical centre for delivery of this Service, as required by the Service Specification. I wish it to be formally recorded, however, that it is the view of this Trust that adoption of a single centre model is not in the best interests of the patients of this region. We have raised this point before repeatedly.

Having considered the international literature, the statistics on performance and clinical advice, we remain firmly of the opinion that patients in this area would be best served by a service based on two surgical centres overseen by a single MDT. This alternative model would ensure consistency of access to surgery for patients across the region whilst maintaining compliance with best practice guidance on surgeon and centre volume. It would facilitate improvement by building on established areas of clinical excellence. It would demonstrate that the principle of providing centralised specialist services is good for patients because it can be implemented in a way that is sensitive to the geography and demographics of a local area rather than on a 'one-size fits all' basis.

If selected to provide a one-site Service, this Trust would deliver this in a way that is inclusive and aimed at supporting local clinicians, maximising access and minimising inconvenience for patients. We do however advocate reconsideration and adoption of the model of a single MDT overseeing two surgical sites.

Yours sincerely

Anna Dugdale

Anna Dugdale
Chief Executive

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3 November 2011

Dear

I hope that you will excuse me for approaching you but we are facing a situation that has the potential to cause damage to the reputation of the NHS as promoting high quality, evidence based care. I would welcome any advice that you can offer.

Unfortunately, the issue here relates to the centralisation of certain services, in particular surgery for liver metastases. I fully support the rationale for consolidation of services in order to promote excellence in patient care. In this case, however, the proposed re-organisation of surgery for liver metastases in our region risks giving consolidation a 'bad name'; it is not evidence-based, locally sensitive or well-considered.

It is proposed to centralise this surgery to a single centre for the whole of the Anglia Cancer Network, notwithstanding the geographical issues in this area and that the demand for this surgery in this region is sufficient to support two 'high volume' centres. Both such centres would be large by international comparison and would exceed professional recommendations on minimum surgeon volumes and international meta-analysis evidence on minimum centre volumes.

The drive for a single centre is to meet the IOG population target of 2 million. IOG guidance on liver resection surgery is not based on minimum Surgeon Volumes or minimum Centre Volumes, and does not take into account the data on actual outcomes that is now available. A recent analysis of outcomes from surgery in the UK, however, suggests that there is no simple correlation between mortality and population-based commissioning.

It is seen therefore that in relying on IOG alone the commissioners are not adequately reflecting the evidence that is now available. It is also perceived that patients are to be offered a service that is not only less accessible, but also delivers worse outcomes than those that currently achieved. A 'quality' requirement for the proposed single centre service is that it should deliver a mortality of <5%, notwithstanding that this is more than double the national average of 2.2% and nearly five times that currently achieved at this Hospital. It is difficult to explain how this is in the best interests of patients or consistent with a NHS aspiring to excellence.

I do not wish to place you in an awkward position but there is a real risk of some scandal over this. The local GPs and MPs have started to become involved and it is only a matter of time before it becomes more public. Any advice you can offer as to how we can ensure that the commissioning decisions are placed on a better evidence base and properly reflect the circumstances of this region would be appreciated.

Please do get in touch if you need any further background or if it would be helpful to discuss.

Yours sincerely

Professor Krishna Sethia
Medical Director

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Our Ref: AD/JPG/cb/LA.11.090

27 November 2012

Dear Carole

Response to Draft NCAT Report Proposed Re-Configuration of Surgical Services for Colorectal Liver Metastases in Anglia

Thank you for asking for comments on the factual accuracy of the draft report prepared for the National Cancer Action Team (NCAT). The draft report is prepared by specialists from national centres of excellence namely Professor B Davidson (Royal Free), Professor G Poston (Aintree) and Mr G Toogood (Leeds).

The reviewers make a number of excellent points. There are however a number of areas where information as quoted in the report is incomplete or misleading. It is obviously very important that any commissioning decisions in this matter are based on up-to-date and correct data and we hope that the following information will assist the reviewers in ensuring that their conclusions are evidence-based and robust. I hope that the comments that follow will be accepted in the constructive spirit in which they are offered as we all strive to achieve the best evidence based outcomes for our patients.

For ease of reference, where possible the comments below follow the sequence of the draft report. In summary, key areas of factual inaccuracy appear to relate to:

1) current position in the reconfiguration process;
2) purpose of the review;
3) referral patterns and population data;
4) clinical outcomes;
5) MDT performance;
6) manpower (sic);
7) academic research;
8) geographical and population factors;
9) case selection;
10) sundry matters.

1 Current Position in the Reconfiguration Process (page 3)

The draft report suggests that provider institutions were "*requested to submit proposals for providing a service for the Network by 31st December 2011*". In fact, following circulation of a draft document, the service specification for a reconfigured service was never finalised and the process was put on hold pending advice from NCAT as to the appropriateness of a population-based commissioning model for the service in this region.

The reviewers may wish to know that by way of e-mail dated 23 November 2011 it was confirmed that "*… the SCG Board met on 22 November and agreed the recommendation for a 3 month postponement of the liver met project. The impact of this is that Trust service proposals will not be expected on 23 December as originally planned…*". In January 2012 NCAT predicted that the outcome of the review would not be available until the autumn of 2012 leading to an extension of the original 3 month pause.

This misunderstanding of the situation may explain why the reviewers apparently expected to see business cases for the proposed service. In fact the preparation of such business cases would have been premature in the circumstances. Repeated reference in the draft report to business cases based on a single centre model gives the unfortunate impression that the outcome of the review was seen as a foregone conclusion rather than it being an open-minded consideration of the position.

2 Purpose of the review (page 3)

On page 3 of the report the reviewers detail in 3 bullet points the matters on which they were to advise. The second of these is "*which organisation(s) are best placed to deliver the service?"*. In this the reviewers appear to have been placed in an impossible position - one cannot assess which organisations are best placed to deliver a service when the service criteria and shape of that service have not been finalised.

In fact, the bullet points do not reflect the declared purpose of the review. The review team may find it helpful to be provided with a copy of the SCG Update Newsletter (Issue 2 January 2012) which, on page 2 under the title "SCG Board agrees a pause", explains that the purpose of the NCAT review was to "*look at the appropriate levels of work for an individual surgeon to undertake in order to provide a safe and effective service for patients with liver metastases*". It appears that the review may have lost sight of this original purpose.[1]

3 Population and Resection Rate Data (Page 5)

The draft report quotes figures for the populations served by the surgical centres in Cambridge and Norwich. The data quoted is now out of date given the recent publication of the results of an audit of liver resection referrals carried out by the Anglia Cancer Network in 2012 (report dated 7 September 2012 - ref AUD74).

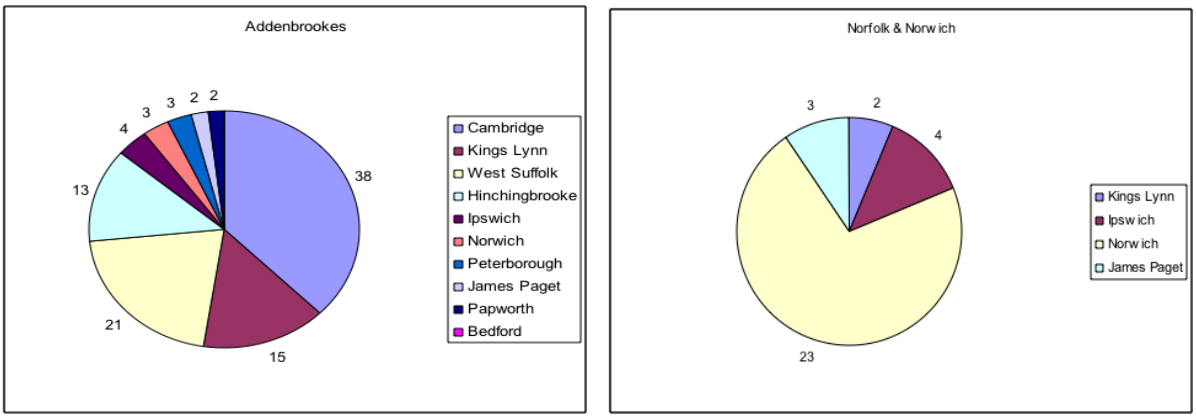
The relevant data is set out in two pie charts on page 3 of the ACN report of that audit as below (Fig 1). The implications are clear - it appears that a significant proportion of patients from Ipswich and Norfolk are currently referred to Cambridge. This has an obvious effect on the size of the respective populations currently served by the two centres and needs to be

[1] For a simple 'quick' answer to the question:

- An international meta-analysis of international data in 2009 confirmed that mortality is reduced when CRLM resection is performed in high volume centres compared with those performing <5 resections pa (Gruen et al (2009) The Effect of Provider Case Volume on Cancer Mortality. CA Cancer J Clin; 59:192-211).
- AUGIS (Association of Upper GI Surgeons) recommends a minimum of 10 major liver resections pa per surgeon (ie 4 surgeons = 40 resections).
- Charnley and Paterson-Brown (2011) reflecting the consensus of an AUGIS working party reported that surgeon volume "*is not a reliable single measure of quality, nor is it a substitute for clinical outcomes … [but] it is the most accurate surrogate indicator available*" (Surgeon volumes in oesophagus and hepatopancreatobiliary resectional surgery; British Journal of Surgery, 98:891-893).
- Begg et al (1998) demonstrated reduced 30 day mortality in American hospitals performing more than 11 hepatic resections a year but beyond the threshold of 11 operations per annum no beneficial effect of increased volumes was seen.
- There is no accepted definition of a "high volume centre". Gruen et al (2009) (ibid) demonstrate however that performing over 34 resections pa places a centre in the highest quartile by volume internationally. They conclude that "*On the basis of mortality outcomes alone, it appears prudent to support volume based referral and high volume centres. However, there are also clearly some low-volume providers who get good results, and therefore referral to relatively low-volume providers should be supported if good outcomes can be demonstrated by process measures or by risk adjusted outcomes..."* (page 208)

reflected in the calculation of 'expected resections per year' if these expectations are to be correct.

Fig 1 – Liver Resection Referrals from Anglia MDTs



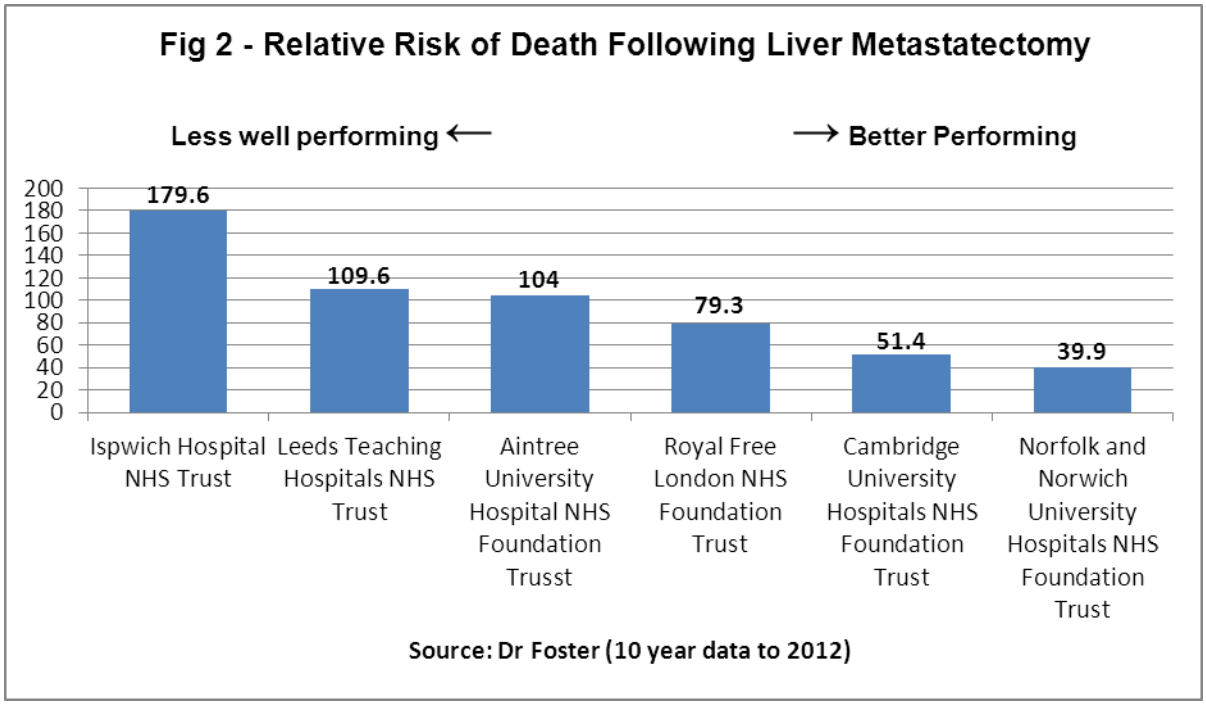
Source: ACN Liver Resection Audit 2012

4 Clinical Outcomes (Page 6)

Table 2 of the draft report provides 'clinical data' for the surgical centres in Norwich and Cambridge. This represents however only a partial picture based on the last 3 years. Fig 2 and 3 below set out 10 year mortality data from the independent Dr Foster database for the 3 surgical centres in the Network, along with national reference centres for comparison. This information is obviously a crucial component of any assessment of quality. Any commissioning decision based on quality or the interests of patients must have a clear focus on these metrics and use of incomplete data in the report is very troubling.

It is suggested on page 4 of the draft report that some performance data in the report may be an amalgamation of historic information from Norwich and Ipswich. The rationale of this approach is difficult to understand and its validity is unclear. As Gruen et al explain, clinical outcomes in hospitals may be affected not only by individual surgeon performance but also by organisational features "*including the way in which teams work together and the institution of best practice protocols*".[2] It is unsafe to assume that such organisational influences will 'transfer' with the patient from one hospital to another and the performance information as quoted appears to be misleading if not simply wrong. This has obvious implications for the conclusions of the draft report.

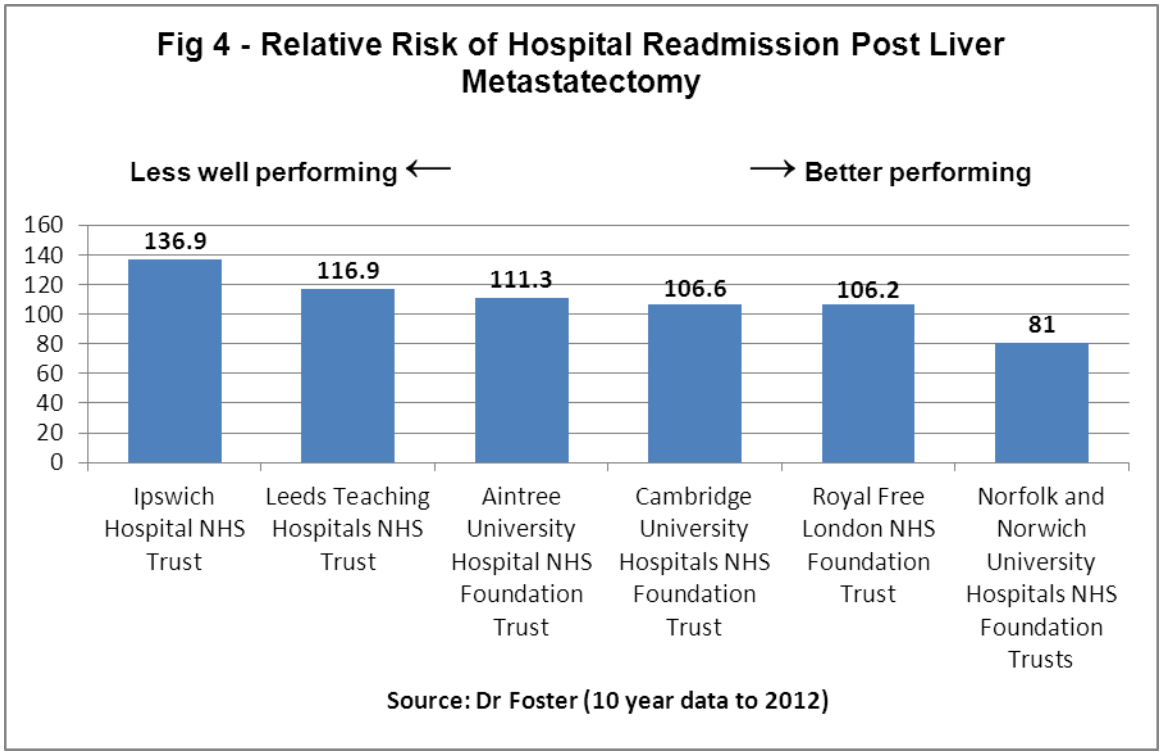
[2] Gruen et al (2009) The Effect of Provider Case Volume on Cancer Mortality. CA Cancer J Clin; 59:192-211 (page 202).



(Fig 3) Relative Risk of Mortality by Surgical Centre Following Liver Metastatectomy Source: Dr Foster (2012)

Peer (Liver group)	Spells	Actual Deaths	%	Expected Deaths	%	Relative Risk
Leeds Teaching Hospitals NHS Trust	1459	30	2.10%	27.4	1.90%	109.6
Aintree University Hospital NHS Foundation Trust	924	21	2.30%	20.2	2.20%	104
Royal Free London NHS Foundation Trust	778	13	1.70%	16.4	2.10%	79.3
Cambridge University Hospitals NHS Foundation Trust	478	5	1.00%	9.7	2.00%	51.4
Norfolk and Norwich University Hospitals NHS Foundation Trust	212	2	0.90%	5	2.40%	39.9
Ipswich Hospital NHS Trust	111	5	4.50%	2.8	2.50%	179.6

As a matter of fact, there is further easily accessible standard data available concerning clinical outcomes. The data on readmission rates for example is again collated by Dr Foster and is reproduced in Fig 4 below.

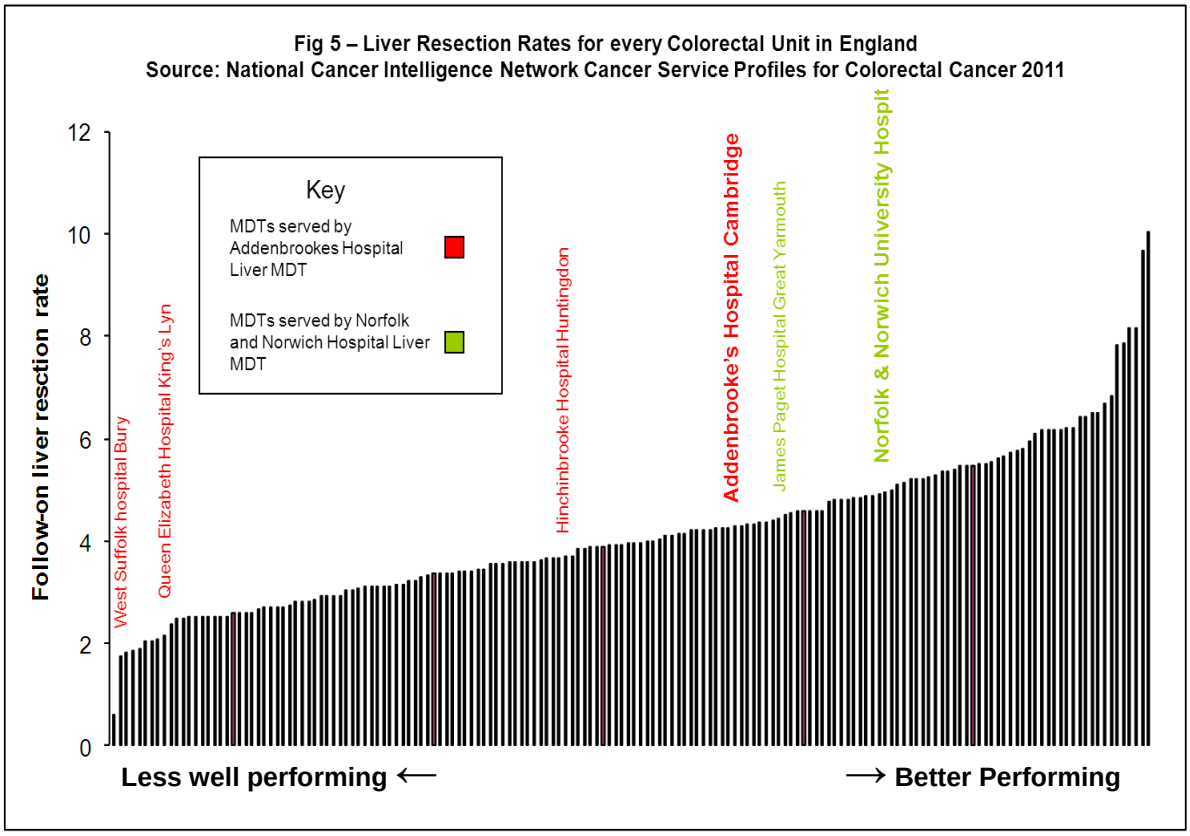


Given that the express purpose of this service reconfiguration is to improve clinical outcomes for patients, we suggest that the omission of this factual context is material.

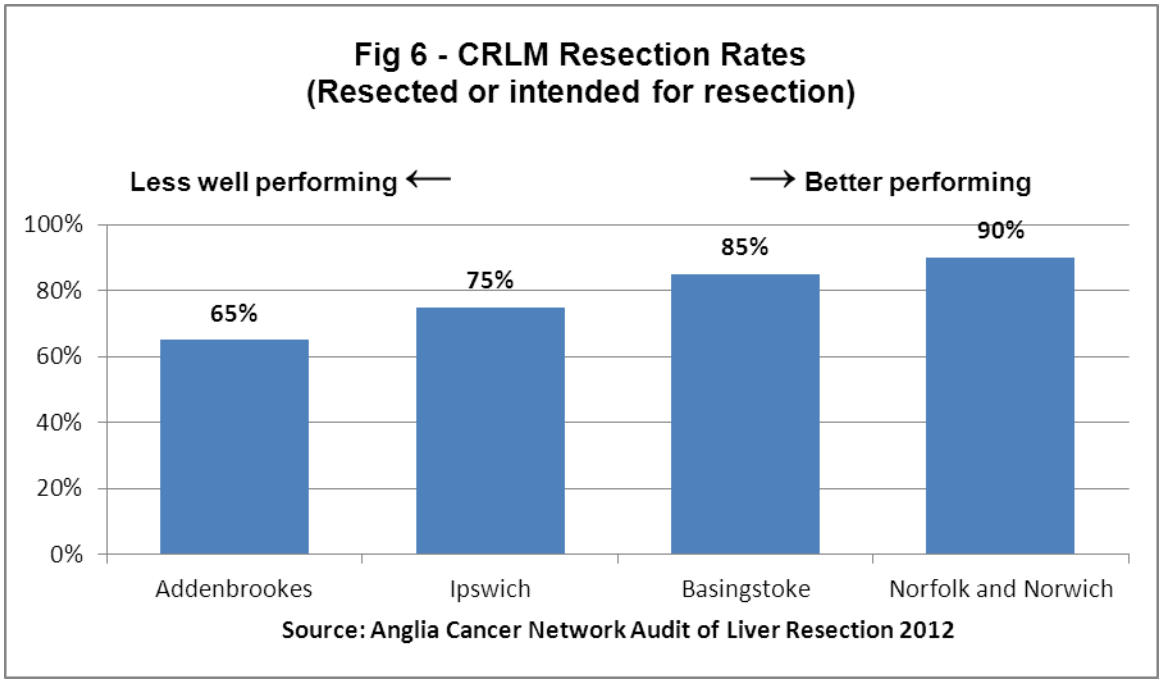
5 <u>Concerning the performance of the liver MDTs in the region (Page 3)</u>

Page 3 of the draft report states the declared aim of the service change as being to improve access to liver metastatectomy (ie to increase the numbers of operations performed). This being so, there is an obvious factual omission in the report concerning the number of referrals made for resection by each of the relevant MDTs.

Fig 5 below details national liver resection rates for patients referred to Liver MDT. It would seem logically important that any reconfiguration of this service should be focused on improving the service for those MDT areas that are less well performing. The reviewers may wish to correct the factual omission from their report by reference to this data, which is analysed in Fig 5 by hospital hosting an MDT and “peripheral” hospitals served by that MDT.



The data reproduced on page 5 of the Anglia Cancer Network audit of liver resection is as set out below with respect to resection rates. This data indicates that the Norwich MDT has the highest resection rate of any MDT in the network.



6 Manpower (sic) (Page 6)

Table 3 of the draft report appears to compare data but is not comparing 'like' with 'like' and is quite misleading – the number of operations currently performed in only one part of the Network would not appear to be sufficient to occupy 4.6 wte surgeons in anyone centre and still meet AUGIS recommendations on surgeon volume.

Concerning the adequacy of training and surgical experience, this section is considered to unfairly represent the background of a number of the staff concerned. Rather than passing any comment on specific individuals however the outcome data referred to at Section 4 above would appear to speak for themselves. For patients it is clinical outcomes that matter rather than surgical CVs and this process is ostensibly about 'improving outcomes'.

7 Patient trials and academic research (Page 9)

Clinical research is of course crucial and should be supported. The Norwich Research Park is the 4th most quoted research site in the UK. The conduct of academic research is however not part of the proposed service specification and it is not clear why there is a section on this in this report.

8 Geographical and population factors (Page 10)

The factual coverage in the report of issues relevant to the Anglia region specifically is extremely limited as is the evidence for the conclusions reached. The review team may find it helpful to be provided with information concerning the population profile by age for this region (recent announcements by the Secretary of State for Health indicate that Norfolk has the oldest population in the country, with Suffolk "'not far behind"). Similarly it may be possible for the ACN to provide the reviewers with a breakdown of the age of patients undergoing liver metastases resection. We understand, from local data, that approximately 60% of these patients are aged 65 and over.

9 Case Selection (Page 10)

The report suggests that the outcomes achieved by the Network Service to date may reflect "*a selection bias with only the most straightforward cases being put forward for surgery*". That may be true of some centres but the 10 year data from Dr Foster shows that the expected death rate in Norwich and Ipswich is high (see Fig 3) indicating high level of co-morbidity in these patients. The speculation on case selection in the report therefore appears to be factually ill-founded and is contradicted by the ACN audit (Fig 6), the NCIN resection rate data (Fig 5) and the case mix information provided to the review team.

10 Independence of review

On a final note, we recognise that even on a national basis the world of specialist surgery is a relatively small circle. To protect the reputational integrity of the reviewers in this case, NCAT may wish to advise them to include a Declaration of Interests section in their report. This is so particularly as they may know or have contact with some of the organisations or associated individuals involved in this review, or may be involved in other similar processes on a national or local basis either through their employers or professional organisations.

Given all that has been said above, the international and national recommendations on surgeon caseload and centre volume, the projected future incidence of CRLM in Norfolk and Suffolk (counties with the oldest populations in the country), and the proven track record in Norwich of delivering the best clinical outcomes in the region, it is difficult to understand the basis on which the draft report has rejected a two-site solution and concluded that patients in Anglia would be well served by a single centre for CRLM surgery based in Cambridge.

We hope that this information is helpful. If material amendments to the draft report are made, we would be happy to comment further on factual matters.

Yours sincerely

Anna Dugdale
Chief Executive