Norfolk, Suffolk and Cambridgeshire Joint Overview and Scrutiny Committee and NHS England

Liver Resection: Local Resolution Meeting

2 April 2014

Report of the Outcomes from the Discussions

Present:

Councillors Sarah Adams (Suffolk), Peter Ashcroft (Cambridgeshire), Adrian Dent (Cambridgeshire), Michael Chenery of Horsbrugh (Norfolk), Tony Goldson (Suffolk), David Jenkins (Cambridgeshire), Dr Nigel Legg (Norfolk), Margaret Somerville (Norfolk.)

Andrew Reed, Director, NHS East of England Area Team; Carole Theobald, NHS East of England Area Team; Pam Evans, NHS East of England Area Team; Dr Rory Harvey, Clinical Director for the Strategic Clinical Network and Chair of the Liver Metastases Steering Group.

In attendance: Theresa Harden, Business Manager, Suffolk County Council; Maureen Orr, Scrutiny Support Manager, Norfolk County Council; Jane Belman, Scrutiny and Improvement Officer, Cambridgeshire County Council.

Summary

This report outlines the process and outcomes from the meeting held between members of the Joint Overview and Scrutiny Committee for Norfolk, Suffolk and Cambridgeshire (the JHOSC), representatives from NHS England's East Anglia Area team as the responsible commissioner for specialised commissioning within the East of England and a representative from the Strategic Clinical Network (cancer services). It aimed at resolving the different views of the Committee and the commissioners about the future provision of specialised liver resection services across the 3 counties. Following facilitated discussion and private deliberation, the JHOSC agreed that to achieve the most effective clinical outcomes for patients, the services should be commissioned from one centre of excellence to be based at Addenbrookes Hospital. The JHOSC was however, concerned about a number of issues that need to be in place to enable positive patient and carer experiences within the service, e.g. transport and physical access, effective communication, seamless care pathways between primary, secondary and specialised services, and effective performance indicators. NHS England agreed that members of the committee should be engaged in the discussions with stakeholders in planning the transition and implementation of the reconfigured service to ensure that the wider issues are adequately addressed.

Meeting Process

It was agreed beforehand that the meeting would focus on the three areas where consensus on the commissioning of liver resection services had not been reached. These were:

1. **In respect of Recommendation 1**: the inaccuracy of the NCIN data relating to the number of patients resected for liver metastases
2. **In respect of Recommendations 3 and 4**: … the preference for a single centralised model for a multi-disciplinary team, assessment and referral process
3. **In respect of Recommendations 5 and 6**: whether or not the CCGs in the three counties are supportive of the proposal; *and* whether or not the referring hospitals in the three counties are supportive of the proposal.

An external facilitator planned and led the meeting. She explained to participants that the aim was to either achieve consensus or reach a point where it was clear that no consensus could be achieved on each of the issues. In the absence of published national guidance on health scrutiny, reconfigurations and local resolution processes, the facilitator sought advice from the Department of Health about what would constitute an acceptable local resolution process. Telephone advice was provided before the meeting by a civil servant from the Department of Health engaged in developing guidance. This was shared with the participants at the meeting prior to the discussion.

Verbal advice from the Department of Health

- There are no rules on how reaching local agreement or resolution should be undertaken, but the process should be open, transparent and clear.
- The resolution process can be undertaken in public or private but councillors must be able to demonstrate how they have taken account of the views of local residents, including how they have collected these views.
- The process and the outcomes of the resolution process must be transparent and must be reported back to the public using usual mechanisms
- A referral to the Secretary of State would need to include an explanation on how the process for local resolution was agreed between JHOSC and NHS England
- The report would need to shine a light on/demonstrate that it was meaningful resolution
- Reporting to Secretary of State and to the public should outline all steps undertaken.

Following discussion of the issues of concern, the facilitator and representatives from NHS England left the room to enable members of the JHOSC to reach a consensus view. They were then invited back into the room and the Chair of the JHOSC explained that the committee had agreed to support the proposal. The final part of the meeting focussed on discussing and agreeing the next steps.

Discussion

Each of the 3 issues of concern were considered in turn .

1. **Recommendation 1**: the inaccuracy of the NCIN data relating to the number of patients resected for liver metastases

Council officers were able to report to the meeting that confirmation had been received from NCIN by e mail that there was a discrepancy between results calculated for CUFHT. A letter will be sent to the Chair of the JHOSC but ahead of

the letter it was confirmed that NCIN had re-run the analysis and had preliminary results. The preliminary results show the percentage of colorectal patients who go on to have a resection for liver metastasis is 5.5% for CUHFT and 5.0% for Norfolk and Norwich. Members noted that the error identified had affected the percentages for trusts in the East of England and that NCIN was currently working to get updated rates signed off and updated on the service profiles.

Members of the JHOSC accepted this information and considered no further discussion was necessary.

2. **Recommendations 3 and 4**: the preference for a single centralised model for a multi-disciplinary team, assessment and referral process

The JHOSC had proposed an alternative approach to NHS England's proposal, i.e. a single centralised model for a multi-disciplinary team, assessment and referral process, *and* surgery to be continued at both sites for a trial period whilst monitoring the referral rates and outcomes for patients over the necessary period of time to ascertain whether this model could deliver the required improvements. The discussion focussed primarily on the feasibility of the counter-proposal and the effectiveness of the current model of care, versus the improvements in patient care and outcomes that the commissioners identified from their proposed single centre model. In particular the difficulties of pursuing the counter-proposal and the likelihood of it achieving improved numbers and outcomes, and meeting the required national quality standards and service specification were outlined by the commissioners. The benefits of providing the service at a Trust that was actively engaged in research around specialised medical conditions were also highlighted.

Discussion between the members of the JHOSC resulted in the agreement that they had been provided with sufficient evidence and assurances that the model proposed by the commissioners would result in the best clinical outcomes for patients. However the strong concerns about issues of access, patient information and support, the need for reliable appointment management and in particular the need for a seamless pathway of care into and out of specialised treatment were preventing the JHOSC from supporting the proposal. During further discussion with the commissioners, Members of the JHOSC were offered the opportunity to receive more information about the whole care pathway and its governance arrangements, as part of the pre-implementation phase and to be involved in the discussions about addressing some of the practical issues for patients and carers that the new commissioning arrangements would require. This led members of the JHOSC to agree that they would support the proposal and would be involved in the discussions with NHS England, CUHFT and other stakeholders about addressing the issues listed in the Conclusions section below.

3. **Recommendations 5 and 6**: whether or not the CCGs in the three counties are supportive of the proposal; *and* whether or not the referring hospitals in the three counties are supportive of the proposal.

NHS England assured the JHOSC that the need for further engagement with key stakeholders was recognised and work to develop the engagement documentation was on-going. NHS England noted that there had been on-going engagement and support from all East of England PCTs as part of the process to develop IOG compliant services. It was noted, that due to the organisational changes to the commissioning bodies there had been limited discussion with new external

stakeholders about the proposal and that this would be undertaken as part of the next stage engagement phase. However, since 2011, there has been engagement with the wider regional colorectal services via the network site specific group, which has at all stages been kept informed and discussed the proposed service changes and whose Chair, Paul Cullen, was a member of the network group leading the service redesign. Mr Cullen is consultant colorectal surgeon in Kings Lynn.

It was also explained that the funding for the specialised services is provided by NHS England so there would be no detrimental financial impacts on local CCGs if a new model of provision is developed.

Assurance was also given that centralising the specialised service at CUHFT would not impact on the clinical effectiveness or viability of Norfolk and Norwich Hospital. Members of the JHOSC accepted this response.

Conclusions

Members of the JHOSC recognise the importance of improving clinical effectiveness of liver resection services and the aim that NHS England has to achieve clinical excellence within the Anglia region. It was accepted that transport to CUFT from some areas would be an issue but agreed that work should be undertaken to mitigate this.

As a result of the discussions and the offer made by NHS England to involve the JHOSC in further discussions about the transition period and the practical issues for access to the service from patients within the rural and furthest parts of the region, the JHOSC supports the proposal for one site at CUHFT to deliver the liver resection service.

The representatives from NHS England agreed that the JHOSC should be involved in discussions about the following issues that would need to be addressed before implementation of the proposal:

- Patient and wider public engagement plans;
- Transport and access issues to enable patients and carers to get to the hospital site. As part of this action NHS England and CUHFT would need to explain:
    - How access and transport issues for patients and families who do not have access to a car have been taken into account, as well as car-drivers?
    - What has changed in parking access since the question was raised in December 2013?
    - What data/traffic analysis has been done to show that this is not a significant issue?
    - How can this data be shown and at what time was it collected?
    - What opportunities are there for patients and carers to receive free parking and/or other concessions during their treatment at CUHFT?
    - It was recognised that transport was a much wider/system issue and that NHS England would not be able to resolve this in isolation, or the short term. The JHOSC has written to all Health and Wellbeing Boards to request action in this area on a system wide basis.

- Transition plans, i.e. how the service will move from 2 to 1 site without compromising patient care;
- Assurance that there will be a clearly designed pathway from referral to rehabilitation for all the geographical areas affected by this service change and that before the new service begins the patient pathway will be fully understood and supported by all those involved in delivering it. The JHOSC would also look for a clear explanation for patients and carers of the whole pathway and the role and involvement of the multi-disciplinary team;
- Clear communication to patients and the public explaining what the service looks like, what the whole pathway looks like, who is responsible for the patients, and when and how that responsibility is passed between providers within the pathway;
- Assurance that there is reliability in booking and that appointments will not be cancelled;
- Explanation of governance arrangements;
- An opportunity to comment on key performance indicators (KPIs).

It was agreed that CUHFT should be invited to future meetings/discussions between NHSE and the JHOSC members. The representatives should include staff with responsibility for access and transport planning in addition to clinicians.

It was also agreed that no one present at the meeting would share the information externally at this stage, and that a joint approach to external communications would be undertaken. However, the communications teams within the local authorities would start to develop the communications plan with NHS England communications team.

Members of the JHOSC stated that they would want to meet again 12 months after the changes in commissioning the service had been implemented to review the effectiveness of the change and comment on any improvements for patients that might be needed.

Next Steps

It was agreed that following the publication and circulation of this report NHS England would carry out an engagement exercise to ensure that stakeholders, patients and carers and interested members of the public are able to influence the implementation of the commissioning process. A further meeting with the JHOSC, representatives from CUHFT and any other appropriate stakeholders will be scheduled to discuss the issues identified in the conclusions above at a date to be agreed.