London Clinical Senate

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Advice to inform a recommendation on the future model and location(s) of radical prostatectomies in north central and north east London

June 2014

Response to Request for Advice to inform proposals for the future model of radical prostatectomies in north central and north east London

Prepared for: **NHS England (London)**
Approved by: **London Clinical Senate Council**
Date: **9 June 2014**

AIMS OF THE REPORT: To provide to NHS England (London):

1. Advice to inform a recommendation on the future model for radical prostatectomies in north central and north east London, with specific regard to:
    I. A comparative analysis of current outcomes data
    II. Outcome measures which should be used to compare radical prostatectomy performance, and
    III. Implications of recently published National Institute for Clinical and Care Excellence (NICE) prostate guidance

Contents

1 Summary

This report presents the London Clinical Senate's advice to NHS England (London) to inform a recommendation on the future model for radical prostatectomies in north central and north east London. It describes the approach that we took, the issues we considered and gives our conclusions.

The Clinical Senate was asked to give advice on three specific issues: the comparability of current outcomes data, the outcome measures which should be used to compare radical prostatectomy performance and the implications of prostate cancer guidance recently published by the National Institute for Clinical and Care Excellence (NICE).

A significant amount of work has taken place over the last few years to develop proposals for the future configuration of specialist cancer services in north central and north east London. This followed the publication of a London Model of Care for cancer services and the establishment of two Integrated Cancer Systems in London, one of which covers this geographical area. We were asked to provide this advice because clinicians and patients in outer north east London continue to have concerns about the proposal to consolidate complex bladder and prostate cancer surgery into a single specialist centre.

We established a Reference Group to assist the Clinical Senate in exploring the issues and formulating advice. This included members from national and professional bodies with specific knowledge and expertise in the management of prostate cancer and from outside of London. We are grateful to them for their contribution and for the impartial way in which they considered the issues we were asked to give advice on. A key part of our approach involved an "evidence session" where we had the opportunity to talk to several clinicians involved in the process to develop recommendations as well as the commissioner. This included clinicians from Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) and University College Hospitals NHS Foundation Trust (UCLH) who presented respective internal audits of current services and discussed their findings. We are very grateful to them for the time they committed and for the candidness with which they responded to our questions and gave their views.

Having considered all of our findings very carefully we concluded that it is not possible to compare current outcomes between BHRUT and UCLH based on the audit data presented due to the large disparities in data type, risk scales, definitions used and populations selected. In considering the outcome measures that should be used we recommend that future audits of surgical outcomes should be based on the British Association of Urological Surgeons (BAUS) database and NICE guidance pending the planned development of measures by the Specialised Urology Clinical Reference Group.

The recently published NICE guidance will have the greatest bearing on the future configuration of services. This clearly states that if commissioners decide to provide robotic prostatectomy for their patient population the procedure should be undertaken in high volume centres with at least 150 procedures per year. Our advice is simply that the NICE guidance should be followed and the implication of this, in so far as it relates to robotic surgery, is that there could only be one compliant service in north central and north east London.

Alongside this review the Clinical Senate was asked to provide advice about the robustness of the overall process through which NHS England developed recommendations for the future configuration of specialised cancer, and cardiovascular, services in north central and north east London. During this work we met patients who were concerned about the prostate cancer proposals. They felt they had not been shown the evidence behind the proposal for a single specialist centre and highlighted particular concerns about the travel implications to a centre which is a greater distance from home. We hope this report will give assurance to patients, and other stakeholders, that issues relating to outcomes and available evidence have been independently considered by a group with significant expertise and the advice provided is unanimous.

We recognise, however, that implementing the NICE guidance will require some changes and present some risk in the overall patient pathway and action will need to be taken to mitigate this. In particular underpinning policies and processes will be needed to ensure effective integration between the specialist centre and referring units and ways of mitigating the impact of the longer journey times to a specialist centre that some patients and their relatives will experience need to be actively explored.

NHS England (London)'s process for developing recommendations on the model of care for radical prostatectomies has ensured that stakeholders have been able to raise concerns and have their views listened to. In our view NHS England (London) has been rigorously fair in the way that these concerns have been addressed. We also believe, especially following publication of the NICE prostate cancer guidance, that sufficient evidence is available to enable a commissioning decision to be made.

Professor Christopher Harrison
Clinical Senate Vice-Chair

2 Background

Following publication of a London Model of Care for Cancer in 2010, London Cancer[1] established a clinically led approach to improving cancer care and outcomes. For urological cancer services this involved the Urology Pathway Board, a multi-professional group of clinicians and patients led by a competitively appointed clinical pathway director. The Pathway Board subsequently established a technical subgroup, which also had representation from all trusts, patients and primary care, to develop a service specification for the provision of services across the pathway to drive improvements. The specification included a recommendation to consolidate complex bladder and prostate surgery into a single specialist centre in order to achieve maximum patient benefit for the population served. This clinically led recommendation was endorsed by the London Cancer Board and published in May 2012, followed by a period of engagement.

In August 2012 London Cancer's constituent trusts were invited to submit expressions of interest (EOI) in providing local and or specialist urological services, demonstrating how the specification would be met. For specialist bladder and prostate cancer EOIs were received from Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) and University College London Hospitals NHS Foundation Trust (UCLH). Following assessment the London Cancer Board determined that BHRUTs EOI did not meet key parts of the specification and advised the Trust that it was unable to support the EOI at that stage. UCLH's EOI was assessed to meet the specification and was supported to submit a full proposal to the second stage. The EOIs were received in early in October 2012 and feedback was confirmed later that month.

As the next stage in the process, in December 2012 UCLH was invited to submit a formal bid setting out detailed proposals for provision of the specialist centre. Following assessment, which included an independent external expert advisor, in February 2013 the London Cancer Board agreed to recommend to commissioners that specialist bladder and prostate cancer surgery should be provided at UCLH.

A further engagement process took place in February and March 2013. Significant concerns were raised by clinicians and patients in outer north east London/Essex about a single site radical prostatectomy service (as proposed at UCLH) and they proposed an alternative two site solution (at BHRUT and UCLH). Concerns particularly related to the implications for patients and relatives of travelling to a central London location. Because of the strength of feedback, NHS England, the commissioner of specialised services, deferred making a decision at that time. Urological cancer services were then incorporated into a wider programme of work that was underway to develop proposals for improving other specialised cancer and specialised cardiac services in north central and north east London.

A Case for Change published by NHS England in October 2013 stated that a one site option and a two site, option would be considered. The two site option involved all complex bladder surgery and most complex prostate surgery being centralised at UCLH with some specialist prostate cancer surgery being offered at BHRUT. A further period of engagement included an options appraisal process with several workshops involving clinicians, patients and commissioners held during November and December 2013. Three options were appraised: a single site option, a two site option and a third hybrid solution (which was the same as the two site option with UCLH as lead provider). The option of a single specialist bladder and prostate cancer centre at UCLH was the highest scoring option.

Clinicians and patients in outer north east London continue to express concerns about a single site. During the engagement process some stakeholders asked about the difference in outcomes being achieved between BHRUT and UCLH and whether any conclusions could be drawn from this. NHS England (London)'s Programme Team did receive additional clinical evidence on prostate cancer surgical outcomes in November 2013[2] (prior to the options appraisal) however BHRUT raised concerns about conclusions being drawn from this and the information was not considered as part of the options appraisal process.

[1] London Cancer is one of two Integrated Cancer Systems in London covering north central and north east London

[2] This information was shared with the Clinical Senate to inform this review

2.1 Scope of Advice Requested

Given patients' and clinicians' on-going concerns, NHS England (London) has asked the Clinical Senate to give an independent view on the clinical evidence to inform a recommendation on the option for radical prostatectomies. Specifically, the Clinical Senate has been asked to provide advice on:

- A comparative analysis of current outcomes data,
- Which outcome measures should be used to compare radical prostatectomy effectiveness, and
- Implications of recently published NICE prostate guidance.

NHS London initially submitted a request for advice in November 2013. It was revised on 11 December 2013 to be clearer about the advice requested and refined again on 14 January 2014 to further clarify scope. A copy of the request is included as Appendix 5.2.

3 Formulation of Advice

3.1 Terms of Reference

The process to formulate advice was led by Professor Christopher Harrison, Clinical Senate Council Vice-Chair. Draft terms of reference for the Council's work were developed following a briefing by the Programme Director for NHS England's process and discussed by the Clinical Senate Council on 21 January 2014. Final terms of reference are included as Appendix 5.3. These include the approach for formulating advice on the overall process through which commissioning recommendations were developed as well as advice relating to the model of care for radical prostatectomies.

Terms of reference were shared with NHS England (London)'s Programme Director and taken to the overarching Programme Board. This ensured that the advice which the Clinical Senate had been asked to provide, and the approach to formulating it, were transparent to all stakeholders. No specific comments or feedback were received.

3.2 Review Process

The Clinical Senate formulated advice between January and April 2014. An expert Reference Group was established to assist the Senate. This included members from national and professional bodies with specific knowledge and expertise in the areas on which the Clinical Senate had been asked to provide advice to ensure the advice was robust and credible and would be supported by the relevant bodies.

- Professor Chris Harrison, Clinical Senate Council Vice Chair, Medical Director and Director of Public Health, Imperial College Healthcare NHS Trust (Chair)
- Mr. Jonathan Ramsay, Consultant Urologist, Imperial College Healthcare NHS Trust and London Clinical Senate Council member
- Mr. Hugh Mostafid, Consultant Urologist, Hampshire Hospitals NHS Foundation Trust and member of the Specialised Urology Clinical Reference Group
- Professor Mark Baker, Director, Centre for Clinical Practice, National Institute for Health and Care Excellence
- Professor Howard Kynaston, Professor of Urological Surgery, Cardiff University (Nominated by the British Association of Urological Surgeons)
- Mr Naeem Soomro, Consultant Urological Surgeon, The Newcastle-upon-Tyne Hospitals NHS Foundation Trust (Nominated by the British Association of Urological Surgeons)

Reference Group members reviewed documentation provided by NHS England (London) relevant to this aspect of the programme. Clinical teams from Barking, Havering and Redbridge University Hospital NHS Trust (BHRUT) and University College London Hospitals NHS Foundation Trust (UCLH) were then invited to present respective internal radical prostatectomy audits to a panel of Reference Group members[3] and to discuss the methodology, findings and conclusions drawn. The panel also met the Programme Director,

[3] Mark Baker was unable to attend

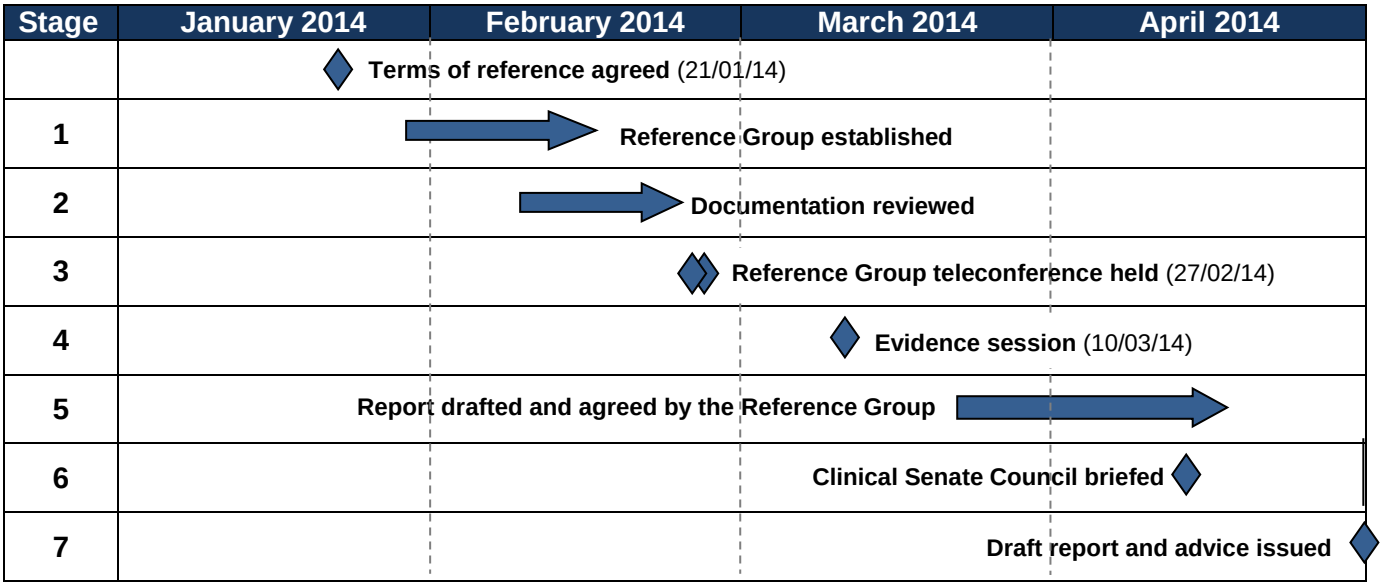
London Cancer's Medical Director and Urology Pathway Director and the Specialised Commissioning Lead. This evidence session was held on 10 March 2014. Also in attendance were:

- Sageet Amlan, Specialist Registrar, Observer
- Sue Dutch, London Clinical Senate Programme Lead, NHS England (London)
- Roger Durack, Head of Quality Improvement, NHS England (London)

This report presents the key issues that were discussed and emergent themes from the evidence session. It is not intended to be a comprehensive record of the discussion. It then sets out the panel's main observations and conclusions. These were considered by the whole Reference Group, together with BHRUT's and UCLH's internal audit presentations and the Reference Group's final conclusions and advice are given in section 4.3.

3.3 Timescale

The Clinical Senate formulated advice between January and April 2014. NHS England initially requested advice by the middle of February 2014 to inform a planned decision point in early March. The Clinical Senate considered the timescale too short to establish a sufficiently credible process. The agreed terms of reference aimed to provide provisional advice by the middle of March and to provide final advice in early April 2014. In practice the process of drafting and agreeing the report took longer than anticipated. Key milestones are noted below:



3.4 Limitations

Wherever possible the panel has attempted to triangulate findings from the information gathered through the evidence sessions and the documentation provided.

The Clinical Senate confirmed date for the evidence session (10 March 2014) on 13 February 2014. The Reference Groups for both the overall and prostate reviews were established with less than the mandatory six weeks' notice for doctors. This resulted in some Reference Group members not being identified early enough to be able to attend the evidence session.

This is one of the early reviews undertaken by the London Clinical Senate and there was no defined process to follow. The approaches adopted were discussed with the Senate Council and shaped by the Reference Groups and are considered fit for purpose. The Clinical Senate will identify any learning and use this to inform further work that it carries out.

4 Review Findings

4.1 Findings from the evidence session

4.1.1 Key points about the process to date

The panel received detailed briefings from stakeholders about the process that has taken place over the last 2-3 years to reach this point and particularly noted the following:

Objectives and approach to developing the proposals for specialist cancer services

It is well recognised that cancer outcomes in London are poor when compared to the UK and the rest of Europe. The overarching objective of this programme of work is to improve cancer outcomes and quality of care for people in north central and north east London.

The brief given to the Urology Pathway Board by the London Cancer Medical Director was to be ambitious in designing pathways to achieve the best possible outcomes and not to feel constrained by current arrangements. The only contemporaneous UK guidance[4] (which for radical prostatectomies referred to a minimum of 50 cases per year) was regarded as unnecessarily conservative. The wider reference group agreed that this guidance is very dated and is not an adequate basis on which to plan the configuration of services today.

North central and north east London has a population of 3.2 million. The London Cancer Model of Care recommended that specialist pelvic cancer centres should serve a population of at least 2 million. A two-site model for a population of that size would lead to one or potentially both centres not meeting the Model of Care population volume recommendation.

Meeting the recommendations set out in the London Model of Care was seen as the minimum standard to achieve. The Urology Pathway Board aspired to improve outcomes beyond that and to match international standards. The Pathway Board drew on the 'Sloan Kettering' model which demonstrated the relationship between volume and outcomes, especially in relation to functional outcomes and considered the evidence to be compelling. This informed the Pathway Board's view that the optimal model to achieve the best possible outcomes was a single specialist pelvic cancer centre and that this would lead to improvements in outcomes through increased volume, enabling development of whole team expertise (surgeon, CNSs, theatre team), specialist support e.g.in radiology, pathology etc. and greater ability to enrol patients into, and conduct, clinical trials.

The service specification and single centre model was agreed by all but one clinician on the Urology Pathway Board.

How outcome data was considered in the process

Current outcomes were not used as a criterion in considering expressions of interest for a single pelvic cancer centre or in assessing the final bid. It was recognised that outcome data quality and completeness in the NHS is generally poor, particularly functional outcome data, since mortality rates for prostatectomy should be very low, and using outcomes in this way has limited value. Making a recommendation by looking at current outcomes in a competitive way was not considered as an approach. The London Cancer Medical Director advised that the focus was on achieving the best possible outcomes in the future and to determine the best centre to provide the service, as part of a broader pathway, by inviting trusts to demonstrate that they could meet the service specification. The Urology Pathway Director confirmed this point, advising that because of the strength of support for the single centre a detail appraisal based on outcome data was not considered necessary or relevant.

[4] National Institute for Clinical Excellence (2002) Guidance on Cancer Services, Improving Outcomes in Urological Cancers, The Manual

There was no suggestion that current services were failing; from available information, including peer review, all four[5] (at that time) centres were considered to be providing a satisfactory service. The criteria for submission of bids did include plans for audit and outcome measurement because it was clear that these are important factors in enabling improvement and being able to fully inform patients about treatment options and the outcomes that they could expect.

The availability of outcome data could be used to demonstrate where current outcomes lie in relation to desired, future outcomes and to provide a baseline against which the impact of a decision on a the future service model can be measured.

Why outcome data is being considered at this stage

The single site option for radical prostatectomies, rather than radical cystectomies, had been the greatest issue of concern identified by stakeholders throughout the engagement process. Clinicians, including clinical commissioners, and some patients in outer north east London support a two-site option in which all complex bladder surgery and most complex prostate surgery would be centralised at UCLH with some specialist prostate cancer surgery continuing to be offered at BHRUT.

During the engagement process some stakeholders asked about the difference in outcomes being achieved between the two sites and whether any conclusions could be drawn from this. At this stage therefore it seemed appropriate at least to review the outcome data. In response, additional clinical evidence on surgical outcomes for prostate cancer was provided by both trusts during November 2013[6]. The data was received before the appraisal of options for providing the service was completed; however, BHRUT raised concerns about conclusions being drawn from the data and as a result, outcomes were not considered as part of the options appraisal process.

The options appraisal identified a single site at UCLH as the highest scoring option. However, to ensure all factors were considered fairly in the light of continuing concerns about a single site option, NHS England (London) sought an independent view on outcomes and on related evidence to inform a final recommendation.

4.1.2 Current outcome data

Clinicians from BHRUT and UCLH presented respective internal audits of current services and discussed these with the panel. This covered the audit methodologies, the findings and the conclusions drawn. The approaches to each audit and the key points from the discussion are summarised below.

Outcome data presented by BHRUT

Radical prostatectomy internal audit data presented by:

- Mr Sandeep Gujral, Consultant, Urologist and Clinical Lead for Urology
- Mr Anand Kelkar, Consultant Urologist and Urology SMDT Lead
- Mr Shiv Bhanot, Consultant Urologist
- Dr Stephen Burgess, Acting Medical Director

This was a retrospective audit covering the two year period April 2010 to March 2012. The primary aim was to look at dataset record keeping and compare local outcomes with national data as an internal quality assurance process. Secondary aims included undertaking a comparative analysis of open versus laparoscopic surgery focusing on cost effectiveness. The lack of clinical governance support, including an

[5] When the process started radical prostatectomies were provided at Barnet and Chase Farm Hospitals NHS Trust (BCF) and Whipps Cross University Hospital NHS Trust (WCUH),which is now part of Barts Health NHS Trust, as well as at BHRUT and UCLH. Since then activity at BCF and WCUH has transferred to UCLH; the panel was advised that due to low volumes and concerns at one centre about high 'positive margin' rates, clinicians providing services at those trusts felt they should be part of a larger service.

[6] This information was shared with the Clinical Senate to inform this review.

audit department, due to financial challenges in the Trust impacted on the audit. This limited the use of questionnaires which had some affect on the breadth of data collection e.g. relating to potency.

The audit drew from the BAUS Cancer Registry dataset which has eight categories: demographics, pre operative data, diagnostics and treatment planning, operative, immediate post-operative care, late complications, histology and follow-up. The database involved forty variables.

- The BHRUT overall average positive margin rate (where the edges of the removed tumour contain cancer cells) was ~22%, which is better than the UK average of ~30%.

- The BHRUT view was that there were enough patient numbers to sustain two radical prostatectomy sites, but that there should be a single Integrated Care System (ICS) and SMDT to support a multiple site model. It was suggested that retaining one site on the outskirts of London (BHRUT), could be beneficial in the future to treat greater patient numbers from Essex and the surrounding areas.

- BHRUT suggested that the trust could purchase a robot to carry out future surgeries if needed.

- BHRUT is seeking NHS England (London's) support for centres dealing with 100-150 patients per annum (below NICE guidance numbers) where local patient opinion is positive.

<u>Outcome data presented by UCLH</u>

Radical prostatectomy internal audit data presented by:

Mr. Paul Cathcart, Consultant Urological Surgeon
Professor John Kelly, Clinical Lead for Urology and Robotic Surgery.

The database has local ethical approval and is populated using multiple data sources, including patient opinion data collected through widely recognised, standardised questionnaire templates. The presentation demonstrated that the database allows compliance with NICE guidance to be shown and is used to inform patients on intervention outcomes to assist with treatment decision making. The team advised that the database also facilitates practice review, learning and continuous improvement.

Examples of data held were length of stay, complication rate, positive margin rate, continence status, erectile dysfunction, stage specific rates, emotional health, effect of operation on ease of travel, social activity, social chores, urinary leakage measures, use of pads, blood loss and operation time.

- The UCLH overall average positive margin rate (where the edges of the removed tumour contain cancer cells) was ~25%, which is better than the average UK rate of ~30%.

- The UCLH team strongly expressed the view that higher volumes of patients led to better outcomes and that this rationale drove their support for centres able to carry out high numbers of radical prostatectomies – more simply, in this area of London, there were not high enough patient numbers to support multiple centres, resulting in NICE guidance on centre numbers being contravened and making patient enrolment into clinical trials and conducting research difficult.

- The UCLH team emphasised the importance of risk stratification in patient selection to identify patients who would benefit from surgery and that NICE guidance on active surveillance over surgery is followed where clinically appropriate.

4.2 The Panel's Discussion

4.2.1 A comparative analysis of outcome data

Observations

The outcomes data presented by BHRUT are comparable with results from a national radical prostatectomy database (the BAUS Cancer Registry). It relied heavily on disease stage definitions that are not well defined across the service. The audit presented related to the period April 2010 to March 2012 and was retrospective. It did not appear to be part of a continuous programme, though the Medical Director confirmed action being taken to strengthen audit support and clinical governance across the Trust. It was felt to lack depth in terms of 'functional outcomes' however the audit had been undertaken for a different purpose.

The outcomes data presented by UCLH was felt to be robust. The patient group was large (~400), data was collected prospectively, and was part of a continuous process running for ~5 years. Data collected included patient demographics, pre-, intra- and post-operative information as well as follow-up data. The type of data held was reported to have been informed by what is collected at larger patient volume centres including MSKCC (Vickers) and NYU (Lepor), which UCLH considered to be 'world-class'. UCLH functional outcome data seems to have been collected in a timely and rigorous way.

The panel felt that the audit data gave *some* insight into the trusts' services, for example: UCLH appears to have a more detailed understanding of functional outcomes and appears to operate on more high risk patients (though use of different risk scores is noted). BHRUT audit seems to show operate on more low risk patients. UCLH audit was able to demonstrate better compliance with NICE guidance as the majority of patients do not have surgery (surgery is the third most common choice after radiotherapy or active surveillance). Both trusts achieve positive margin rates (mean average) above the England average. The BHRUT data was not contemporaneous and was felt by the panel to be more reflective of practice two or three years ago.

Conclusion

i. The evaluation of proposals that resulted in a recommendation for one surgical site at UCLH was made independently of outcome data.

ii. The outcome data indicated that radical prostatectomy surgery was of a high standard at both sites. The overall average positive margin rate at both trusts is better than the average UK rate. Reasons behind the higher complication rates at BHRUT were noted to have been resolved.

iii. The internal audit data presented by BHRUT and UCLH does not permit any direct comparison of radical prostatectomy outcomes between the two services, due to the large disparities in data type, risk scales, definitions used and populations selected.

iv. It would be inappropriate to base the decision as to a single or two site model on the data presented.

4.2.2 Which outcome measures should be used to compare radical prostatectomy effectiveness

Observation

A BAUS audit and national data set already exist.

The panel agreed that the outcome audit data presented from UCLH had good depth and was in excess of that collected by BAUS. It provided a good indication as to the type of data that could be collected to compare radical prostatectomy outcomes.

The panel noted that the Specialised Urology Clinical Reference Group (CRG) is currently considering this issue and will be making a recommendation on what outcome measures should be used. The intention is to specify a set of outcome measures that show the quality of prostatectomies in real time via a series of quality dashboards which analyse routinely collected data. This will also provide a national reference of criteria. This is not expected to be available for two to three years.

The NICE prostate cancer clinical guideline CG175 issued in January 2014 includes a clinical audit tool.

Conclusion

i. The panel concluded that the presentations went someway to indicating the wide choice of potential outcome measures that could be used to compare radical prostatectomy effectiveness. However the patient groups presented were not comparable so that a decision based on these data alone would be inappropriate.

ii. Additionally, it was concluded that Patient Reported Outcome Measures (PROMS) are in their infancy for this procedure.

iii. Trusts should participate in the BAUS national prostatectomy audit.

4.2.3 Implications of recently published National Institute for Clinical and Care Excellence (NICE) prostate guidance

Observation

Recent NICE prostate guidance[7] states "Commissioners should ensure that robotic systems for the surgical treatment of localised prostate cancer are cost effective by basing them in centres that are expected to perform at least 150 robot-assisted laparoscopic radical prostatectomies per year".

The data from the audits of presented to the panel show that the number of radical prostatectomies carried out at UCLH (reported to be ~300 per year)[8] exceeds the threshold recommended by NICE and the number of radical prostatectomies carried out at BHRUT is significantly below the recommended threshold (~159 across two years or, an average of ~80 per year, in the audit presented, though this data is not current; more recent data of ~180 across two years, an average of 90 per year, was reported but not presented).

The audit data for BHRUT indicated that a higher proportion of low risk patients are operated on than at UCLH. The panel acknowledged that there are varying interpretations of criteria for selecting appropriate cases for surgical intervention however felt that even taking the broadest criteria by modern standards some low risk patients would not be operated on. As the BHRUT data related to surgery carried out two to four years ago the panel considered that because of general trends in clinical practice for the treatment of radical prostatectomies the number of operations on low risk patients is likely to have declined further. Further, because of the lower risk profile of the patients from BHRUT, outcome data may not be comparable with the national average had they been standardised for risk.

BHRUT did submit an expression of interest in providing a local and specialist service for bladder/prostate and renal cancer in the early stage of the process. The London Cancer Board concluded that this would not meet the specification for the single site option recommended by the Urology Pathway Board, which included a requirement for specialist bladder and prostate surgery to be co-located with specialist gynecological cancer surgery (as the clinical model advised by clinicians).

At a later stage in the process, in response to feedback from clinicians and patients during the Urology Case for Change engagement (February-March 2013), NHS England did consider a one site option (UCLH) and a two site option (UCLH and BHRUT) plus a hybrid of the latter in which UCLH would be the lead provider and BHRUT would undertake prostate surgery only).

[7] NICE Clinical Guideline CG175 Prostate Cancer: diagnosis and treatment (January 2014)
[8] Further to the evidence session the actual number of radical prostatectomies in 2013/14 has been confirmed as 276

To put NICE guidance in context, surgery relating to bladder and prostate cancer is usually carried out at the same site, providing a comprehensive radical pelvic surgery service. It is rare to separate them. BHRUT proposes that because of the relatively low number of radical cystectomies carried out at the Trust these operations should be carried out at UCLH and BHRUT would retain radical prostatectomies. The Programme Director advised that in the options appraisal process the scoring criteria assumed that this arrangement would be supported by the Specialised Urology CRG.

The panel considered interdependencies and the potential impact of these arrangements during the evidence session and was assured that:

- No significant risks have been identified in relation to bladder surgery at BHRUT transferring to UCLH
- The need to have an effective on call system in place to ensure skills are available for emergency surgery provision e.g. nephrectomy, is acknowledged
- Trauma related cases at BHRUT would be supported by the Royal London Major Trauma Centre
- Further co-dependencies and impacts will be fully explored in the next stage of the programme
- No problems were identified in relation to managing pelvic fractures if the number of pelvic resection centres reduces to one. Arrangements for provision of cover across sites currently exist and the majority will be treated at the Royal London Major Trauma Centre.
- Ensuring patients are effectively supported by Specialist Multi-Disciplinary Teams (SMDTs) as a consequence of relocating significant surgical activity in teams has been considered and a model developed to for this. The MDT/SMDT model has been developed in line with NICE guidance.

<u>Conclusions</u>

i. UCLH currently meets the NICE guidance threshold for robotic surgery and if the single site model is implemented it would continue to meet the standard, despite supporting patients to consider the choice of active surveillance instead of surgery, where clinically appropriate.

ii. Current prostate activity at BHRUT would not be sufficient to meet the NICE guidance threshold for robotic surgery. The numbers of patients meeting the criteria for surgery are likely to have decreased and will continue to do so compounding the issue that BHRUT currently would not meet the NICE guidance minimum standard for patient volume. The panel also questioned the financial viability of the suggestion that the Trust could purchase a robot to carry out future surgery.

iii. Based on the data presented, and current patient flows, there is insufficient patient volume for radical prostatectomy surgery to support more than one NICE compliant service in north central and north east London.

iv. Agreeing a service configuration that is not compliant with NICE standards would set a precedent that could have significant repercussions across the country.

v. If less than 50 radical cystectomies are carried out per year at any one site, then these would need to be carried out at UCLH.

vi. Concerns have been raised about the implications of longer journeys and increased travel times to a single site for some patients and their relatives. Practical ways of mitigating the impact need to be explored and feasible solutions should be implemented.

vii. If specialist surgery is no longer carried out at any site, surgical resource should be maintained by encouraging surgeons to engage with the specialist centre to maintain their surgical lists and SMDT resource should also continue to retain patient management locally. It is also important that where specialist services are no longer provided, surgeons and the wider surgical team at that site are supported to develop the non-specialist aspects of the pathway. This is often overlooked in service change processes and opportunities to improve quality and outcomes for the non-specialist patient population are missed. The panel heard that the London Cancer proposals include plans to strengthen local services.

viii. There has been strong support and a clear rationale for a one site option since the Urology Pathway Board agreed the service specification. This is supported by a clear evidence base as described by NICE and the specialised urology CRG.

4.3 Conclusions and advice

The Clinical Senates advice in summary is:

Comparability analysis of current outcome data

1. The audits presented by BHRUT and UCLH are not directly comparable. Whilst both services demonstrated outcomes that compare well with or better than national averages the data from UCLH gives a broader range of outcome measures. The data from BHRUT indicates that a greater proportion of lower risk patients receive surgery compared with the service at UCLH. It would, however, be inappropriate to use the audit data alone as a basis for determining the future configuration of radical prostatectomy surgery.

Outcome measures which should be used to compare radical prostatectomy performance

2. Future audits of surgical outcomes should be based on the BAUS database and NICE guidelines, pending development of measures by the Specialised Urology Clinical Reference Group. The Reference Group for this review noted, however, that the advice requested relates to a very narrow aspect of care for patients with prostate cancer and that this is a relatively small proportion of the workload required in the overall pathway for the diagnosis and management of prostate cancer. A key challenge in the patient management of prostate cancer is to avoid over diagnosis and over treatment. Most men with low risk disease should be encouraged to opt for less invasive treatments than radical prostatectomy. A further important outcome measure to consider would be the proportion of men with low and intermediate risk disease who received the various treatment options covered positively by NICE Guidance.

Implications of NICE prostate cancer guidance

3. The recent publication of NICE Guidance CG175 on prostate cancer clearly states that if commissioners decide to provide robotic prostatectomy for their patient population the procedure should be undertaken in high volume centres with at least 150 procedures per year. If this procedure is to be provided therefore, the implication of this guidance, in so far as it relates to robotic surgery, is that there could only be one compliant service in north central and north east London. NHS England (London) should be clear in its commissioning of this surgical service which will enable a final decision to be made on the preferred site for such surgery. It follows that a two site model would only be feasible if radical prostatectomy surgery at the second, smaller site is limited to either open or laparoscopic surgery. This raises issues of equity as the commissioner would effectively be commissioning a different provision of service for the populations at each site.

4. Even at the level of 150 robot-assisted laparoscopic radical prostatectomies per year as recommended by CG175, the robot would only be utilised for about 30% of its available time during normal working hours. A lower level of activity would be wasteful and, even if supported by charitable funds, would be incompatible with good practice as the learning curve for surgeons is so long. Advice from the Reference Group is that it is currently estimated that outcomes for individual surgeons do not plateau until they have carried out around 600 procedures.

5. The Reference Group saw no advantages in separating prostate surgery from bladder surgery. The overall strategy for pelvic tumour management requires a coordinated approach. The options appraisal process included an option in which radical cystectomies would be referred to UCLH, because of the low numbers carried out at BHRUT, whilst BHRUT would retain radical prostatectomies and it was assumed that this arrangement would be supported by the Specialised Urology CRG. The Reference Group sought further advice on this issue from the Specialised Urology CRG Chair who confirmed that the CRG would not support this option. The CRG's advice was that the scoring criteria should reflect a requirement for all cystectomies and prostates to be undertaken within the centre.

6. Significant work has taken place through London Cancer's Urology Pathway Group to determine a specification for consolidating complex bladder and prostate cancer surgery into a single specialist centre. It follows that north central and north east London can only have one specialist centre with that specification. Based on the data presented to this review the Reference Group observed that UCLH would be able to fulfil this specification and exceeds the NICE guidance threshold for robotic radical prostatectomies whereas BHRUT does not.

7. In order to provide a comprehensive treatment for men with localised prostate cancer, the centre selected to provide robotic radical prostatectomy should also have the facility to offer and provide all recognised treatments such as Intensity Modulated Radiotherapy and Brachytherapy.

8. Any changes in patient pathways from BHRUT to UCLH will present some risk in terms of the overall patient pathway in the diagnosis and management of prostate cancer and some of the risks have been acknowledged through this process. This must be borne in mind with any service reconfiguration where surgery is undertaken at a central location and action will need to be taken to mitigate them. A single UCLH team would be very large and would require specific arrangements for MDT meetings, links with local services and follow up policies. These may all require a degree of networking, retaining the active involvement of referring teams.

9. The Reference Group noted that the principles supporting a decision on the model of care for men with localised prostate cancer in north central and north east London would be equally applicable across London.

5 Appendices

5.1 Glossary of Acronyms

Acronym	Expansion
BAUS	British Association of Urological Surgeons
BHRUT	Barking, Havering and Redbridge University Hospitals NHS Trust
CRG	Clinical Reference Group
EOI	Expression of Interest
HWB	Health and Wellbeing Board
ICS	Integrated Care System
MDT	Multi-Disciplinary Team
MSKCC	Memorial Sloan Kettering Cancer Center
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NYU	New York University
PROMS	Patient Reported Outcomes Measure Score
SMDT	Specialist Multi-Disciplinary Team
UCLH	University College London Hospitals NHS Foundation Trust
UCLP	University College London Partners
UPB	Urology Pathway Board
UPG	Urology Pathway Group
UTG	Urological Technical Group

5.2 NHS England's request for advice

Template to request advice from the London Clinical Senate

Name of the lead (sponsoring) body requesting advice: NHS England (London)

Type of organisation: Assurance & external clinical review for specialised commissioning

Name of main contact: Nigel Littlewood

Designation: Deputy Head of Service Reconfiguration

Email: Nigel.Littlewood@nhs.net Tel: 020 7932 9005 (internal 3005) Date of request: 25/11/13 (updated 14/01/14)

Please note other organisations requesting this advice (if more than the lead body noted above):

Please state as clearly as possible what advice you are requesting from the Clinical Senate.

1. Clinical review of the programme to consolidate, mainly specialised, cancer and cardiac services in north central and north east London, prior to formal final engagement on commissioner recommendations. The scope of this assurance review is to test whether a sufficiently robust clinical process was adopted by NHS England to arrive at the recommended options, considering the clinical involvement and evidence used.

2. In addition, a specific focus of the review is requested relating to future model and location(s) of radical prostatectomies, including consideration of the recent clinical outcomes data for robotic and non-robotic radical prostatectomies conducted by UCLH and BHRUT respectively. This advice should support a decision to determine where radical prostatectomies should be conducted recognising that engagement with some clinicians and patients in outer north east London and West Essex has suggested strong desire to retain a radical prostatectomy service at BHRUT, if clinically viable (UCLH as sole provider and UCLH as a lead bladder / prostate provider with BHRUT performing some non-robotic radical prostatectomies). This advice should compare current outcomes data, consider the implications of NICE prostate guidance (published 8th Jan 2014) and recommend which outcome measures should be used to compare radical prostatectomy performance. This advice will be shared with key stakeholders, and needs to demonstrate an independent view, it is expected to utilise expert urology clinical advice from outside of London, with links to the national clinical reference group.

Please state your rationale for requesting the advice? (What is the issue, what is its scope, what will it address, how important is it, what is the breadth of interest in it?).

Significant time, effort and money have been invested in developing the scheme which clinicians believe will save lives and improve the quality of life for many others across north and east London. The Case for Change has been shared with national leads, and is broadly supported by James Palmer, Sean Duffy and the clinical reference groups. The Case for Change has recently gone out to initial engagement (5 weeks) ending on 4th December with over 540 stakeholders.

There has been some interest shown by patient groups (prostate in particular), which has led to correspondence between a local MP and NHS England CE, as well as a number of written exchanges between the groups and the London Director of NHS England.

External assurance mitigates the risk of successful challenge to making these changes.

The rationale for the prostatectomy advice is to provide a clear independent report, which includes a review of recent audit data (attached) on clinical outcomes has been queried, and the commissioner led options appraisal has identified a relatively small difference between the overall scores for the two options. Given the contention around this option, further clinical advice is sought, in the context of future NICE guidance and current national specifications.

What is the purpose of the advice? (How will the advice be used and by whom, how may it impact on individuals, NHS/other bodies etc.?).

NHS England is the significant majority commissioner of these specialised services. Assurance of the scheme is being led by the Reconfiguration Team within the Transformation Directorate with a 'Chinese wall' between it and the regional direct commissioning function of NHS England which is leading the scheme.

The Reconfiguration Team is seeking external clinical assurance of the robustness of the process in evaluating the ULCP proposals by NHS England (the non-financial options appraisal), in line with best practice and likely required by forthcoming national guidance for service reconfiguration. This will form part of an overarching assurance exercise.

The prostate review will be published and shared with key stakeholders, and targeted engagement is planned in mid February 2014, to share the outcomes of the review, which will be used to inform the commissioner recommended option for radical prostatectomies.

Please provide a brief explanation of the current position in respect of this issue(s) (include background, key people already involved, relevant data and supporting information, views on methodology to be applied).

The case for change was published in October 2013 and is attached to this request form. This is a result of clinicians within UCL Partners considering their response to the London models of care for cancer and cardiovascular services, published in 2010.

NHS England's London Medical Director approved the case for change prior to publication.

The Senate is requested to provide a desk-top review of the case for change, the scope of this assurance review is to test whether a sufficiently robust clinical process was adopted by NHS England to arrive at the recommended options, considering the clinical involvement and evidence used.

Depth of clinical involvement and support is also requested to be tested and while a small number of telephone interviews may be required to support the review, it is expected that this would mainly be a paper-based exercise.

Clinicians with expertise relevant to each of the pathways and with no / no perceived conflict of interest are requested as essential. For the prostate advice, it is desirable if some of these clinicians could be seen as external to the London system.

When is the advice required by? Please note any critical dates.

The business case is due to be completed by the middle of February and further engagement on this is aimed to begin at the end of March, with approvals undertaken during March 2014. Full assurance, including external clinical assurance, will need to be completed prior to approval. The advice therefore is requested by the middle of February 2014.

Has any advice already been given about this issue? If so please state the advice received, from whom, what happened as a consequence and why further advice is being sought?

Described above

Is the issue on which you are seeking advice subject to any other advisory or scrutiny processes? If yes please outline what this involves and where this request for advice from the Clinical Senate fits into that process (*state N/A if not applicable*)

Service change is subject to scrutiny by local authorities, the local authorities have confirmed that they do not require formal section 244 consultation, they do wish to undertake scrutiny of the business case and future engagement. While not directly part of this process, the Senate's advice will be included / referred to in engagement with local authorities.

If the issue on which you are requesting advice relates to a provider organisation please note: (*state N/A if not applicable*)

(a) What action the provider Board has already taken to address it?
n/a

(b) Whether discussions have taken place between the provider Board and CCG(s) to address the issue and action taken as a result
n/a

(Clearly providers and CCGs are part of the programme in working these proposals up)

If the issue on which you are seeking advice relates to the urgent and emergency care pathway please note what action the local Urgent Care Board has taken to address it (*state N/A if not applicable*).

n/a

Please note any other information that you feel would be helpful to the Clinical Senate in considering this request.

The prostatectomy clinical outcomes data collated for both BHRUT and ULCH, along with the initial comparison by London Cancer. National standards, Prostate NICE guidance (Jan 14).

5.3 Terms of Reference

Request for advice on proposals to consolidate, mainly specialised cancer and cardiac services in north central and north east London

Terms of Reference

Introduction

NHS England (London) has asked the Clinical Senate to provide independent clinical advice on proposals to consolidate, mainly specialised, cancer and cardiac services in north central and north east London. NHS England is the significant majority commissioner of these services and the advice provided by the Clinical Senate will contribute to NHS England's assurance of the scheme. To avoid conflicts of interest, this assurance process is led by the Reconfiguration Team within the NHS England (London)'s Transformation Directorate with a 'Chinese wall' between it and NHS England's regional direct commissioning function which is leading the scheme.

Scope of advice requested

The advice which the Clinical senate has been asked to provide is in two parts:

1. To give advice on whether NHS England adopted a sufficiently robust clinical process to arrive at the recommended options, considering the clinical involvement and evidence used. As part of this, advice on the depth of clinical involvement and support is also requested.

2. To give advice on a specific aspect of the proposals relating to the future model and location(s) of radical prostatectomies which will be used to inform the commissioner recommended option for radical prostatectomies. The request has three elements, specifically to advise on:
    a. A comparative analysis of current outcomes data
    b. Which outcome measures should be used to compare radical prostatectomy performance
    c. Implications of recently published NICE guidance on prostate cancer

Process for formulating advice

Professor Chris Harrison, Clinical Senate Council Vice-Chair, will lead the process. A briefing session has been held with the NHS England team requesting the advice. A range of documentation about the process adopted by NHS England has been submitted and explained and key documents have been reviewed.

1. Review of the overall process NHS England adopted to arrive at recommended options

The following process is proposed:

Step 1: Establish a Reference Group (see proposed composition below)
Step 2: Brief the Reference Group and circulate documentation for desk-top assessment
Step 3: Reference Group teleconference to share desk-top assessment findings, identify issues where further exploration, clarification or validation is required and agree local stakeholders to be invited to discuss these issues.
Step 4: Panel (drawn from the Reference Group) "hearing" session (¾-1 day) to undertake the following:
    a. Finalise key lines of enquiry (issues for exploration, clarification or validation)
    b. Hold an evidence session with stakeholders involved in NHS England's process to seek responses to key lines of enquiry
    c. Debate and finalise conclusions
    d. Agree the process for follow-up of any outstanding issues
Step 5: Prepare a report setting out overall findings and recommendations (shared and tested with the Reference Group)
Step 6: Share the report with the Senate Council, debate and test conclusions
Step 7: Issue the report and advice to NHS England (London)

Reference Group composition

- Professor Chris Harrison, Clinical Senate Council Vice-Chair
- Experienced clinician with expertise in cancer services
- Experienced clinician with expertise in cardiac services
- Two London Clinical Senate Lay Members
- A GP
- A Director of Nursing (drawn from the London Clinical Senate Council or Forum)
- A Medical Director (drawn from the London Clinical Senate Council or Forum)
- A member of another Clinical Senate (either East of England, South East Coast or Thames Valley)

Membership will ensure a mix of teaching hospital/non-teaching hospital perspectives. All London members will be selected from parts of London unrelated to the changes proposed to ensure there are no conflicts of interest. Neighbouring Clinical Senate's will be asked to nominate a clinician with no conflicts of interest bearing in mind that UCL Partners extends into Herts, Beds and Essex.

Outcome

NHS England is seeking external clinical assurance of its process in line with best practice and likely to be required by forthcoming national guidance for service reconfiguration. It is also specifically seeking advice on whether it has deployed a robust clinical process to arrive at the recommended options, considering the clinical involvement and evidence used. There is no agreed definition of what "robust" looks like in this context and requirements of forthcoming guidance can only be anticipated at this stage. The Clinical Senate Council will draw on the Planning and delivering service changes for patients' guidance, published in December 2013 to inform its approach and the formulation of advice; this includes guidance on testing an evidence base.

The outcome will be a judgement on whether the process adopted to arrive at the recommended options is considered to be sound and reasonable in its approach taking account of the extent of clinical involvement, the underpinning evidence and how this was used. Although NHS England (London) has not asked specifically for patient and public involvement to be taken into account, the Clinical Senate Council believes this is an important element of any such process and therefore will consider it. The reference group composition will enable a judgement to be made by involving a mix of experts in the relevant clinical fields, patients, senior health professionals able to take a broader and system view, and an independent clinical perspective from outside of London.

2. Advice on proposals relating to future model and location(s) of radical prostatectomies

The following process is proposed:

Step 1: Establish Expert Reference Group (see proposed composition below)
Step 2: Brief the Reference Group and circulate relevant documentation for review
Step 3: Reference Group teleconference to share views on approach and key issues
Step 4: Panel (drawn from the Reference Group) "hearing" session (1 day) to undertake the following:
  i. Receive a presentation of outcome data followed by Q&A session with each provider site
  ii. Debate and finalise conclusions on comparative analysis
  iii. Debate and agree what outcome measures should be used to compare performance
  iv. Debate an agree implications of the NICE guidance on the proposals considered
Step 5: Prepare a report setting out the review team's findings and recommendations
Step 6: Share the report with the Senate Council, debate and test conclusions
Step 7: Issue report and advice to NHS England (London)

Reference Group composition

- Professor Chris Harrison, Clinical Senate Council Vice-Chair
- Mr Jonathan Ramsay, Consultant Urologist/Andrologist, London Clinical Senate Council Member
- Director, Centre for Clinical Practice, NICE or nominee
- Chair of the Specialised Urology Clinical Reference Group or nominee
- Clinical Audit Lead, British Association of Urological Surgeons (BAUS)
- Statistical support

A discussion with the National Clinical Director for Cancer is also proposed.

Outcome

The Clinical Senate will provide advice on: the conclusions that can be drawn from the audit data that has been shared; the outcome measures that should be used to compare radical prostatectomy performance and the implications of recently published NICE prostate guidance on the model of care for radical prostatectomies. The involvement of relevant experts in the reference group will ensure credibility of the advice.

Resources

The Clinical Senate Programme Lead will support Professor Harrison in the overall planning and delivery of the processes to formulate the advice.

NHS England (London) has offered logistical support to assist in organising teleconferences/Reference Group meetings/panel sessions if required. This would be overseen by the Clinical Senate Programme Lead to ensure there is no conflict.

NHS England (London) will fund costs associated with review team members' time/backfill, travel, accommodation and other sundry expenses as necessary.

Timescale

NHS England has requested the advice by the middle of February 2014. The business case for these proposals is due to be completed by the middle of February and further engagement on this is aimed to begin at the end of March 2014, with approvals undertaken during March. Full assurance, including external clinical assurance, will need to be completed prior to approval.

The initial request for advice was submitted on 25 November 2013. It was revised on 11 December 2013 to be clearer about the advice requested and refined again on 14 January 2014 to further clarify the scope. A full suite of documentation, supported by a summary paper to enable clear navigation through it, was also received on 14 January 2014.

It is essential that the process through which the Clinical Senate formulates its advice is robust and the approach outlined is designed to do this. This will have an impact on the timescale. It is anticipated that provisional advice could be provided in mid-March 2014 with final advice provided following discussion by the Senate Council at its meeting on 1 April 2014.

London Clinical Senate
6 February 2014

5.4 Evidence Session Programme

5.4.1 10 March 2014 – Radical Prostatectomies

Process to formulate advice on proposals relating to future model and location(s) of radical prostatectomies in north central and north east London

EVIDENCE SESSION PROGRAMME – 10 MARCH 2014

Time	Activity	Purpose
9.30 - 10.00am	Panel preparatory session	
10.00 - 10.30am	Neil Kennett-Brown Programme Director	Overview of the programme and background to the prostate review
10.30 - 11.00am	Mr John Hines Urology Pathway Director	Explore the Pathway Director's perspectives of prostate outcomes (UCLH and Barts)
11.00 - 11.45am	Presentation from UCLH Mr Paul Cathcart Consultant Urological Surgeon Professor John Kelly Clinical lead for Urology and Robotic surgery	Presentation of UCLH audit data/ outcomes submitted by the Trust in respect of prostate cancer Opportunity to ask questions about the data and other issues arising from the presentation and submission
11.45am - 12.30pm	Presentation from BHRUT Dr Stephen Burgess Acting Medical Director Mr Sandeep Gujral Consultant Urologist and Clinical Lead for Urology Mr Anand Kelkar Consultant Urologist and Urology SMDT Lead Mr Shiv Bhanot Consultant Urologist	Presentation of BHRUT audit data/ outcomes submitted by the Trust in respect of prostate cancer Opportunity to ask questions about the data and other issues arising from the presentation and submission
12.30 - 1.00pm	Dr Kathy Pritchard-Jones Medical Director, London Cancer	Explore the Medical Director's perspectives of prostate outcomes (UCLH and Barts)
1.00 - 1.15pm	Simon Williams NHS England Specialised Commissioning	Explore commissioner rationale for this review
1.15 - 2.30pm	Panel debates and finalises conclusions (with lunch)	
2.30 - 3.00pm	Session ends (subject to extent of panel discussion)	

5.5 Reference Group Members

Professor Chris Harrison is currently Medical Director and Director of Public Health at Imperial College Healthcare NHS Trust and London Clinical Senate Council Vice Chair. He has held a series of senior medical leadership roles in district health authorities, regional offices, strategic health authorities, the Health Protection Agency, foundation trusts, the private sector and Academic Health Sciences Centres in the North West of England and London. Prior to his current role he was medical director of The Christie NHS Foundation Trust Cancer Centre in Manchester and Director of Manchester Cancer, the Cancer Programme of the Manchester Academic Health Sciences Centre. He was also a non-executive director of London Cancer, the Cancer Programme of UCLP.

As a member of the board of the Organisation of European Cancer Centres from 2011 -2013 and chair of its accreditation committee he has been involved in setting and improving standards of cancer care organisation across Europe.

Mr. Jonathan Ramsay has been a Consultant Urologist since 1988. His NHS commitments have always been shared between 'Teaching' and 'District General' Trusts. Jonathan is currently working between Imperial College Healthcare NHS Trust and the West Middlesex University Hospital NHS Trust. Previous experience includes reviews of urological services outside London and peer review for testicular cancer. Jonathan currently sits on the North West London CCG Reconfiguration Board, and was a member of the NHS London Emergency Surgery Standards Group. Jonathan is also a member of the London Clinical Senate Council.

Mr. Hugh Mostafid is a consultant urologist based in Basingstoke. He is currently a member of the NHS England Specialised Urology Clinical Reference Group as well as a member of the executive committee of the British Association of Urological Surgeons' section of Oncology where he serves as Audit Lead. With both roles Mr Mostafid is heavily involved in defining and measuring treatment outcomes for urological cancer.

Professor Mark Baker is the Director of the Centre for Clinical Practice which includes the Clinical Guidelines programme and the Medicines and Prescribing Centre. He joined the staff of NICE in 2009 as Consultant Clinical Adviser to the Internal Guidelines Team and took up his post as Director of CCP in April 2012. Prior to joining NICE Mark held a wide range of positions in the NHS in Yorkshire, including Trust Chief Executive, Regional Director of Research and Development, Strategic Health Authority Medical Director, Cancer Network Director and Medical Advisor to the Department of Health on cancer. He has also held senior (chair level) academic appointments.

Mark has been extensively involved in the development of NICE Guidance including the Cancer Service Guidance programme, as chair of the guideline development groups on prostate cancer and lung cancer and in his current post.

Professor Howard Kynaston is Professor of Surgery at Cardiff University and Honorary Consultant Urologist at the University Hospital of Wales. He has been a consultant with an interest in prostate cancer for 18 years and has been on many national and international committees involved in prostate cancer research. He has worked with and on behalf of the British Association of Urological Surgeons on many aspects of cancer care and most recently provided urological advice to the National Institute for Health and Care Excellence (NICE) cancer coordinating centre when updating its guideline on the diagnosis and management of prostate cancer (CG175).

Mr Naeem Soomro is a Consultant Urologist and Associate Medical Director and at Newcastle-upon-Tyne Hospitals NHS Foundation Trust. He is also Director of Robotic Surgery and has developed a multi-specialty robotic surgery programme by acquiring two Da Vinci Si robots. Mr Soomro is a member of the National Institute for Health and Care Excellence Diagnostic Advisory Committee on bio markers for prostate cancer and a member of the British Association of Urological Surgeons where he is a member of a group developing guidelines for robotic surgical training to be adopted by BAUS.

5.6 Conflict of Interest Declarations

Professor Christopher Harrison was a Non-executive Director at London Cancer until December 2013.

5.7 List of Participating Stakeholders

See sections 5.4.1.

6 Contact Details

For information relating to this report please contact:

England.londonclinicalsenate@nhs.net