Clinical Senate
Yorkshire and the Humber

"An independent source of strategic clinical advice for Yorkshire and the Humber"

Clinical Senate Review

for

Yorkshire and the Humber

Vascular Services

April 2016

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1. Chair's Foreword

1.1 The Yorkshire and the Humber Clinical Senate welcomes the opportunity to work with Specialised Commissioners on the development of their model for vascular services across Yorkshire and the Humber. The Senate convened an expert clinical working group to undertake this work on its behalf and I would like to thank them for their diligence and commitment to this review. In its consideration of the question, the Senate focused on providing impartial clinical advice on the long term sustainability of the services, highlighting to commissioners issues to further explore in their continuing conversations with stakeholders.

1.2 The Senate recognises the importance of the decision on this service. The domino effect these service changes may have on Interventional Radiology and other co-dependent services should be fully considered. Commissioners of all parts of the pathway need to be fully engaged in the next stages.

1.3 I hope that this provides the balanced clinical overview that was requested and proves useful in progressing the project through to its next stage, where the final options for the service model are developed. We hope to have the opportunity to work again with commissioners on the development of the option that can provide the highest possible quality of vascular services for the population of Yorkshire and the Humber.

2. Summary of Key Recommendations

2.1 The Senate reviewed the service specification but as this is a national specification, the Senate did not comment upon these nationally agreed standards in detail. The Senate noted that if Yorkshire and the Humber is to meet the population, workforce and quality standards within the specification, there will need to be significant changes to the current service model.

2.2 The Vascular Standards document was developed by the Yorkshire and the Humber Specialised Commissioners who extracted the standards from the national service specification developed by the Clinical Reference Group. The Senate agreed that overall these standards were comprehensive.

2.3 The Senate welcomed the detail within the stocktake which provides an assessment of the current provision of vascular services across Yorkshire and the Humber. The main comment from the Senate on this document is with regard to the discrepancies in the data. The Senate accepts that the Hospital Episode Statistics (HES) and Vascular Society data are the most robust sources, but even when taking the discrepancies into account, the Senate has clinical concerns with the patterns of some of the service delivery.

2.4 In the development of the options, the Senate advises commissioners to consider the following issues in more detail:

2.4.1 Consideration of the Wider Pathway

The arterial centre is only one part of the wider pathway for the vascular patient and commissioners need to consider the totality of the service, including the integral and important role of the spoke site, intermediate care and community services. Commissioners also need to consider the wider bed capacity of the vascular hubs, including intensive care, in their further discussions. Specialised Commissioners must therefore work with Clinical Commissioning Groups (CCGs) to explore these questions and ensure CCGs understand the impact of proposals on their services.

2.4.2 Populations for a Centralised Service

Commissioners are advised that 800,000 is the minimum population required for a centralised service and that the catchment population may need to be bigger to ensure the sustainability of the service.

2.4.3 Clarity on the Timetable

Commissioners are advised to set a realistic but challenging timescale to implement the chosen model to avoid the stagnation of provider sites moving to become “spoke” providers. Commissioners also need to give a clear message setting out the process for decision making and the outcomes on which to commission the future service.

2.4.4 The Consideration of Co-dependencies

Commissioners need to demonstrate the impact of the vascular configuration on the key co-dependencies in the next stages of the option appraisal. The co-dependencies are listed in the Vascular Standards and National Service Specification. Commissioners also need to take into account other re-organisations, like the planning and delivery of urgent and emergency care centres, which will impact on the vascular service.

2.4.5 Consideration of Boundary Issues

It is noted that Yorkshire and the Humber is a fairly self-contained patient flow but there are residual flows across to Lincolnshire, Nottinghamshire and Teesside which require further consideration in the next stages of the review.

2.4.6 Consideration of the Workforce and Equipment

The Senate advises commissioners to acknowledge that the pool of Vascular Surgeons and Interventional Radiologists is likely to reduce as a result of this reorganisation. This reduction has been experienced during the reorganisation of vascular services elsewhere in England. Commissioners will want to ensure that the vascular reconfiguration does not result in the inadvertent centralisation of other activity due to the knock on effects of the workforce losses. The Senate also suggests that commissioners consider the implications of potential spoke provider sites delaying or not investing in vascular services which may in turn have the unintended consequence of increasing the workload at the hub. The entirety of the workforce required to deliver the vascular service should be considered as part of the reorganisation planning process; advice concerning the workforce may be provided by Health Education England.

2.4.7 Engagement with the Public

Commissioners have confirmed that they will be engaging with the public early on in the development of the options with the key message that this is about safety of care and the sustainability of the service, and is not financially driven. Commissioners are aware that the transport of patients and the travel facilities for patients, many of whom are likely to be older patients, needs to be a strong consideration.

2.4.8 Consideration of the Investment

In the next stage of discussions, commissioners are advised to test out whether the centres interested in being an arterial hub in the reorganised service, are capable of making the investment required for the delivery of the arterial hub service including across the wider workforce. The Senate also advises commissioners to work with those centres who are not designated as arterial hubs to fully recognise the potential of their role in the pathway.

3. Background

Clinical Area

3.1 The overall purpose of the vascular services project is to commission and implement the optimum model of service provision for vascular services across Yorkshire and the Humber. This model must best meet the needs of patients and address any identified issues of inequality of access and be within available resources from providers who are able to meet the full NHS England service specification (2013/14 NHS Standard Contract for Specialised Vascular Services (Adults), NHS England)[1].

3.2 This review builds on the work of a previous vascular services review in 2009/10 led by the then Yorkshire and the Humber Specialised Commissioning Group. This review resulted in firm recommendations to reduce the number of provider units delivering the arterial component of the vascular service and regional changes were made. Despite these changes, a number of providers still do not meet the requirements set out within the NHS England service specification. Providers have requested firm strategic direction from NHS England with regard to the future service models for the region which are required to meet the specification and ensure sustainable and high quality vascular services. In April 2015 commissioners completed an Independent Regional Stocktake to provide the data and evidence to inform this review. Commissioners now have a refreshed mandate to consider the model for vascular services as there is now a national service specification and a national set of standards.

3.3 In the next few months the commissioners will be working with stakeholders to develop the potential options for the future service with them. The option appraisal will be completed mid 2016/17. In the interim, all providers are under provider derogation against the service specification. In 2016/17 the contracts will reflect the decision making timetable. The implementation of the revised model will be in 2017/18.

Role of the Senate

3.4 The Yorkshire and the Humber Clinical Senate was approached by commissioners to work with them in two stages. In this first stage, the advice from the Senate will be used during the development of the options appraisal document and impact assessment. The Senate advice will also be used by the Specialised Commissioning team in their development of a workable solution to the commissioning derogation.

3.5 The question the Senate has been asked to consider is:

Considering the service specification and the stocktake from Public Health England, can the Senate review the developed services standards and consider options for service delivery, advising on any clinical concerns or adverse impact and identify a preferred option?

[1] Revised enhanced specification currently being consulted on by NHS England

3.6 The formal report from the Senate will go to the Directors of Commissioning Operations (DCO) Assurance team for Yorkshire and the Humber, who will use it alongside commissioner feedback on the engagement work done locally, to determine levels of clinical assurance on the proposed changes.

3.7 Further consultation will be required from the Senate when a full options appraisal and recommendations have been developed, which will coincide with the Directors of Commissioning Operations (DCO) stage 2 assurance process.

Process of the Review

3.8 The Senate received the request from commissioners for review on 30th November 2015, indicating that the review would be completed during January and February 2016. Senior professionals from a wide range of professions involved with vascular services, together with patient representation, were invited to join an Expert Working Group, set up specifically for the purposes of this review. Invitations avoided anyone employed by a Yorkshire and Humber organisation and all members were required to follow the Senate Conflict of Interest Policy and Confidentiality Agreement. A full summary of the declarations of interest can be found at Appendix 2. The Senate completed the appointment of all members of the Working Group by 7th December. The Working Group were provided with the Stocktake document upon their appointment to provide background information and commissioners provided the full evidence to support this review to the Senate on 8th January 2016. The Terms of Reference were agreed on 22nd December 2015.

3.9 The Senate Working Group held a teleconference on 11th January to aid their discussions. The questions arising from this teleconference were provided to commissioners on 13th January and a reply received on 26th January. Commissioners also provided isochrone maps to the Senate, demonstrating travel times across Yorkshire and the Humber. The Senate Working Group was able to explore issues further with commissioners in a meeting held on 28th January. A record of this meeting was provided to commissioners on 12th February.

3.10 The Working Group members held a further teleconference on 16th February. The report was drafted following this discussion and the final draft was provided to commissioners for comment on 5th March 2016. The report and commissioner comments will be provided to the Senate Council for final ratification on 16th March 2016.

4. Evidence Base

4.1 This is an area rich in detailed guidance, underpinned by strong evidence. In considering its recommendations, the Senate has drawn upon the recommendations and the published evidence. The National Institute for Health Research Report[2] provides a summary of the evidence base. This report has updated the references with more up to date publications where available.

4.2 There is strong evidence to support the link between hospital and surgeon volumes of activity and the outcome for arterial surgery. [3456] The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reviewed the treatment of a key vascular procedure, abdominal aortic aneurysm surgery, in 2005.[7] The NCEPOD found a considerable number of hospitals undertaking small numbers of abdominal aortic aneurysm interventions and concluded that, given its own findings and other evidence, 'serious consideration' should be given to concentrating elective open aortic aneurysm surgery into fewer hospitals and that only surgeons with vascular expertise should operate on emergency aortic aneurysm patients. The NCEPOD also put forward evidence that patients with ruptured aortic aneurysm can be transferred safely for journeys of more than 1 hour by road, or over 25 miles. Since then, there has been a drive to centralise services, and there is emerging evidence that this centralisation of vascular services in the UK is resulting in better outcomes.[8]

4.3 The Vascular Society for Great Britain and Ireland (VSGBI) has used the available evidence to underpin its professional guidance and recently updated its guidance in 2015. [9]

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[2] Insights from the Clinical Assurance of Service Reconfiguration in the NHS: the drivers of reconfiguration and the evidence that underpins it – a mixed method study. National Institute for Health Research

[3] Chikwe J, Cavallaro P, Itagaki S, Seigerman M, Diluozzo G, Adams DH. National outcomes in acute aortic dissection: influence of surgeon and institutional volume on operative mortality. Ann Thorac Surg 2013;95:1563–9. http://dx.doi.org/10.1016/j.athoracsur.2013.02.039

[4] AbuRahma AF, Stone PA, Srivastava M, Hass SM, Mousa AY, Dean LS, et al. The effect of surgeon's specialty and volume on the perioperative outcome of carotid endarterectomy. J Vasc Surg 2013;58:666–72. http://dx.doi.org/10.1016/j.jvs.2013.02.016

[5] Karthikesalingam A, Hinchliffe RJ, Loftus IM, Thompson MM, Holt PJ. Volume–outcome relationships in vascular surgery: the current status. J Endovasc Ther 2010;17:356–65. http://dx.doi.org/10.1583/10-3035.1

[6] Holt PJE, Poloniecki JD, Gerrard D, Loftus IM, Thompson MM. Meta-analysis and systematic review of the relationship between volume and outcome in abdominal aortic aneurysm surgery. Br J Surg 2007;94:395–403. http://dx.doi.org/10.1002/bjs.5710

[7] National Confidential Enquiry into Patient Outcome and Death (NCEPOD). Abdominal Aortic Aneurysm: A Service in Need of Surgery? NCEPOD; 2005. URL: www.ncepod.org.uk/2005report2/Downloads/AAA_report.pdf

[8] Earnshaw JJ, Mitchell DC, Wyatt MG, Lamont PM, Naylor AR. Remodelling of vascular (surgical) services in the UK. Eur J Vasc Endovasc Surg 2012;44:465–7.

[9] The Vascular Society of Great Britain and Ireland. The Provision of Services for Patients with Vascular Disease 2015

5. Recommendations

5.1 In developing its response, the Senate has considered the component parts of the question asked by commissioners.

The Service Specification

5.2 The service specification provided as part of the evidence for this review, is a nationally produced document. The specification draws upon the recommendations and published evidence of the Department of Health, The Vascular Society, the Royal College of Radiologists, National Confidential Enquiry into Patient Outcome and Death and all relevant NICE Guidance. As the service specification is a national specification, the Senate did not comment upon these nationally agreed standards in detail. The Senate noted that within the service specification it states that a population of 800,000 is often considered the minimum population required for a centralised vascular service. The Senate recognises that under the current model of service, the outcomes for vascular patients are good. If Yorkshire and the Humber is to meet the population, workforce and quality standards within the specification, there will need to be significant changes to the current service model.

5.3 It was noted that the document does not take into account the 2015 Provision of Services for Vascular Patients Guidance from the Vascular Society[8] and refers only to the 2012 version of the standards. The Senate wishes to make reference to this as the 2015 guidance states that endovascular interventions may be performed by Vascular Surgeons or Interventional Radiologists and also states that rotas combining interventional vascular radiologists and endovascular trained surgeons are a potential solution to the shortage of these specialists.

5.4 The Senate discussed this issue further in this review. The consensus was that some Interventional Radiologists will be able to perform a small amount of surgery but the cross over between the roles at this time would be minimal. Interventional Radiologists will continue to provide a premier service for vascular patients but it was agreed that currently, this dual role is unlikely to impact on the solutions required for Yorkshire and the Humber, but this may evolve over the next generation of clinicians. It was agreed that a rota of both roles was currently required for every inpatient site.

The Stocktake

5.5 The Senate welcomed the detail within the document which provides an assessment of the current provision of vascular services across Yorkshire and the Humber. The main comment from the Senate on this document is with regard to the discrepancies in the data. In discussion, commissioners recognised that the 3 sets of data Hospital Episode Statistics (HES), Vascular Society data for electives and individual provider data did not correlate. This led to the commissioner's decision to include the HES and Vascular Registry data within the document for comparison. It was noted that it is a requirement of the service specification for providers to collect the data and the Senate recommends that this issue needs to be highlighted to providers in further discussions. In discussion with commissioners, it was agreed that ideally there would

be 3 years of accurate data available, consistent with HES, for the next part of the review.

5.6 The Senate acknowledged the variation in the data and accepted that the HES and Vascular Society data are the most robust sources. Even taking that into account, the Senate has clinical concerns with the patterns of some of the service delivery, for example, activity related to population size and proportion of endovascular aneurysm repair (EVAR) compared to open repair. The Senate suggests that this is discussed further with providers.

5.7 The Senate also recommends that the document would benefit from the inclusion of all the pre-visit submissions from the Trusts within the stocktake and from further information on the wider workforce, e.g. specialist nursing staff, laboratory support.

Vascular Standards Document

5.8 The Senate understands that the Vascular Standards document was developed by the Yorkshire and the Humber Specialised Commissioners who extracted the standards from the national service specification developed by the Clinical Reference Group.

5.9 The Senate agreed that overall these standards were comprehensive. The Senate agreed that the standards would particularly benefit from:

- further information in the interventional radiology section to include how interventional radiology services are going to be maintained at non arterial service sites (the Senate detailed comments on workforce are provided in paragraph 5.24)

- further detail about the availability of intermediate care and its relationship to the delivery of the reorganised service. This issue is discussed further in paragraph 5.14

The Options for Service Delivery

5.10 The Senate understands that in the next stage of the review, commissioners will develop their options transparently with patient and public involvement and that their second round of clinical visits will involve discussion of the potential options. The options to be considered will include:

- do nothing – but this will mean an inability to meet the national specification and the standards
- arterial centres located in the Major Trauma Centres only
- sequential change with some variation, including 2 arterial sites in some geographies

5.11 The Senate was asked to consider options for service delivery, advise on any clinical concerns or adverse impact and identify a preferred option. The advice from the Senate at this stage in the discussion is that commissioners may wish to consider between 3 – 5 arterial units. 3 large vascular units does need to be considered as an option but this will need careful consideration of their ability to cope with the

workload. On the basis of population size alone Yorkshire and the Humber could consider 6 arterial units based on the 800,000 figure and a population of over 5 million. The Senate felt however, that this number of sites would have long term sustainability and affordability issues particularly when considering the workforce implications. For similar reasons the population size for 5 units may also be considered as too small. The Senate agrees that it is advisable to co-locate vascular units and major trauma units but this should not be the commissioners default position as workforce, skills availability, financial viability, bed space etc. all need to be considered.

The Senate advises commissioners to consider the following issues in more detail in their next stage of discussions with stakeholders.

Consideration of the wider pathway

5.12 The arterial centre, the "hub", is only one part of the wider pathway for the vascular patient and commissioners need to consider the broad view of the vascular pathway and the integral and important role of "spoke" sites. Specialised commissioners must therefore work with CCGs to explore these questions and ensure CCGs understand the impact of proposals on their services. Commissioners of every part of the pathway need to be fully engaged with the next stage of this work.

5.13 The impact on primary care needs careful consideration in the next stages of the review, for example in the management of the diabetic foot and the flow out of the arterial centre back into the community. The Senate advises that the opportunities for integrated models will be different in the different geographies and this needs to be reflected in the options appraisal work. If the organisation of the pathway is right, the majority of patients can be looked after in their local community. The appointment of diabetic foot specialists and venous leg ulcer specialists can support this way of working. Primary care is likely to need additional resources to support this model.

5.14 In their further discussions with providers, commissioners are advised to confirm with the provider Trusts that their proposals to ensure that models for repatriation of patients from the arterial "hub" to intermediate care or the community are in place and funded. Investment in the intermediate care services may reduce the pressure on beds at the arterial centre. Unless commissioners get this part of the pathway right there will be bed blockage at the "hub".

5.15 Commissioners are also advised to further consider the capacity of the "hub" Intensive Care Units which cannot be easily expanded. This becomes part of a wider question about the bed capacity of the vascular hubs which commissioners will need to take into account.

Populations for a Centralised Service

5.16 The service specification states that a population of 800,000 is the minimum population required for a centralised vascular service. In discussion, commissioners were reminded by the Senate to consider 800,000 as the minimum population required and were advised that the catchment population may need to be significantly bigger to ensure a sustainable service. This issue is also considered in paragraph 5.11. This needs further consideration in the analysis of the data. A population of 1.2 million was discussed as a recognised figure for a super specialist centre (2013/14 NHS Standard Contract for Specialised Vascular Services (Adults), NHS England).

5.17 Commissioners also need to take into account population forecast and consider the possible impact of an expanding and increasingly elderly population.

Clarity on the Timetable

5.18 Commissioners are advised by the Senate to ensure that the timetable is set, even if sequential steps are required to achieve this. Commissioners are advised to be clear with providers that it is not advisable to negotiate following the decision, so that progress on service change can be made.

5.19 The difficulties of sequential change were discussed by the Senate and it is recommended that commissioners set a realistic but challenging timescale to implement the chosen model to avoid the stagnation of sites moving to either hub or spoke status. It was recognised that in the interim stages some sites may lose staff and cease investment in their service. Recommendations from commissioners need to be underpinned by a firm timescale to implement the change.

5.20 The Senate also advised commissioners to discourage Trusts from investing in hybrid operating theatres or staff in advance of any decision on the model, in an attempt to improve their chances within the review process. This will result in investment not being planned on the basis of the decision which is a poor use of public funds. Commissioners need to give a clear message, setting out the process for decision making and the outcomes on which future service will be commissioned.

The Consideration of Co-Dependencies

5.21 In their discussions, the Senate considered the key co-dependencies and advised that commissioners need to demonstrate the impact of the vascular configuration on these services. The co-dependencies are listed in the Vascular Standards and National Service Specification. It was noted that the major trauma centres and cardio-thoracic centres are located in Leeds Teaching Hospitals NHS Trust, Sheffield Teaching Hospitals NHS Foundation Trust & Hull & East Yorkshire Hospitals NHS Trust and the renal centres at Sheffield Teaching Hospitals NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust, Bradford Teaching Hospitals NHS Foundation Trust, York Teaching Hospitals NHS Foundation Trust, Hull & East Yorkshire Hospitals NHS Trust & Doncaster & Bassetlaw Hospitals NHS Foundation Trust.

The Senate agrees that an association between major trauma centres and arterial centres seems to be an obvious starting point for the option considerations.

5.22 In their further discussions, commissioners also need to take into account other re-organisations, such as the delivery of urgent and emergency care, which will impact on the vascular service.

5.23 The next stage of the commissioner work also needs to consider the ambulance service bypass policy for the vascular model. It was recognised that an aortic aneurysm is very difficult to diagnose pre hospital and the ambulance service need a protocol fit for practice. Other areas are already using bypass protocols and the commissioners may wish to explore these to see if they might be applicable locally. This work would also need to include an understanding of travel times and frequency and how this may impact on the effectiveness of ambulance service delivery.

Consideration of Boundary Issues

5.24 The Senate notes that Commissioners confirmed in discussion, that Yorkshire and the Humber was a fairly self-contained patient flow, recognising some residual flows particularly across to Lincolnshire, Nottinghamshire and Teesside. Commissioners confirmed that they are aware of Doncaster being in discussion with Lincoln regarding links between the Trusts but no formal agreements have been reached. The geography and travel times around North East Lincolnshire do require further consideration in the next stages of the review.

Consideration of the Workforce and Equipment

5.25 The ability to maintain a rota of both Interventional Radiologists and Consultant Vascular Surgeons on every inpatient site is the key limiting factor in agreeing a sustainable number of arterial sites. The Senate advises commissioners to acknowledge that the pool of Vascular Surgeons and Interventional Radiologists is likely to reduce as a result of this reorganisation. Evidence from reviews in other parts of the country has shown that Trusts will be unwise to assume that staff displaced from one Trust will move to another. Commissioners will want to ensure that the vascular reconfiguration does not result in the inadvertent centralisation of other activity due to the knock on effects of the workforce losses.

5.26 It was noted by the Senate that the documentation provided does not take into account the training programme and how new staff will come through the system and fit into the proposals for the service model.

5.27 The Senate also suggests that commissioners consider the age of equipment within their next stage of discussion and consider the significant knock on impact of interventional radiology and on other work in their clinical assessment of the options. Spoke sites may hold off investing in vascular services which will impact on the procurement of their interventional radiology facilities for example, which in turn will have the unintended consequence of increasing the workload at the hub.

Engagement with the Public

5.28 Commissioners are advised that in their public presentations it needs to be made clear that there will be vascular services covering the whole population and only if the patient requires highly specialised arterial surgery, will they have to travel outside of their local area. For most patients there will be no change. This is a widespread service with arterial centralisation and it would be helpful if the broad pathway could be presented in discussions with the public. The public may find it helpful to compare the number of AAAs to diabetic foot patients for example, to gain an understanding of the scale of the change. It may also be helpful to use the analogy of the centralised cardiothoracic service and central and peripherally provided percutaneous coronary interventions (PCIs) which is now an accepted model of care.

5.29 Commissioners have confirmed that they will be engaging with the public early on in the development of the options, with the key message that this is about safety of care and the sustainability of the service and is not financially driven.

5.30 Patients are likely to be concerned at the distances to travel. Commissioners are aware that the transport of patients and the travel facilities for patients, many of whom are likely to be older patients, needs to be a strong consideration.

5.31 Within vascular services, patients often face great complexity in their pathway with the need to access a range of related services across the spectrum of acute, intermediate and primary care. The importance of community and intermediate services should not be underestimated in this review.

Consideration of the Investment

5.32 In the next stage of discussions, commissioners are advised to test out whether the centres interested in being an arterial “hub” are capable of making the investment required. It is recognised that sometimes there is a disconnect between the clinical willingness and the ability of the provider Trust to invest in the service. Commissioner discussions need to explore with providers that the investment is not just the theatres, but beds, potentially intensive care unit and also workforce. It is not currently clear whether providers will have access to the use of the transformation funds for this service change.

5.33 Please also note the comment in paragraph 5.19 regarding the need for commissioners to discourage Trusts from investing in hybrid operating theatres or staff in advance of any decision on the model.

5.34 The Senate also recognises that the workforce investment is wider than the Interventional Radiologists and Vascular Surgeons, and this team investment is challenging. In their discussion with Trusts, commissioners are advised to consider the supporting workforce like the tissue viability nurses and podiatrists for example, as all are important components of the pathway. Pressures already in the system need to be considered, e.g. gaps in the radiology workforce.

5.35 The Senate also advised commissioners to consider the strong clinical leadership required in the non-arterial centres to develop the spoke services and to work with those centres who were not designated as arterial hubs, to fully recognise the potential of their role in the pathway. The Vascular Society has documents on hub and spoke models which may help in the recognition of the services that can remain locally delivered.

6. Summary and Conclusions

6.1 The Yorkshire and the Humber Clinical Senate wishes to support the Specialised Commissioners in the planning and delivery of reorganised vascular surgical services for Yorkshire and the Humber building on the previous reorganisation in 2005.

6.2 The national vascular service specification is accepted. It is noted that it has not yet been updated to reflect the 2015 Provision of Services for Vascular Patients Guidance from the Vascular Society.

6.3 The Yorkshire and the Humber Specialised Commissioners Vascular Standards document is comprehensive but would benefit from further work concerning interventional radiology and intermediate care.

6.4 The options for service delivery were considered. The do-nothing option is not supported. The other options require consideration of a number of issues before a decision on the number of arterial centres can be made.

6.5 It is key that the wider vascular service and particularly its delivery, is fully considered in any determination of options. Centralisation of an arterial service will cause significant pressure on the bed capacity, including intensive and high dependency care, in the provider of the centralised arterial service.

6.6 Both the size of the population to be served and the timetable for implementation of the reorganisation require further discussion.

6.7 Another important factor in any service reorganisation is the future availability of specialised workforce. Experience elsewhere suggests that this workforce tends to shrink during the reorganisation implementation.

6.8 The Senate noted that at present the possibility of obtaining transformation funding for this reorganisation is uncertain.

6.9 The Specialised Commissioners are advised that a clear clinical narrative for the reorganisation is available and is extensively described during the public engagement process.

APPENDICES

Appendix 1

LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

Council Members

Professor Chris Welsh, Senate Chair

Dr Sally Franks, GP, Dr Penn & Partners, Leeds

Dr Ben Wyatt, GP, Brig Royd Surgery, Ripponden

Assembly Members

Peter Allen, Citizen Representative

Rebecca Bentley, Nursing Professional Lead & Non-Medical Prescribing Lead, Bradford District Care Foundation Trust

Co-opted Members

Ruth Chipp, Vascular Nurse Specialist, City Hospitals, Sunderland

Dr Claire Cousins, Lead Consultant Interventional Radiologist, Cambridge University Hospitals Foundation Trust

Dr Stephen D'Souza, Consultant Interventional and Vascular Radiologist and IR Lead, Lancashire Teaching Hospitals NHS Trust

Dr Paul Eyers, Vascular Consultant, Taunton and Somerset Hospitals Foundation Trust

Dr Stephen Gilligan, Clinical Director Critical Care, Consultant in Anaesthesia & Intensive Care, East Lancashire Hospitals Foundation Trust

Mr Simon Hardy, Consultant Vascular Surgeon, East Lancashire Hospitals Foundation Trust

Andy Swinburn, Associate Director of Paramedicine, East Midlands Ambulance Service

Appendix 2

PANEL MEMBERS' DECLARATION OF INTERESTS

Name	Reason for Declaration	Proposed way of Managing Conflict
Dr Stephen D'Souza	Knows the IRs at Sheffield, Doncaster and Hull well.	You have informed the Senate that you have a professional friendship with the Interventional Radiologists in some of the Trusts affected by this review. You do not have any direct or indirect pecuniary interest in this review or non-pecuniary personal benefit. We have agreed that we can manage the Conflict of Interest by your abiding by the Working Group's confidentiality agreement which requires you not to divulge or disclose any of the confidential information during the process of that review.
Mr Simon Hardy	I hold posts for Cumbria and Lancashire (AAA Screening Director, Vascular lead for the SCN) and I worked in a neighbouring Trust (East Lancs) to the area concerned	You have informed the Senate that you hold a post in a neighbouring Trust to this review. You do not have any direct or indirect pecuniary interest in this review or non-pecuniary personal benefit. Your conflict is therefore notes but we agree that you can participate in this work on behalf of the Senate.
Dr Stephen Gilligan	I currently work at a Vascular Centre in Lancashire bordering the Yorkshire and Humberside region. Potentially a reorganisation may affect patient flow across traditional boundaries. I once worked in a neighbouring Trust to the area concerned	You have informed the Senate that you hold a post in a neighbouring Trust to this review. You do not have any direct or indirect pecuniary interest in this review or non-pecuniary personal benefit. Your conflict is therefore notes but we agree that you can participate in this work on behalf of the Senate.
Andy Swinburn	The vascular proposals include services on the south of the Humber including North and North East Lincolnshire which also fall within the EMAS catchment.	You have informed the Senate of a potential conflict of interest in that you work for an organisation whose catchment includes services south of the Humber which may be affected by the vascular services review. You do not have any direct or indirect pecuniary interest in this review or non-pecuniary personal benefit. Your conflict of interest is therefore noted but as the conflict is limited to your role as an employee of East Midlands Ambulance Service NHS Trust we can agree that you can participate in this work on behalf of the Senate.
Chris Welsh	Non-executive director of a NHS Trust outside the Yorkshire and the Humber region.	

COUNCIL MEMBERS DECLARATION OF INTERESTS

There are several members of the Council who declared a conflict in this issue:

Sewa Singh, Medical Director, Doncaster & Bassetlaw Hospitals NHS Foundation Trust, Jon Hossain, Consultant Vascular Surgeon & Deputy Post Graduate Dean, Health Education England – Yorkshire and the Humber, Jon Ausobsky, Consultant General Surgeon, Bradford Teaching Hospitals NHS Foundation Trust, Mark Millins, Lead Paramedic for Clinical Development, Yorkshire Ambulance Service NHS Trust. Their conflicts of interest were due to their employment in a position of authority at a provider Trust whose vascular services were under consideration as part of this review. The Chair allowed their participation in a Council debate but none were a member of the expert working group.

Appendix 3

CLINICAL REVIEW

TERMS OF REFERENCE

TITLE:

YORKSHIRE AND THE HUMBER VASCULAR SERVICES REVIEW –

SERVICE STANDARDS AND OPTIONS FOR SERVICE DELIVERY

Sponsoring Organisation: NHS England North Specialised Commissioning (Yorkshire and the Humber)

Terms of reference agreed by: Vicky Broadley, Senior Supplier Manager

Date: 22 December 2015

1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: Professor Chris Welsh, Yorkshire and the Humber Clinical Senate Chair

Citizen Representative: Peter Allen

Clinical Senate Review Team Members:

Name	Job Title
Chris Welsh	Senate Chair
Peter Allen	Patient Representative
Dr Claire Cousins	Lead Consultant Interventional Radiologist, Cambridge Univ. Hospitals FT
Mr Simon Hardy	Consultant Vascular Surgeon, East Lancashire Hospitals FT
Dr Paul Eyers	Vascular Consultant, Taunton & Somerset Hospitals FT
Dr Stephen D'Souza	Consultant Interventional and Vascular Radiologist and IR Lead
Rebecca Bentley	Nursing Professional Lead & Non Medical Prescribing Lead, Bradford District Care FT
Dr Ben Wyatt	GP and Yorkshire and the Humber Senate Council member
Dr Sally Franks	GP and Yorkshire and the Humber Senate Council member
Andy Swinburn	Associate Director of Paramedicine, EMAS
Ruth Chipp	Vascular Nurse Specialist
Mr Stephen Gilligan	Clinical Director Critical Care, Consultant in Anaesthesia & Intensive Care

2. AIMS AND OBJECTIVES OF THE REVIEW

Question: Considering the service specification and the stocktake from PHE, can the Senate review the developed services standards and consider options for service delivery, advising on any clinical concerns or adverse impact and identify a preferred option?

Objectives of the clinical review (from the information provided by the commissioning sponsor):

The overall purpose of the vascular services project is to commission and implement the optimum model of service provision for vascular services, across Yorkshire and the Humber: that best meets the needs of patients; addressing any identified issues of inequality of access; and within available resources; from providers who are able to meet the full NHS England service specification.

The advice from the Senate during the development of the options appraisal document and impact assessment will be used by the Specialised Commissioning team in their development of a workable solution to the commissioning derogation.

The formal report will go to the DCO Assurance team for Yorkshire and Humber, who will use it, alongside commissioner feedback on the engagement work done locally, to determine levels of clinical assurance on the proposed changes.

Further consultation will be required from the Senate when a full options appraisal and recommendations have been developed which will coincide with the DCO stage 2 assurance process.

Scope of the review: Early advice from the Senate to inform a clinical service model.

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: 18th December 2015

Agree the Terms of Reference: by 31st December 2015

Receive the evidence and distribute to review team: 4th January 2016

Working Group Teleconferences: 11th January and 16th February 2016

Meeting with commissioners: 28th January 2016

Draft report submitted to commissioners: 29th February 2016

Commissioner Comments Received: 11th March 2016

Senate Council ratification; 16th March 2016

Final report agreed: by 31st March 2016

Publication of the report on the website: to be agreed with commissioners

4. REPORTING ARRANGEMENTS

The clinical review team will report to the Senate Council who will agree the report and be accountable for the advice contained in the final report. The report will be given to the sponsoring commissioner and a process for the handling of the report and the publication of the findings will be agreed.

5. EVIDENCE TO BE CONSIDERED

The review will consider the following key evidence:

- Service specification
- Project Initiation Document
- Project plan
- Vascular review stocktake (PHE)
- Risk and issue registers
- Communications and engagement plan
- Most recent highlight report(s)
- Draft options appraisal
- Draft service standards

The review team will review the evidence within these documents and supplement their understanding with a clinical discussion.

6. REPORT

The draft Clinical Senate report will be made available to the sponsoring organisation for fact checking prior to publication. Comments/ correction must be received within 10 working days.

The report will not be amended if further evidence is submitted at a later date. Submission of later evidence will result in a second report being published by the Senate rather than the amendment of the original report.

The draft final report will require formal ratification by the Senate Council prior to publication.

7. COMMUNICATION AND MEDIA HANDLING

The final report will be disseminated to the commissioning sponsor, provider, NHS England (if this is an assurance report) and made available on the Senate website. Publication will be agreed with the commissioning sponsor.

8. RESOURCES

The Yorkshire and the Humber Clinical Senate will provide administrative support to the clinical review team, including setting up the meetings and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

9. ACCOUNTABILITY AND GOVERNANCE

The clinical review team is part of the Yorkshire and the Humber Clinical Senate accountability and governance structure.

The Yorkshire and the Humber Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

10. FUNCTIONS, RESPONSIBILITIES AND ROLES

The **sponsoring organisation** will

i. provide the clinical review panel with agreed evidence. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance. The sponsoring organisation will provide any other additional background information requested by the clinical review team.
ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.
iii. undertake not to attempt to unduly influence any members of the clinical review team during the review.
iv. submit the final report to NHS England for inclusion in its formal service change assurance process if applicable

Clinical Senate council and the **sponsoring organisation** will:

i. agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

Clinical Senate council will:

i. appoint a clinical review team, this may be formed by members of the Senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.

ii. endorse the terms of reference, timetable and methodology for the review
iii. consider the review recommendations and report (and may wish to make further recommendations)
iv. provide suitable support to the team and
v. submit the final report to the sponsoring organisation

Clinical review team will:

i. undertake its review in line the methodology agreed in the terms of reference
ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
iii. submit the draft report to Clinical Senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
iv. keep accurate notes of meetings.

Clinical review team members will undertake to:

i. commit fully to the review and attend all briefings, meetings, interviews, and panels etc. that are part of the review (as defined in methodology).
ii. contribute fully to the process and review report
iii. ensure that the report accurately represents the consensus of opinion of the clinical review team
iv. comply with a confidentiality agreement and not discuss the scope of the review nor the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the Clinical Senate Manager, any conflict of interest prior to the start of the review and /or materialise during the review.

END

Appendix 4

BACKGROUND INFORMATION

The evidence received for this review is listed below

- Draft Service Specification No. A04/S/a
- Project Initiation Document Version 0.6
- Project Plan Version 3
- Vascular Review Stocktake (PHE) April 2015
- Risk and Issue Registers Version 1
- Communications and Engagement Plan
- Most recent highlight report(s) September 2015 & January 2016
- Draft Service Standards

Following discussion with commissioners the Working Group was also provided with isochrone maps providing travel times across the geography.