NHS
Yorkshire and the Humber
Clinical Senate

Free and full independent and impartial clinical advice

Sherriden McKiniry
Local Service Specialist
Specialised Commissioning (Yorkshire & Humber)

Via email

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14th June 2019

Dear Sherry

Senate Review of Proposed Aortic Dissection Rota

Thank you for the opportunity to review your proposals for a Yorkshire and the Humber wide Aortic Dissection rota.

The objectives of this review are for the Senate to provide you with independent clinical oversight of the proposed clinical model to assist in its further development. Our advice will inform the next steps in implementing the aortic dissection service. The members of the clinical review panel who reviewed the proposals through email and teleconference discussion during April 2019 are listed within the Terms of Reference enclosed with this letter. Thank you for the helpful telephone call with commissioning and clinical leads on 29th April which improved our understanding of your proposals.

In summary your proposal is that all patients with acute aortic dissection in Yorkshire and the Humber will be operated on by an experienced and specialist surgeon which requires a region wide rota with one hospital, with a specialist surgeon on call, taking all patients with aortic dissection.

The questions you asked us to consider are:

- Is the proposal clinically acceptable?
- Are the risks associated with additional travel mitigated by providing best practice?

I hope this letter provides a constructive summary of our comments and advice.

Key Recommendations

1. **To develop your proposals to clearly define the patient pathway from arrival at the local ED through to specialist surgery.**

2. **To amend your proposals to reflect the inclusion of North Lincolnshire and Goole Hospitals NHS Foundation Trust**

3. **A standard education package/ programme must be developed as part of these proposals.**

4. **In the long term this specialist aortic service should be provided in a single centre for Yorkshire and the Humber**

5. **To establish a dedicated aortic dissection rota at the 3 specialist centres**

6. **To establish a comprehensive auditing system for AAD which captures the whole pathway from the point of query AAD through to surgical outcomes. The audit to be supported by a specialist MDT.**

In answer to your first question, the Senate is strongly supportive of your proposals for the aortic dissection rota and agrees that these are clinically appropriate. Taking account of the high mortality prior to diagnosis (~ 40%) and the 5-20% surgical mortality in the sub-group who make it to surgery, we agree with the proposals to require surgery to be always undertaken by experienced cardiothoracic surgeons. The proposals are in line with the recommendations in the GIRFT Programme National Specialty Report on Cardiothoracic Surgery published in March 2018 which recommends the creation of rotas of specialist surgeons allied to networks of referring hospitals to cover geographic areas. The report also recommends the establishment of formal agreements between referring hospitals, receiving specialist units and ambulance services for transfer of Acute Aortic Dissection (AAD) patients to the relevant specialist centre and that these arrangements should include a dedicated phone number for referrals and service co-ordination. We very much welcome your proposals as a step in the right direction towards improving the current service and meeting these recommendations. However, commissioners must recognise that this should only be an interim proposal to minimise the current risk and that further steps need to be made towards greater centralisation of the service. Commissioners will be aware of the need to review this proposed model when the NHSE Service Specification for Thoracic Aortic Dissection is published to ensure that it meets the standards set.

You also ask whether the risks associated with additional travel are mitigated by providing best practice. Your proposals set out the increase in travel times in Appendix 2 with a median increase of 50 minutes and 9 journeys increased by over 60 minutes. Travel times are very important, and we fully recognise the importance of the patient moving as quickly as

possible from presentation to surgery to improve the patients' chance of survival. We recognise however, that the delays in the patient pathway currently are often due to the delayed diagnosis of these patients. Diagnosis can take several hours, especially if the diagnosis is not considered at an early stage, and the improvements in time to diagnosis brought about by education and the single point of contact leading to rapid transfer will, in our view, mitigate against the risks of the additional travel.

The focus of the proposals presented to us however is very much on the surgery which raised several questions with the panel on the pre–tertiary centre pathway, particularly the steps being taken to reduce the time to diagnosis and the intermediate steps between diagnosis and surgery, equally vital to the surgical success of the proposal. Our discussions with you provided reassurance on many of these points but we would have liked to have seen much more detail about the whole patient journey from first call to surgery to be able to put the surgical outcomes in their proper context. Our understanding of this pathway and our recommendations in relation to these are set out below.

Recommendation: To develop your proposals to clearly define the patient pathway from arrival at the local ED through to specialist surgery.

The geography of the proposals

The panel noted that Scunthorpe and Grimsby hospitals, part of North Lincolnshire and Goole Hospitals NHS Foundation Trust, are not listed in the relationships with Hull as we would have expected. You confirmed that this was an oversight on your part and you will amend the proposals to include them. The increased travel time to Leeds and Sheffield from Grimsby are 46 minutes and 39 minutes respectively and from Scunthorpe 20 minutes and 19 minutes. You also confirmed that you would discuss their inclusion with East Midlands Ambulance Service (EMAS).

Recommendation: To amend your proposals to reflect the inclusion of North Lincolnshire and Goole Hospitals NHS Foundation Trust

The plans for emergency ambulance pick up and where the patient will be taken for initial assessment

You confirmed that in discussion with ambulance services you have agreed that ambulance transfer will follow the leaking aneurysm protocol which is a priority 1 service with an 8 minutes response time with a paramedic on board. The receiving point at hospital will be an Intensive Care Unit (ICU) or if no ICU is available the patient will transfer straight to the operating theatre. The patients will not have to pass through the Emergency Department (ED) again. We agree with this approach and have no further comment.

Education and training to shorten the time from presentation to diagnosis

Within Yorkshire and the Humber for the last 3 years the mean time from presentation at the ED to the CT scan for diagnosis has been 8.4 hours. We agree with you that the delay in diagnosis time is likely to be due to the delay in recognising the symptoms of AAD rather than a queue for the CT scan. Within your proposals you refer to your plans to run an

awareness campaign with the ambulance service and in partnership with NHS England focussing on the Emergency Departments, Acute Medical Units (AMU) and cardiology departments of all participating hospitals to improve understanding of AAD. We would have liked to have seen more detail about this planned education and training. Local hospitals will be referring to centres which they are not used to which brings room for confusion and ensuring absolute clarity on the process is easy to say but difficult to do well. In discussion you confirmed that the detail of the standard education package has not yet been worked through.

We are agreed that the change to the pathway with the Single Point of Contact will be an opportunity to increase awareness and focus the minds of those in diagnosis. You confirmed that from the start date of the rota all hospitals will be aware of the new single point of contact and that this arrangement will be included in the induction of all new ED trainees to provide certainty that new ED doctors will know who to call. Some of the greatest gains in these proposals will be from education in diagnosis and from the single point of contact leading to rapid transfer. Your plans for this need to be made clearer. We recommend that you make the most of this opportunity to raise awareness with an effective education package.

Recommendation: A standard education package/ programme must be developed as part of these proposals.

The CT imaging

In discussion we raised questions about:

- the availability of CT scans to ensure there was no delay to diagnosis;
- the standardisation of the quality of these scans;
- the ability for all sites to transfer a direct image of the CT scans to allow surgical teams to be organized and a surgical plan formulated ahead of the patient's arrival on-site.

In discussion you confirmed that all participating hospitals have CT scans available 24/7 365 days a year and all hospitals have the means to transfer these electronically between all sites. You confirmed that not all hospitals have specialist reporting by vascular radiologist but that receiving surgeons should be able to interpret the image. Our questions on this point were addressed.

The logistics of the transfer and level of medical support for that transfer

From our telephone conversation with you it seems our panel discussion has mirrored much of the discussion you have had between surgical colleagues on the level of medical support for transfer. We agree with your practical view that the priority is to get the patient to the specialist centre as soon as possible and not to delay that transfer by waiting on the availability of an anaesthetist. You may wish to include in your protocol that Trusts should be willing to provide the medical support for transfer in circumstances where this is judged to

be required. We also advise that you define the competencies required for a clinician to accompany a transfer.

Your definition of an experienced and specialist surgeon

The GIRFT standards recommend that acute aortic syndrome patients are only operated on by rotas of acute aortic syndrome specialist teams You propose that all patients with acute Type A aortic dissection in Yorkshire and the Humber will be operated on by an experienced and specialist surgeon. Our understanding is that this means the surgeons are subspecialist in thoracic aortic surgery. Having the surgery performed by an expert surgeon is the right way forward and your proposals have our support.

The GIRFT report also recommends that all surgeons on the rotas meet minimum activity thresholds which are to be defined by the NHSE Thoracic Aorta Working Group within the next 12 months. The report also looks at the relationship between activity levels and mortality and concludes that over a three-year period, comparing non-elective activity with mortality (not-risk adjusted), higher rates of mortality are associated with lower volumes of activity. It cites 13 of the 17 providers with less than 70 aortovascular procedures in 3 years reporting above average mortality. The Yorkshire and the Humber figures will place this geography in that category. There are currently 30 aortic dissections a year across Yorkshire and the Humber which are evenly split between the 3 sites and you expect that this will increase to 60 per year due to the improved diagnosis brought about by this change. Even with the increased numbers, which will take several years to achieve, the number of aortic dissections will be 6 – 7 per surgeon and 20 per centre (surgeons also have 15 – 20 elective aortic procedures per year.) Although we support your proposals and recognise that these offer the best solution currently, to get the best outcomes in the future we recommend that you centralise expertise more than is suggested in these proposals. Your current proposals must therefore only be seen as a step towards a single centre Yorkshire and the Humber service. Commissioners will be aware of the need to develop the model in response to the minimum activity thresholds if these are defined.

Recommendation: In the long term this specialist aortic service should be provided in a single centre for Yorkshire and the Humber

Uniformity of surgical management

Your proposed model will increase the number of AAD surgical procedures in time and this process should also start to get uniformity of surgical management through standardising protocols. Colleagues from Barts Hospital in London have offered to meet with the Yorkshire and the Humber surgeons to discuss the surgical management in more detail, and the lessons learnt from their own implementation of a similar process. I understand that this offer has been welcomed and I hope that you are able to make the arrangements for this meeting.

ICU and theatre capacity and surgical team rotas

The Senate panel raised questions about how the proposal fits with the capacity of ICU and theatre facilities at the surgical centres and the internal organization of those centres. Our considerations were how quickly a specialist surgeon and theatre team could be mobilised to proceed to surgery or whether lack of theatre space, ICU space or lack of cardiothoracic anaesthetists / teams, or the specialist surgeon already occupied on another operation, would subvert the success of the proposal.

In discussion you confirmed that with the small numbers being discussed there is no issue with ICU and theatre capacity across the 3 centres. You also confirmed that the centre on call will always take the patient unless they are deemed medically unfit for surgery and the centre will not refuse a patient on the basis of bed availability. We agree with this approach.

We also discussed whether there should be a dedicated aortic dissection rota to ensure the availability of the specialist centre and the Senate advises that this is required as you cannot risk the dedicated surgeon being in another operating theatre at the time of an AAD referral. We fully recognise the importance of the dedicated surgical team in delivering improved outcomes.

Recommendation: To establish a dedicated aortic dissection rota at the 3 specialist centres

Audit

Comprehensive audit is essential in monitoring the impact of these changes. In discussion with you we emphasised the need to audit the whole AAD pathway, ideally from the first point of contact with a health care professional, and not just the surgical results. The audit for this new rota needs to start at the point of query AAD so that delays in definitive tests and issues with transit for example can all be monitored, including capturing patients who are diagnosed but don't make it to surgery. Your audit should also measure the surgical outcomes in each of the 3 units. We acknowledge that there may be an increase in mortality in the early months of this new process because of patients who would have previously died now receiving surgery.

In discussion you confirmed that you will establish a quarterly governance meeting across the 3 centres to review all referrals and use this time to reflect on practice and travel times and continue to develop and improve protocols. We welcome this approach and also your intention to attend the annual national meeting of AAD where you will present your data and seek feedback and peer review.

Currently all 3 hospitals have their own individual aortic MDTs. We recommend the establishment of a single MDT across Yorkshire and the Humber for this specialist aortic work.

Recommendation: To establish a comprehensive auditing system for AAD which captures the whole pathway from the point of query AAD through to surgical outcomes. The audit to be supported by a specialist MDT.

Involving patients' views

We understand that you have shown this proposal to Aortic Dissection Awareness UK and Ireland, a patient's association who campaign to raise awareness for aortic dissection and supports sufferers and those bereaved by the condition. The charity has given their support to this proposal as a step in the right direction.

You may also wish to involve the local Healthwatch teams in helping to spread the key messages and to help raise awareness about this condition and its risks.

Conclusion

The Senate is strongly supportive of your proposals for an aortic dissection service for Yorkshire and the Humber and agrees that these are clinically appropriate. We agree with the proposals to require surgery to be always undertaken by surgeons experienced in cardiac and aortic surgery and agree that the risks of the additional travel should be mitigated by the improved pathway brought about by this change. We advise however that this model should only be seen as an interim proposal to minimise the current risk and that further steps need to be made towards a single centre Yorkshire and the Humber service.

The focus of the proposals presented to us is very much on the surgery which raised several questions with the panel on the pre–tertiary centre pathway, equally vital to the surgical success of the proposal. Our discussions with you provided reassurance on many of these points but we would have liked to have seen much more detail about the whole patient journey from first call to surgery. Our recommendations in relation to this include developing the detail of the education package, the requirement for comprehensive audit and a dedicated aortic dissection rota. We also advise that you keep these proposals under review and ensure that when the NHSE Service Specification for Thoracic Aortic Dissection is published that it meets the standards set.

We hope our comments are helpful to you.
Yours sincerely

Chris Welsh
Senate Chair
NHS England – North (Yorkshire and the Humber)

cc: Graham Cooper, Consultant Cardiac Surgeon, Sheffield Teaching Hospitals

NHS
Yorkshire and the Humber
Clinical Senate

CLINICAL REVIEW

TERMS OF REFERENCE

TITLE: Yorkshire and the Humber Aortic Dissection Rota

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

Terms of reference agreed by: Sherry McKiniry, Local Service Specialist, Specialised Commissioning (Yorkshire & Humber) and Joanne Poole, Senate Manager, Yorkshire and the Humber Clinical Senate

Date: 27th March 2019

1. CLINICAL REVIEW TEAM MEMBERS

Name	Job Title	Organisation
Professor Chris Welsh	Chair of the Yorkshire and the Humber Clinical Senate and Chair of this panel	
Stephen Bush	Consultant in Emergency Medicine and Clinical Director in Emergency and Speciality Medicine	Leeds Teaching Hospitals NHS Trust
Ed Smith	Consultant in Emergency Medicine	York Teaching Hospitals NHS Trust
Peter Allen	Lay Member	
David Ita	Lay Member	
Denise White	Lay Member	
Stephen Edmondson	Consultant Cardiothoracic Surgeon, Clinical Director for Cardiac and Thoracic Surgery	Barts Health NHS Trust
Professor Charles Knight	Consultant Cardiologist and Managing Director	Barts Health NHS Trust
Ravi de Silva	Consultant Cardiothoracic Surgeon	Royal Papworth Hospitals NHS FT
David Jenkins	Consultant Cardiothoracic Surgeon	Royal Papworth Hospitals NHS FT
John Bourke	Consultant Cardiologist	Newcastle Upon Tyne Hospitals NHS Foundation Trust
David Harling	Consultant Anaesthetist	The Rotherham NHS Foundation Trust

2. AIMS AND OBJECTIVES OF THE REVIEW

Question: Is the proposal clinically acceptable? Are the risks associated with additional travel mitigated by providing best practice?

Objectives of the clinical review (from the information provided by the commissioning sponsor): To provide advice to NHS England, North, Specialised Commissioning (Yorkshire and the Humber), Leeds Teaching Hospitals, Hull and East Yorkshire Hospitals and Sheffield Teaching Hospitals in the development of their proposals. The advice will inform the next steps in implementing the aortic dissection service

Scope of the review: The review will focus on the above questions using the written evidence provided to the panel supplemented by discussion between the panel and the clinical and commissioning leads.

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: 15th March 2019

Agree the Terms of Reference: end March 2019

Receive the evidence and distribute to review team: Panel appointed late March and evidence distributed as they were appointed

Teleconferences:

- The first panel discussions scheduled for 9th and 15th April 2019
- The discussion with commissioners and Trust clinical leads scheduled for 29th April

Draft report submitted to commissioners: 17th May 2019

Commissioner Comments Received: within 10 working days of receipt of the draft

Senate Council ratification; 21st May (subject to commissioner comments received)

Final report agreed: end of May 2019

Publication of the report on the website: within 28 days of the report being ratified by the Senate Council

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:

- Proposal to Establish a Rota for the Surgical Treatment of Acute Type A Aortic Dissection Across Yorkshire and the Humber version 8
- Supporting Letter from Medical Directors dated 25th January 2019

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 but is expected to be within 28 days of ratification by the Senate Council.

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
v. respond to the request for evaluation of the Senate input once the report is finalised
vi. agree to the publication of the Senate report on the Senate website within 28 days of the report's ratification at the Senate Council

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