East Midlands Clinical Senate

FINAL REPORT

Lincolnshire Adult Vascular Surgery Review

Report of the Clinical Senate Review Panel

Held on 6 August 2014

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Contents

FOREWARD BY CLINICAL SENATE CHAIR

The NHS needs to continually modernise and transform in order to deliver high quality care now and for future generations. Clinical Senates have a unique role to play in supporting the NHS in enhancing quality and delivering sustainability by providing independent clinical leadership and advice. We hope that, by bringing an expert clinical voice, we can contribute in a positive way to the future development of adult vascular surgery in Lincolnshire.

We have aimed to achieve a balance between access to local services and improving their quality and safety for the whole population of Lincolnshire, recognising that the provision of safe and sustainable health services requires providers with experienced and well trained staff caring for sufficient numbers of patients to maintain skills and expertise.

I would like to express my thanks to the panel members for their contributions and time, and representatives from NHS England Specialised Commissioning, East Midlands Strategic Clinical Network for cardiovascular services, United Lincolnshire Hospitals NHS Trust, and Doncaster and Bassetlaw Hospital NHS Foundation Trust for their presentations and contributions to our discussion. Finally, I would like to thank the East Midlands Clinical Senate team for supporting and coordinating the review process.

Professor Dave Rowbotham

Co-Chair East Midlands Clinical Senate

1. SUMMARY & KEY RECOMMENDATIONS

Recommendation One

1.1 The panel were in complete agreement with United Lincolnshire Hospitals Trust (ULHT), East Midlands Strategic Clinical Network (SCN) for cardiovascular services and commissioners that safe and sustainable vascular surgery should be available and provided within Lincolnshire.

Recommendation Two

1.2 The panel **unanimously supported option two** - to deliver a local model of provision based at Lincoln County Hospital (LCH) via a partnership/network model with another organisation (Doncaster and Bassetlaw NHS Foundation Trust in this option appraisal). The panel also felt that this realised efficient and effective co-location arrangements with other services (e.g. cardiology, renal, acute stroke, trauma) and was consistent with the stated aim to establish the major Lincolnshire emergency centre in Lincoln. Furthermore, this partnership model gives the opportunity for the development of a high class service within Lincolnshire in partnership with an already established service. The panel recommends that further work is undertaken by commissioners and providers to develop plans for this option as rapidly as possible.

Recommendation Three

1.3 The panel **unanimously did not support option one** - to allow ULHT a further twelve months to deliver the agreed specialised commissioning derogation plan. The panel recognised the extreme effort and commitment shown by ULHT in their attempts to attract suitably qualified, substantive staff to establish a fully functional and safe service based at Boston. Despite the recent non-substantive appointment of two interventional radiologists from overseas, the panel felt it was highly unlikely that that the service will be able to meet, or be close to meeting, the service specification within the time period.

Recommendation Four

1.4 The panel **unanimously did not support option three** - for vascular surgery to be provided wholly by provider(s) external to Lincolnshire. This was felt not to be in the best interest of the patients of Lincolnshire. For example, ULHT needs a sustainable interventional radiology service to support all of its acute medical services and the local provision of vascular services is central to its ability to achieve this. However, the panel thought that this option would be the likely outcome if option one was adopted.

Recommendation Five

1.5 The panel **unanimously did not support option four** - to procure a new service provider to deliver services in Lincolnshire. However, the panel recognised that this would need further consideration (along with option three) if the service in Lincolnshire is not able to meet the required standards.

Recommendation Six

1.6 The panel **unanimously did not support the establishment of endovascular aneurysm repair (EVAR)** in the current service configuration. However, the panel recommended that plans to deliver EVAR should be developed as part of option two.

2. Background

2.1 A number of reviews of the provision of vascular services (including vascular surgery) across both the East Midlands and Lincolnshire have taken place over recent years. In 2010, the East Midlands Strategic Health Authority (EMSHA) conducted a review of vascular surgery provision which included all provider Trusts across the East Midlands. In October 2011, the EMSHA's recommendation for Lincolnshire patients was that ULHT should deliver a Type 2 vascular surgery service (see table 1) to serve the local population based on the regional specification that was produced at that time.

Table 1: Classification of vascular surgery services

24/7 Type 1 Centre	A major service offering all arterial procedures including complex cases
24/7 Type 2 Centre	A service offering the majority of vascular interventions, excluding extremely complex procedures, defined within protocols sharing personnel with a type one centre
Type 3 Centre	Either: (i) a service offering elective day surgery with the support of type 1 and/or type 2 centres Or: (ii) a service not offering vascular intervention but rapid referral to a type 1 and/or type 2 centre

2.2 The main provider of acute services in Lincolnshire is ULHT with sites in Lincoln, Boston and Grantham. The area of Lincolnshire covered by this review has a population of 715,000 covering a large geographic area. It has poor transport links with no motorway and only 37 miles of dual carriageway. It has an aging population profile, particularly on the east coast. There are high numbers of migrant and seasonal workers.

2.3 In 2011, both the provider and local commissioner were in agreement for a Type 2 vascular service to be located at the Pilgrim Hospital, Boston. Since 2011, the service at Boston has undertaken infrastructure changes and developed pathways to deliver the service and staff training. The service has also undertaken recruitment of a number of staff.

2.4 In November 2012, the East Midlands SCN for cardiovascular services completed an assessment to understand the progress and challenges towards the implementation of the Type 2 vascular service for Lincolnshire patients. This acknowledged that the recruitment of 4 additional interventional radiologists had been challenging but was

critical to the delivery of a full service within Lincolnshire. At that time, the SCN recommended that the EVAR service at Pilgrim Hospital should only commence once a safe complement of interventional radiologists had been fully inducted and mentored with robust governance measures to ensure safe practice. Until such time, the ULHT vascular team were advised that the Trust's EVAR cases should be undertaken at a Type 1 centre.

2.5 In 2013, the NHS Commissioning Board (later renamed NHS England) developed a service specification for specialised vascular surgical services for adults. During 2013, ULHT reviewed their current service against the national specification and identified that they were not compliant due to a shortfall in the required workforce numbers and applied for derogation (a time-limited permission to operate at less than full compliance subject to a compliance plan being agreed with commissioners).

2.6 During the derogation period, ULHT requested permission to commence a limited and closely monitored EVAR service. In January 2014 ULHT were advised that they were not to commence an EVAR service until formal approval was provided by specialised commissioning. In April 2014, the SCN were asked to meet with colleagues at ULHT to discuss the Trust's vascular service development, including EVAR and to determine what plans and governance were in place for delivering EVAR and also to have a view of the wider workforce issues. Recommendations were made to ULHT, if they were to commence a very limited EVAR service, about the considerable support they would need from an external proctor.

2.7 Following the April 2014 review, Professor Aly Rashid (Medical Director, Lincolnshire and Leicestershire Area Team with responsibility for specialised commissioning) requested support from the East Midlands Clinical Senate to review options for the future provision of a vascular surgery service in Lincolnshire. The Clinical Senate asked the SCN to work with both commissioners and providers to consider options for the future delivery of a safe and sustainable service for the population of Lincolnshire that would then be considered by a panel convened by the Clinical Senate.

3. Clinical Senate Role

3.1 The East Midlands Clinical Senate review of the Lincolnshire Adult Vascular Surgery Service was commissioned by the NHS England Lincolnshire and Leicestershire Area Team. The Clinical Senate review panel was convened to provide an independent clinical review of the options proposed by the East Midlands Cardiovascular Strategic Clinical Network.

3.2 The panel membership (Appendix 1), declarations of interests (Appendix 2), meeting agenda (Appendix 3), meeting notes (Appendix 4) and terms of reference (Appendix 5) are included in this report.

4. Current Service

4.1 The current Type 2 vascular service at ULHT is based at Pilgrim Hospital, Boston. One of the reasons for establishing the service at Pilgrim Hospital was to serve the east coast population who were faced with a prolonged travel time (1 hour and 20 minutes) for treatment if the service was based at LCH site.

4.2 The recruitment of interventional radiologists to provide a high quality sustainable service continues to be problematic. Vascular interventional radiology capacity has decreased since the service commenced at Pilgrim Hospital; currently 1 substantive and 2 recent non-substantive appointments (commencing by October 2014) with on-going recruitment attempts continuing from abroad and within the UK.

4.3 There are 5 vascular surgeons (3 substantive) with plans to increase to 6 if activity undertaken in other Trusts outside Lincolnshire is repatriated. Two of the 3 substantive surgeons have undergone a degree of training to perform EVAR and the team have an ambition to perform limited simple EVAR procedures in Boston as soon as possible.

4.4 Comprehensive vascular surgery services, including elective and emergency EVAR, are currently available in Nottingham, Leicester and Doncaster. A small number of patients are also referred to Cambridge.

4.5 ULHT has approached DBHFT to consider a partnership with respect to interventional radiology and vascular surgery This has led to the concept of a vascular surgery service for patients in Lincolnshire based at LCH in partnership with DBHFT i.e. option 2 considered by the Clinical Senate at this review.

5. National Recommendations

5.1 In their report “The Provision of Services for Patients with Vascular Disease 2012” the Vascular Society of Great Britain and Ireland (VSGBI) stated an expectation that all patients with vascular disease should have 24/7 access to a specialist vascular team in all parts of the UK for both elective and emergency care. These specialist teams should be made up of vascular surgeons, specialist nurses and anaesthetists, interventional radiologists and radiographers, clinical vascular scientists, occupational and physiotherapists. The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) called for a reorganisation of vascular services for emergency and elective care to optimise outcomes for patients in their 2005 report “National Enquiry into Perioperative Deaths: Abdominal Aortic Aneurysm”. In 2008, the European Society for Vascular Surgery Second Vascular Surgery Database Report 2008 showed that the UK had the highest mortality rates in Western Europe following elective abdominal aortic aneurysm surgery (UK - 7.9%, best in Europe – 2%)

(Vascunet 2008)(2) with a poor uptake of new endovascular technology. Since then, a considerable amount of work has been undertaken to remedy this situation.

5.2 The VSGBI report "The Provision of Services for Patients with Vascular Disease, 2012" concluded that high quality, world-class vascular care can be delivered in the UK with the establishment of high volume vascular centres involving a centralised service or a modern clinical network. They recommended that all patients should be able to consult with a vascular specialist at their local hospital, but they may have to travel to obtain access to diagnostic and interventional facilities. Only in this way can equality of access and the patients' desire for a local service be delivered alongside the best possible elective and emergency outcomes for individual patients.

5.3 More recently (Vascular Surgery UK Workforce Report 2014-3), the VSGBI have stated that "Acute NHS Trusts who wish to host a vascular surgery service must provide 24/7 availability of the facilities necessary to assess, diagnose and treat vascular emergencies. To provide 24/7 vascular emergency care in a safe and sustainable way we need larger teams working in fewer hospitals, ideally linked with acute stroke, cardiothoracic, renal and major trauma services."

5.4 The national service specification for vascular surgery was produced to support further re-structuring of vascular services to meet the requirements around reducing mortality with adoption of specialist procedures (including EVAR) delivered safely and sustainably with the required competent workforce numbers.

6. Consideration of Options

6.1 **Option One: Allow ULHT a further twelve months to deliver the agreed derogation plan**

6.2 The panel are supportive of both the ULHT and the commissioner's view that vascular surgery should be provided within Lincolnshire and see this as central to developing and maintaining a sustainable interventional radiology service supporting all acute medical services within Lincolnshire.

6.3 The panel recognised the comprehensive and energetic efforts that ULHT had employed to resolve staffing issues over the last 2 years. Despite these efforts, the panel felt that it was highly unlikely that the Trust would be able to attract sufficient staff with the required training and experience to meet the required staffing levels within 12 months and most likely beyond this.

6.4 The panel were aware of the Lincolnshire Health and Care (LHAC) strategic review and the potential designation, consistent with Sir Bruce Keogh's review of urgent and emergency care, of one 'specialist' emergency centre for the county at LCH. The inter dependencies of other clinical services would call into question a strategic decision to

establish the vascular surgery service as a stand-alone unit at Boston Pilgrim Hospital.

6.5 The panel also highlighted the considerable risk that the likely failure of this option would lead to a vascular surgery service for Lincolnshire patients provided outside the county.

6.6 For the reasons outlined, **the panel unanimously does not support option one** - to allow ULHT a further 12 months to deliver the agreed specialised commissioning derogation plan.

6.7 **Option 2: Deliver a local model of provision via a partnership/network model with another Trust**.

6.8 The current GP registered population of Lincolnshire is 740,000; however, data presented to the panel for open AAA repair indicates that 40% access services outside of the county. A minimum population of 800,000 is recommended within the service specification with a general clinical accepted standard of 1 million being the optimal catchment area. The development of a partnership model would allow the required population standard to be met for a sustainable service.

6.9 A potential partner, Doncaster and Bassetlaw Hospitals NHS Foundation Trust (DBHFT) has been identified by ULHT. The panel received evidence that the Boards of both hospitals have given support for a partnership between the Trusts. However, DBHFT clearly stated at the review that they would only be able to support a partnership model for vascular surgery if the services in Lincolnshire were based in Lincoln.

6.10 ULHT raised concern about the travel time for patients from the east coast of Lincolnshire to Lincoln. This was considered by the EMAS member of the panel who felt that the “blue light” time for transfer would be approximately one hour. Also, the panel’s independent clinical experts advised that the recommended time is indicative and the service patients receive upon arrival is just as important.

6.11 The panel considered there was a far greater likelihood of recruiting staff, especially interventional radiologists and vascular surgeons, both with a partnership arrangement and by relocating services to LCH. The panel also felt that, through partnership with an established vascular service, the necessary support would be available to develop the required competence and experience within the Lincolnshire team as recruitment progresses and the team develops.

6.12 The panel thought that this option will deliver a safe and sustainable service with a greater likelihood of repatriation of vascular cases delivered out of area presently. The panel also thought this option would support the drive to deliver 7 day services.

6.13 For the reasons outlined, **the panel unanimously supported option two** - to deliver a local model of provision in Lincolnshire via a partnership/network model with another organisation (DBHFT in this proposal) as the preferred option. The panel

recommended that work is undertaken as soon as possible by commissioners and providers to further develop the plans.

6.14 The panel acknowledged that complex planning and capital development (including equipment and facilities for a first-class EVAR service) is required to deliver this option.

6.15 The panel were concerned that working with an organisation without sufficient contracting safeguards could lead to the erosion of service provision within Lincolnshire. It is recommended that agreements/contracts between partners and commissioners were established at an early stage.

6.16 This option included high-level phased plans for the delivery of the service from Lincoln. During the early phase, it was proposed that emergency cases should be transferred from Boston to DBHFT. The panel considered this arrangement unacceptable and that it was possible to develop a phased plan that made this prolonged transfer time unnecessary.

6.17 **Option 3: Vascular surgery to be provided by the provider/s external to Lincolnshire**

6.18 This option is likely to deliver a service that would meet some of the required service specification.

6.19 However, the panel felt that travel times would be unacceptable for many patients.

6.20 This arrangement would have a significant detrimental effect on the many essential non-operative aspects of a vascular surgery service.

6.21 The ability to provide a comprehensive and sustainable interventional radiology service at ULHT is of particular importance. The panel felt that without vascular services the Trust's recruitment issues would be further compounded in this regard.

6.22 For these reasons **the panel unanimously did not support option three** - for vascular surgery to be provided wholly by provider(s) external to Lincolnshire. However, it was a model that may have to be adopted if progress is not made in establishing a safe and sustainable service in Lincolnshire.

6.23 **Option four: Procure a new service provider to deliver services in Lincolnshire**

6.24 The panel could see no advantage to immediately procuring a new service provider and there was no detail provided on the availability and suitability of present providers. The panel did recognise, as for option 3, that this may have to be

considered/adopted if progress is not made in establishing a safe and sustainable service in Lincolnshire.

6.25 **The panel unanimously did not recommend option four** - that a new provider be sought at this time**.**

7. Summary and Conclusion

7.1 The panel were unanimous in their view that vascular surgery services should continue to be provided within Lincolnshire and recognised the extreme efforts of clinical and managerial staff at ULHT in attempting to secure additional clinical staff for the service at Boston.

7.2 The panel felt that, on the basis of the information supplied, discussions with presenters and expert independent clinical opinion, the provision of a vascular surgical service at Boston was unsustainable and not in the best interests of the population of Lincolnshire.

7.3 The panel welcomed the proactive approach that had been taken by ULHT to begin discussions with DBHFT around a partnership arrangement to deliver vascular surgical services based at Lincoln. More work is required to develop this partnership and plan; however, the panel was unanimous in recommending that this is clearly the best of the four options presented for consideration.

Glossary of Terms

AAA – Abdominal Aortic Aneurysm Repair

DBHFT – Doncaster and Bassetlaw Hospitals Foundation Trust

CVD – Cardiovascular Disease

EMCVD – East Midlands Cardiovascular Network

EMSCN – East Midlands Strategic Clinical Network

EMSHA – East Midlands Strategic Health Authority

EVAR – Endovascular Aneurysm Repair (a graft placed under x-ray guidance, usually via the groin arteries)

IR – Interventional Radiologists

LCH – Lincoln County Hospital

LHAC – Lincolnshire Health and Care (multi stakeholder whole system review)

NCEPOD – National Confidential Enquiry into Patient Outcome and Death

SCN – Strategic Clinical Network

ULHT – United Lincolnshire Hospitals NHS Trust

VSGBI - Vascular Society of Great Britain and Ireland

References

1. National Vascular Service Specification 2013-14
   http://www.england.nhs.uk/wp-content/uploads/2013/06/a04-spec-vascu-adult.pdf

2. Surgery UK Workforce Report 2014 - Vascular Society of Great Britain and Ireland
   http://www.vascularsociety.org.uk/wp-content/uploads/2014/07/VS-UK-Workforce-Report.pdf

4. The Provision of Services for Patients with Vascular Disease, 2012 - Vascular Society of Great Britain and Ireland
   http://www.vascularsociety.org.uk/wp-content/uploads/2012/11/Provision-of-Services-for-Patients-with-Vascular-Disease.pdf

5. National Enquiry into Perioperative Deaths (NCEPOD). **Abdominal Aortic Aneurysm: a Service in need of Surgery.**
   London 2005. *www.ncepod.org.uk/2005aaa.htm*

6. The European Society for Vascular Surgery Second Vascular Surgery Database Report 2008
   http://www.esvs.org/sites/default/files/file/Vascunet/Vascunet%20report%202008.pdf

Appendices

Appendix 1 – Membership of the review panel

Professor David J Rowbotham – Panel Chair
Clinical Director, NIHR Clinical Research Network
Co-chair, East Midlands Clinical Senate

David Rowbotham is Clinical Director of the NIHR Clinical Research Network: East Midlands and Emeritus Professor of Anaesthesia and Pain Management, University of Leicester. Other current roles include: board member, East Midlands Academic Health Science Network; council member and treasurer, Royal College of Anaesthetists; advisor to the British National Formulary; Civilian Advisor in Anaesthesia, Royal Navy; and Director and board member, British Journal of Anaesthesia. Past responsibilities include: Consultant in Anaesthesia and Pain Management, University Hospitals of Leicester; Clinical Director, Leicestershire, Northamptonshire and Rutland Local Comprehensive Research Network; Director of Research and Development, University Hospitals of Leicester; Dean, Faculty of Pain Medicine, Royal College of Anaesthetists; Chair, National Institute for Academic Anaesthesia; and Vice President, Association of Anaesthetists of Great Britain and Ireland. .

Fred Higton – Panel Member
Patient representative

Educated as a chemist at London University and has worked for over 35 years in the Pharmaceutical industry developing medicines. Ran his own Pharmaceutical Consultancy. Now retired. Fred is also a cartoonist and caricaturist.

Dr Julie Hall – Panel Member
Executive Director of Forensic Services, Nottinghamshire Healthcare NHS Trust. East Midlands Clinical Senate Council Member

Julie is an Executive Director of Forensic Services for Nottinghamshire Healthcare NHS Trust. She has over 25 years' experience as a clinician, academic, author and director. Julie holds the title of Queens Nurse, is a Senior Fellow of the Institute of Mental Health and Visiting Fellow in the College of Social Science at the University of Lincoln. She maintains an active research portfolio focusing on how mental health care is organised, care pathways and service evaluation. Julie is highly committed to the ambition of continuous improvement in the quality of services and outcomes for patients.

Dr Claire Cousins – Panel Member
Lead Interventional Radiologist, Addenbrooke's Hospital, Cambridge

Consultant Interventional Radiologist since 1993, initially at Hammersmith Hospital, London and at Addenbrooke's since 1999. Lead IR Consultant since 2008. East of England CRG representative for IR. Chair of the International Commission on Radiological Protection. Specialist interests: Vascular IR, particularly EVAR (established service in 2001), arteritis and genetic aortic syndromes.

Sue Hardy
Chief Nurse / Deputy Chief Executive
Southend University Hospital NHS Foundation Trust

Sue is both a nurse and midwife, having worked in the NHS for almost 30 years. She has worked in a number of different hospitals throughout the UK and currently has the position of Chief Nurse at Southend University Foundation Trust Hospital. Sue has been a Director of Nursing for over 7 years, with the last 3 years at Southend. She is also the Deputy Chief Executive.

Sue has extensive experience in quality management and leading organisational change, where she puts the patient at the heart of everything she does. As a member of the East of England Clinical Senate Council, Sue is a passionate about patients receiving safe, high quality care and is a champion for patients receiving a positive patient experience.

Ben Anderson – Panel Member
Consultant in Public Health & Executive Lead for Population Healthcare Public Health England East Midlands Centre

Ben has over 10 years' experience in Public Health, working in both the NHS and Local Government before joining Public Health England earlier this year. Ben's previous Consultant posts in North Lincolnshire and Derby City saw him lead on Maternal and Child Health, where he delivered numerous projects integrating health and social care pathways.

Daryll Baker – Panel Member
Consultant Vascular Surgeon, Royal Free Hospital

Mr Daryll Baker is a Consultant Vascular Surgeon based at the Royal Free Hospital. Trained in Oxford and was appointed to his first Consultant post in 1996 Sub-specialist interests; varicose vein surgery

Awaiting photo

Peter Bainbridge (PB)
Locality Quality Manager EMAS

Sarah Hughes
EM Clinical Senate Manager

Sarah Hughes is the Clinical Senate Manager

Atiya Chaudhry-Green
Senior Quality Improvement Lead

Sheila Darji EM Clinical Senate PA

Appendix 2 – Declarations of Interest

Name	Personal pecuniary interest	Personal family interest	Non-personal pecuniary interest	Personal non-pecuniary interest
Dave Rowbotham	None	None	None	None
Fred Higton	None	None	None	None
Julie Hall	None	None	None	None
Claire Cousins	None	None	None	None
Daryll Baker	None	None	None	None
Ben Anderson	None	None	None	None
Sue Hardy	None	None	None	None
Peter Bainbridge	None	None	None	None
Sarah Hughes	None	None	None	None
Atiya Chaudhry-Green	None	None	None	None

Appendix 3 – Panel meeting agenda

CLINICAL SENATE VASCULAR SERVICES REVIEW
WEDNESDAY 6TH AUGUST 2014 10.00AM – 2.30PM
EVERYDAY CHAMPIONS CENTRE, JESSOPS CLOSE,
NORTHERN ROAD INDUSTRIAL ESTATE,
OFF BRUNEL DRIVE, NEWARK, NOTTINGHAMSHIRE, NG24 2ER

Teas & Coffees will be available 9.30am

Indicative time	Ref	Item	Presenter
10.00am	1.	Welcome, introductions and declarations of interest	Dave Rowbotham
10.15am	2.	Review of documentation	All
10.45am	3.	Presentation from specialised commissioning on commissioning context for vascular services – 10 minutes presentation, 20 minutes Q&A	Jon Gulliver Clinical Service Specialist Specialised Commissioning (Leicestershire and Lincolnshire AT)
11.15am	4.	CVD network presentation – current issues and options for future - 10 minutes presentation, 20 minutes Q&A	Jo James CVD Network Manager EMSCN & Senate
11.45am	5.	ULHT – current position and views on future options – 10 minutes presentation, 20 minutes Q&A	Paul Hogg Senior Business Manager ULHT Neil Hepburn Deputy Medical Director Lincoln County Hospital ULHT Mr Jayarama Mohan Clinical Director for Surgery Pilgrim Hospital ULHT Sewa Singh Medical Director Doncaster Royal Infirmary
12.15pm	6.	Panel discussion and formulation of new recommendations **(include working lunch)**	Dave Rowbotham and panel members
2.30pm	7.	Finish	

Appendix 4 – Notes of panel meeting

MINUTES OF THE LINCOLNSHIRE ADULT VASCULAR SURGERY INDEPENDENT CLINICAL REVIEW PANEL
WEDNESDAY 6TH AUGUST 2014 10.00AM – 2.30PM
EVERYDAY CHAMPIONS CENTRE, JESSOPS CLOSE, NORTHERN ROAD INDUSTRIAL ESTATE, OFF BRUNEL DRIVE, NEWARK, NOTTINGHAMSHIRE, NG24 2ER

Present:
Dave Rowbotham, EM Clinical Senate Co-chair (DR), Chair
Sarah Hughes, EM Clinical Senate Manager (SaH)
Atiya Chaudhry-Green, EM Clinical Senate Senior Quality Improvement Lead (ACG)
Sheila Darji, EM Clinical Senate PA (SD) & Minute Taker
Daryll Baker, Consultant Vascular Surgeon (DB), Royal Free Hospital
Claire Cousins, Consultant Interventional Radiologist (CC), Addenbrookes Hospital Cambridge
Julie Hall, Head of Forensic Services (JH), Nottinghamshire Healthcare
Ben Anderson, Centre Executive Lead for Population Healthcare Consultant in Public Health (Healthcare) (BA)
Peter Bainbridge, Locality Quality Manager EMAS (PB)
Sue Hardy, Chief Nurse/Deputy Chief Executive (SH), Southend University Hospital NHS Trust
Fred Higton, Patient Representative (FH)

In attendance:
Jon Gulliver, Specialised Commissioners (JG), Lincolnshire and Leicestershire Area Team
Jo James, EMSCN (JJ) – CVD
Paul Hogg, (PH), United Lincolnshire Hospitals NHS Trust
Neill Hepburn (NH), United Lincolnshire Hospitals NHS Trust Lincoln County Hospital
Mr Jayarama Mohan (JM), United Lincolnshire Hospitals NHS Trust Pilgrim Hospital
Mr Sewa Singh (SS), Doncaster and Bassetlaw Hospital Foundation NHS Trust

1.	**Panel Pre-meeting – Welcome & Introductions – Dave Rowbotham** DR opened the meeting and welcomed the panel members and thanked all for their participation. Introductions were made around the room. There we no conflict of interests declared. Confidentiality was explained as part of the review process. SaH gave a brief explanation of the review process. DR stated that the Lincolnshire and Leicestershire Area Team Medical Director had requested an independent review of the Lincolnshire Adult Vascular Surgery Services in his remit as the medical director of the lead organisation for Specialised Commissioning. The East Midlands Cardiovascular Strategic Clinical Network

	(EMSCN CVD) had been asked to conduct an options appraisal. The terms of reference were discussed alongside reviewing the background information sent to panel members in preparation prior to the review taking place. Paper 7 was highlighted as the recent correspondence with respect to the EMSCN CVD team to undertake a review and look at options. DR explained that the panel has been asked to review the options from this paper and recommend the best option.
2.	**Panel discussion** FH asked for clarification around what exactly is covered by vascular services and also the difference in the 3 levels of services. DB gave a detailed explanation. He explained vascular services offer treatments for blood vessel disease. The majority of patients do not have vascular surgery; they are managed in other less invasive ways. Vascular surgeons operate on veins and arteries. Most hospitals can deal with vein problems which are more common e.g. leg ulcers, swollen legs, varicose veins. They are usually not urgent and not complex. Artery procedures are more complex and undertaken at specialist units e.g. carotid endarterectomy (stroke prevention), aortic aneurysm repair, unblocking of arterial blood supply to legs. DB explained these procedures and what was required for them to be carried out. Arterial surgery is performed in a hospital offering a level 1 or 2 service. Endovascular aneurysm repair (EVAR) was also explained. This is less invasive and requires close working between the surgeon and an experienced interventional radiologist. Most patients do not undergo surgery but often require input from the vascular surgery service for assessment and advice on management e.g. this is common in patients with diabetes. CC described the role of an interventional radiologist (IR). These doctors are experts in the use of minimally invasive techniques for the repair of arterial aneurysms and unblocking of important arteries; these remove the need for major surgery and all its associated complications. IRs work in partnership with vascular surgeons and EVAR is a good example of this. The best outcomes are obtained when IRs and surgeons work together and are available 24/7. DR stated that one of the major concerns is the number of trained IRs in the UK. CC confirmed that there was a significant shortage (approximately 220-250) and approximately 50% of advertised consultant jobs are not filled. CC stated that we are not training enough nationally. A small percentage of fully trained radiologists become IRs. CC explained Type 1 and 2 services should have a recommended workforce of 6 IRs and 6 surgeons and this is difficult to achieve. BA queried the amount of surgery that needed to be performed to maintain competence of the surgical and radiological staff. DB stated the vascular society recommends 50 operations per unit. Optimum travel time for emergencies is one hour and there is a need to ensure slick hospital/patient pathways and reduction in

	delays for patients accessing care in A&Es and diagnostic tests etc. It was recognised the specialists commissioner paper also point to 10 procedures (including both elective and non-elective abdominal aortic aneurysm (AAA) repairs) per operator. DR queried whether ambulance staff can recognise patients who require immediate transfer to a vascular centre. PB stated some patients can be diagnosed on initial assessment but there are others where the diagnosis is made in A&E. DR also highlighted that a vascular surgeon's workload also involves a significant amount of time offering advice for other services. SaH advised the panel that there is currently a national review of urgent and emergency care and a local Lincolnshire sustainable services review which is also looking at urgent and emergency care. Currently there are ED departments in Lincoln, Boston and Grantham and part of that review is looking at one major emergency centre where complex care will be concentrated. No decision has been made but this centre is likely to be in Lincoln. DB raised a query about vascular access for the renal service which is an important part of the vascular surgery service. He was interested to find out how the present service is involved in this. DB added that he works in a vascular surgery service in London which involves a network of seven hospitals with all major procedures performed in one hospital with clinics held in all the other hospitals. JH wanted further information about the competency and experience of the surgeons to undertake EVAR. CC felt that from the information provided to the panel they were far off meeting the required experience levels to establish an EVAR service. However, she wanted to clarify this with the team. CC asked for clarification about the location of major trauma centres in the East Midlands. It was confirmed that the only major trauma centre in the region was in Nottingham. Following the pre-meeting with panel members, DR explained there will be presentations from specialised commissioning, EMSCN CVD Network and ULHT to understand their perspectives and there will be the opportunity to ask questions. DR confirmed that the panel is being asked to give an impartial clinical view on the presented options for a safe and sustainable vascular surgery service in Lincolnshire. We are not expected to have expertise in financial matters; however, we could offer comments on the practicalities and challenges of implementation in any of our recommendations
	Presentations
3.	**Presentation 1: Specialised Commissioning Jon Gulliver** Introductions were made around the table. A paper had previously been circulated to panel members. JG gave the panel members an outline background to specialised commissioner's view on the ULHT service. The NHS England compliance process against national service specifications was

undertaken in April 2013. Services were asked to declare compliance or non-compliance. ULHT sought derogation in Oct 2013 mainly due to shortfall in staffing. Derogation was offered for 12 months until October 2014 at which time the service was expected to reach compliance. In February 2014, ULHT asked to commence a limited EVAR service in Boston but specialist commissioning were not happy to sign this off due to lack of 24/7 cover by staff. ULHT were asked not to commence the service at that time.

The EMSCN CVD was asked to develop options for a safe and sustainable vascular surgery service in Lincolnshire. One of these options was to provide this service in partnership with Doncaster and Bassetlaw Hospital Foundation Trust (DBHFT) with a vascular surgery service in Lincoln. It was the view of the commissioners that ULHT alone couldn't meet the full national specification under present arrangements and the partnership with DBHFT is a good option recognising some time would be needed to develop plans.

Panel Q&A session

SaH asked about the service specification and any flexibility around the mandated workforce numbers as around the country there are a number of services that can't meet the specification. JG stated a pragmatic view needs to be taken with other factors being taken into account. e.g. the delivery of patient care in a timely manner. The issue with this service is the lack of workforce and geographical issues. Specialised commissioning need a level of reassurance on compliance.

JH asked how a partnership model would work with half the resources. JJ advised the aim is for DBHFT to support Lincolnshire with a view to expanding the team and further develop services in Lincolnshire. It isn't about splitting resource but adding to the resource.

CC asked about the one interventional radiologist and whether they cover both sites. JJ added that additional resources are provided via a chamber from Nottingham. Better IR cover would immediately be available by joining with DBHFT

CC raised a concern around the capacity to undertake EVAR. JJ confirmed that a proposal had been put forward by ULHT for a very limited EVAR service and it would not be a full service by any means.

DR asked the panel whether a 600,000 population and 10 operations per surgeon was an adequate basic requirement. All felt on the basis of information supplied a 600,000 population was too low for a comprehensive service. DB and CC advised that the recommendation nationally is nearer 1 million.

JG said that ULHT cannot support a stand-alone service; we support the need for them to work in partnership.

	DR asked how firm the commitment is between the two trusts (ULHT and DBHFT). JJ confirmed DBHFT is totally committed as it allows them to meet their population numbers, as per national recommendations which they don't at the moment. ULHT consultants are very clear they would like another 12 months to develop their service in Boston. SH asked whether DBHFT staff would work some of their time at Lincoln County Hospital (LCH). JJ confirmed that is the understanding. CC advised DBHFT and Sheffield undertake similar numbers of procedures and queried if they have resources to deliver the service and partnerships. JJ stated they have advised they are in a position to form a partnership and are absolutely committed and are interested in jointly recruiting posts.
4.	**Presentation 2: East Midlands Cardiovascular Strategic Clinical Network** **Jo James** JJ gave the panel members background to the reviews undertaken by the EMSCN CVD Network and its predecessor. JJ explained the network had two clinical leads, Mr Gary Hicken, Vascular Surgeon and Dr Mario DeNunzio Interventional Radiologist who had supported the work of the network since 2011. In 2010, the Strategic Health Authority reviewed vascular services across the whole of the East Midlands and went through a procurement process to agree type 1 vascular service centres and Boston was agreed to have type 2 centre. In March 2013, the EM CVD SCN undertook a wider review of all the cardiovascular services in terms of numbers and workforce. Lincolnshire had real issues about the sustainability of its services and the review identified areas for commissioners to look at. In April 2014, the EMCVD SCN network were asked to advise on whether EVAR could be undertaken at Boston. It was identified that there were systems in place, with proctorship, to support a very limited service. However, the bigger issue is that it not a sustainable service with one IR and a limited number of substantive vascular surgeons. At the time, ULHT were already looking at a partnership with DBHFT. The EM CVD SCN supported this approach. In summary the EM CVD SCN shared their summary of four options: • Option 1 - To allow ULHT another 12 months derogation to develop the service in Boston. • Option 2 - To develop a partnership arrangement with an alternate trust, in this case, DBHFT. • Option 3 – services are provided by a provider wholly outside of Lincolnshire • Option 4 - to procure a new partner to provide the service within Lincolnshire. JJ stated that the EMCVD SCN Network favoured option 2.

	Panel Q&A session DB queried where the carotid service was situated. JJ confirmed that is was in Boston. JG advised there is currently a review ongoing on the wider Lincolnshire issues and the complexity of moving services, especially within Lincolnshire, should not be underestimated. CC commented that LCH would need the infrastructure to support a robust service. CC queried whether it was sensible to commence a very limited EVAR service at Boston when there is already EVAR provision out of county. If a network approach and a move to Lincoln is recommended then an EVAR service could commence there. Caution was also raised about the possibility that DBHFT might dominate the partnership performing increasingly more procedures on Lincolnshire patients. JH asked who the lead accountable organisation for the delivery of the service in the partnership model would be. JG stated from a contracting point of view there would need to be a prime contractor; however, further work on this would need to be undertaken. BA added there was a need to liaise with the Yorkshire and Humber specialised commissioning colleagues which JG confirmed had not been done to his knowledge and made a note of this DB queried how enthusiastic ULHT Trust Board were to keep the vascular service? JJ stated the service has the complete backing of ULHT to keep services locally and they are enthused by the partnership as a potential solution. JG added that the local CCG commissioners view was that services should be delivered in Lincolnshire. The appetite is for services delivered close to home. CC asked how committed the vascular surgeons are in Boston to moving to Lincoln? JJ said that this is a potential concern as the surgeons are committed to making the service work on the Boston site. DR summarised that the network option preferred by the SCN and specialised commissioners has its challenges. DR asked JJ to confirm what services would be provided in Lincoln and under the partnership arrangement. She responded that it would be likely there would be outpatients at Boston and a full vascular service in LCH. SH asked if there any other providers that ULHT can link in with e.g. Peterborough or Kings Lynn? CC confirmed that there is not a vascular service at Peterborough or Kings Lynn. DR asked why NUH and UHL was not considered. JJ advised that they went with the present partnership as both trusts were supportive of it. JG and JJ were thanked very much for their contributions and left the meeting.
5.	**Presentation 3: ULHT & DBHFT Paul Hogg, Mr Mohan, Neil Hepburn and Sewa Singh**

	Introductions were made around the table. DR explained the process and the aim to produce an independent view of the presented options for the provision of vascular surgical services in Lincolnshire. He stressed that the recommendations are advisory only but he hoped that they would help the process. PH gave the panel members background information on the present service and the challenges it faces, including the current options. He stressed that it was the local commissioners view that services should be provided within Lincolnshire. EVAR is presently performed electively outside Lincolnshire's in different centres including at DBHFT. He confirmed that ULHT are not meeting the national specification for the vascular surgery service and had not started an EVAR service. The EMCVD SCN network had recommended the possibility of commencing a limited service at Boston but the commissioners have not agreed to this and it has not been implemented. Currently, there are 5 vascular surgeons – not enough activity and finances to recruit to the sixth post as yet. In terms of standards they should have 24/7 IR and surgeons on the same site. This can't be met that at the moment. The minimum population is 800,000 and ULHT serves about a 783,000 population. Also, access should be provided to patients within the hour. DBHFT has considered proposals which will help keep service in Lincolnshire. This partnership proposal (option 2) moves the centre from Boston to Lincoln; however, patients on the east coast would be disadvantaged because of transfer times. This would mean access to IR support within hours and out of hours patients could transfer to Doncaster. Within 1 to 2 years, the vision would be that vascular service would offer services locally (elective and 24/7 emergency) with support of the DBHFT team. Within 2-3 years all elective & emergency Vascular Surgery undertaken at Lincoln and out of hours IR flourishing at Lincoln. IRs is the major reason why the specification is not met. IR recruitment is extremely challenging within the UK, one of the problems being no EVAR service and so IRs don't want to come. Recruitment has commenced internationally. By Oct 14, ULHT will have 3 IRs at the Boston site. A 30 % premium enhancement did not help to recruit IRs. Two one year fixed term appointments have been made of 2 IRs. PH outlined the risks of failing to develop a local EVAR service in Lincolnshire. Surgeons won't be attracted and the current workforce may leave. There are similar issues with IRs; however, they are involved in lots of other work not just vascular. There are risks associated with starting an EVAR service locally in that we have limited resource [(proposal is to start with elective patients in a controlled manner with a proctor on site]. Vascular surgeons and the IR have been to other centres, the next step is to start in Lincolnshire with selective group of patients with the proctor on site - this will help recruitment of IRs and surgeons. In terms of workload, ULHT feel they could meet the required numbers.

	ULHT initially entered into discussions because they had 1 IR but now there are 3 (albeit the 2 new appointments from overseas on non-substantive with a one-year contract). The current proposal is to start EVAR procedures to see if more IRs can be attracted to develop the service in Boston. ULHT would like to have a longer period of derogation with the understanding that if recruitment is unsatisfactory they will move to the network model. A plan was presented as to how EVAR could be developed at Boston. PH shared a map highlighting the county's geography and patient travel times. Originally, the decision to base the service at Boston was based on patient travel times. The local commissioners are very clear they want a Lincolnshire based service. The current vascular team support the model they have and would like to develop it. However, they are happy to move to a network model if it keeps service in Lincolnshire. The initial trust board view was to go with the network model; however, in light of new IR recruitment, they support either model proposed equally. Specialist commissioners have been clear in saying ULHT don't meet the service specification and the CVD network have been very supportive. **Panel Q&A session.** CC asked how ULHT currently provide out-of-hours IR in Lincoln and the two hospitals at the moment? For example, what happens to a patient who requires an intervention by an IR (e.g. gastrointestinal or uterine haemorrhage). PH said that there is not an on-call system and patients most go to Nottingham from Boston and Lincoln. There is no written formal pathway but agreement with Nottinghamshire consultants. SS added that in recent weeks DBHFT has taken patients also. CC asked for a clarification of the role of the Nottingham IR chamber. Do they provide a broad spectrum of IR services. PH explained that the Nottingham IR team provide a non-NHS private arrangement undertaking elective interventions at both sites. DB clarified that Boston has performed 40 open AAA repairs with others undertaken outside Lincolnshire. JM clarified that there are 5 vascular surgeons with 1 in 5 on-call rota taking at Boston. DB asked about the DBHFT relationship, what type of service agreement was going to take place e.g. joint appointments, SLAs, handover arrangements. SS explained that, as well as being Medical Director, he was a vascular surgeon. He explained that ULHT had approached DBHFT to explore the possibility of collaboration with Lincolnshire, particularly around IR. Geographically, they can only support the vascular surgical service if the Lincolnshire base is established at LCH. Both sides have entered into discussion on how immediate support could be provided within and outside normal working hours. Current plans are to start daytime support in LCH and the next step is to consider when some support for emergency IR could start at Lincoln.

DB asked about financial implications for relationship with DBHFT. How much will it cost and does Lincoln have a hybrid theatre? Concern was raised by ULHT about the finance required to relocate the service. PH said the plan is to try to make service work in Boston if not, investment would be needed at the Lincoln site and DBHFT would support and help. PH confirmed that there was not a hybrid theatre at Boston; they have C-arm equipment that will be movable to the Lincoln site.

JM provided some background as the lead vascular surgeon for ULHT. The service was set up within 2 years and patients have given it a good rating. There is a good vascular laboratory and vascular technicians. A one-stop service is in place. There is a dedicated on-call surgical rota. IR is the main local issue reflecting a national issue which is not being addressed. Currently, they have 1 substantive IR with 2 non-substantive appointments (1 year contract) that have been have been recruited to from abroad. A UK trainee about to complete training has expressed some interest in coming to the Boston service. He thought that the service was nearly fully established and wanted more to make further progress before moving the service. He highlighted the fact that Peterborough and Kings Lynn have lost their vascular service so some patients in Lincolnshire will be disadvantaged because of this. IR support is needed in Lincoln as part of 7 day services requirements.

DR asked what ULHT colleagues felt are the disadvantages of moving the service from Boston to Lincoln? JM advised that a good team has been established e.g. the vascular laboratory team will not be willing to move and this will destabilise the service. Presently, there is no infrastructure to support service in Lincoln. JM advised that patients from east and south of the county would not get timely access. Travel from Skegness, in his view, would take 1 hour 20 min to access Lincoln.

CC asked what currently happens to people requiring emergency procedures who can't be dealt with at Boston. PH advised that patients go to Nottingham, Leicester and DBHFT whichever is closest.

SaH asked about the wider review of services in Lincolnshire and the potential impact of changes to these services e.g. major emergency centre. JM replied that when they looked at major emergency centre did not have to factor vascular within it. Not everywhere has co location of services e.g. heart service and vascular services.

NH added that the clinical strategy of how ULHT will provide services is still being worked through. However, there is a need to provide in county emergency care whether that is provided in one or 2 major centres. Currently, ULHT has many services on 2 sites and these needs to be rationalised. What is clear is that a vascular service is needed and much improved IR capacity. It is not just vascular but acute medical care falls over if IR is not in place. Main concern for the Trust Board is to find solutions to IR capacity.

DR queried if the ULHT Board have a view on where the services should be provided. NH replied that it is difficult for DBHFT to support the service in Boston, but some time is needed to work on the reality of what this means.

JH asked about the likelihood of the posts continuing that are not substantive JM stated they have deliberately have not recruited substantively, they are waiting for EVAR to start to appoint the best candidates. JH asked in a partnership model who the lead provider would be. SS confirmed both boards support the partnership, initially it would be an SLA and as it develops looking at joint appointments.

CC understood that there was a workforce of 3 substantive surgeons and EVAR experience of these individuals will still be too low to offer an EVAR service. JM replied that one surgeon (Mr Arya) is very experienced and during a fellowship has done 20-30 EVARs in Dublin. Mr Lee Chong is fully trained and does them at DBHFT at present. CC asked if the one vascular IR based in Boston covers and works at Lincoln County Hospital. JM confirmed this.

JM added that two further IRs have been recruited, one from Greece and one from Italy. One with EVAR experience and the other limited experience. It is difficult to gauge international recruit's skills. SaH asked if is it was easier to recruit to Lincoln? NH confirmed that it was easier; however, moving people around is also challenging.

PH added that lots of services are on 2 sites e.g. stroke, trauma, etc. but present networks have not being able to resolve this challenge. SaH queried if there are plans to have an air ambulance service? Trauma services are looking into this but there are complexities about night time flying in the county.

DB asked about co-location with renal dialysis e.g. who looks after fistula bleeds. Lincoln hospital has a dialysis service in the daytime. A neurology service is provided by Sheffield and Nottingham and cardiothoracic service provided by Leicester or Nottingham.

DR asked how long the partnership model would take before getting to the final stage? PH advised following on from the experience of set up at Boston it would take 18 months. NH added that no space is available presently for a vascular surgical service at Lincoln; this would necessitate moving some elective services to other sites.

DR asked if option 1 was chosen (to continue with Boston as the centre), how long would be needed to bring it up to the required specification in the context of the national picture and the time already spent trying to achieve the specification. JM felt that starting EVAR would make a difference to recruitment. PH said that ULHT would have to provide IR at Boston, DBHFT cannot provide it in Lincoln only because the distances are two great.

	CC stated that to have a satisfactory IR service you need 6 sufficiently trained and experienced IRs and that the trust is currently a long way off this. DB asked about the current situation with respect to IR and how seriously ULHT are taking the recruitment challenge. NH replied they were taking this very seriously and all sorts of measures have been taken including a 30% recruitment premium. ACG asked DBHFT how they are going to support recruitment of IRs within Lincolnshire and how have they have done this in their service. SS stated that staff needs to feel they are part of team and DBHFT have been proactive with supporting trainees in the Yorkshire and Humber region. SaH asked what would happen if the current staff leave? NH confirmed they would rely on the chamber system offered by Nottingham. SS confirmed that DBHFT would like to help ULHT to recruit staff and do their best to help out of hours by reviewing images, giving advice etc. He also stated that he agreed that it was unacceptable not to offer a 24/7 service. SaH confirmed the process for next steps and a report would be available in 2/3 weeks to share with the teams for an accuracy check. PH, NH, JM & SS were thanked for attending and left the meeting.
	Lunch
6.	**Panel discussion and review of the options** The panel reconvened and a lengthy discussion was held around the documentation provided to the panel, presentation of colleagues, the question/answer sessions, and the pros/ cons associated with each option as proposed by the EM SCN CVD network. **<u>Option 1</u>** The panel was unanimous that, based on the evidence provided and the opinions of the panel's expert clinicians, that it is extremely unlikely that ULHT will meet the required number of vascular surgeons and IRs within 1 year and beyond, notwithstanding the recent trial appointments of 2 non-substantive IRs to a fixed contract. The panel thought that ULHT would require more than one year to provide a comprehensive Endovascular Aneurysm Repair (EVAR) service. Also, the panel thought that a stand-alone service at Boston would be very unlikely to attract sufficient and sustainable workforce to deliver a high quality vascular service and that it was unlikely such a service would be able to repatriate the activity currently flowing to centres outside of Lincolnshire.

Adopting this option would mean that ULHT would have challenges with respect to co-dependencies in the light of the current wider strategic review proposals.

The panel thought there was a very considerable risk that the failure of this option would lead to the provision of vascular surgical service out with the county of Lincolnshire. The panel was supportive of both the ULHT and commissioners view that services for patients remain within Lincolnshire.

The panel was entirely unanimous in all of these discussions and conclusions.

Option 2

The panel were unanimous in recommending that option 2 would be the best option to deliver a sustainable service with a significantly greater chance of recruitment of a skilled and competent workforce within a timely manner. This provides greater opportunity to support the Keogh recommendations for 24/7 wider services and cover to all the hospital sites within Lincolnshire.

Option 2 also presented increased training opportunities with greater opportunity and likelihood of repatriation of vascular cases delivered out of area presently.

The panel identified and discussed some of the challenges associated with this option that will need to be met including financial plans and service level agreements. There was concern that one possible outcome would be that all services will become provided by DBHFT and that any arrangements should mitigate against this. Also there was a danger that DBHFT may pull out of the partnership during the phased introduction and/or the complex commissioning arrangements may inhibit progress.

The panel discussed at length the issue of prolonged transfer times to Lincoln for patients on the East Lincolnshire coast. ULHT stated that a main argument for the service be based at Boston was that these transfer times were unacceptable. The opinion of the experts' clinical members was that that the slightly increased travel time would be mitigated by a functional and effective patient pathway and close collaboration with EMAS. PB advised that the likely transfer time in an ambulance with blue lights is in the region of 55 minutes.

In the early phases of this proposal, it was suggested that patients with vascular emergencies would be transferred from Boston to Doncaster. The panel thought that this was unacceptable but saw no reason why this was necessary.

The panel discussed the significant managerial challenges in realising this option. They all accepted that these were very real. However, in the light of all that has that had been presented and discussed they still felt unanimously that option two was clearly the best.

Option 3

	The panel was unanimous in not supporting option three which was for vascular surgery to be provided wholly by provider(s) external to Lincolnshire. The panel were concerned about the travel times that would result for many patients if this option was progressed. The panel also discussed the impact of losing vascular surgery on other services provided by ULHT. It was seen as an essential service that needs to remain provided within the county. The panel also discussed how this option may become a reality if the current service becomes unsustainable necessitating swift remedial action by commissioners. **Option 4** The panel discussed option four and were unanimous in their view that there was no benefit to the patients of Lincolnshire in pursuing this option as a first choice. The panel did however recognise that this option may need further consideration (along with option 3) if, for whatever reason, the current service became unsustainable. **Final remarks** SaH advised the panel that a draft report would be circulated to all panel members before end of 8th August 2014 for comments. These would be reviewed and a further draft would be issued to contributors for comments on matters of accuracy only. It is anticipated that the final report will be available by Friday August 22nd.
7.	DR thanked all panel members for their contributions and the meeting was closed.

Appendix 5 – Full terms of reference of the panel

CLINICAL REVIEW: TERMS OF REFERENCE

Title: **Lincolnshire Vascular Services Review**

Sponsoring Organisation: **NHS England**

Clinical Senate: East Midlands

NHS England regional or area team: **Leicestershire and Lincolnshire**

Terms of reference agreed by: **Professor Dave Rowbotham**

on behalf of East Midlands Clinical Senate and

Professor Aly Rashid

on behalf of sponsoring organisation Leicestershire and Lincolnshire Area Team

Date: 30.6.14

Clinical review team members

Professor Dave Rowbotham	Co-chair East Midlands Clinical Senate
Daryll Baker	Consultant Vascular Surgeon, Royal Free Hospital
Claire Cousins	Consultant Interventional Radiologist, Addenbrookes Hospital Cambridge
Julie Hall	Head of Forensic Services, Nottinghamshire Healthcare
Ben Anderson	Consultant in Public Health, PHE
Peter Bainbridge	Locality Quality Manager EMAS
Sue Hardy	Chief Nurse/Deputy Chief Executive, Southend University Hospital NHS Trust
Fred Higton	Patient Representative
Sarah Hughes	Clinical Senate Network Manager

Atiya Chaudhry-Green	Senior Quality Improvement Lead

Aims and objectives of the clinical review

The Clinical Senate is asked to advise on the optimal model of acute vascular services (AAA repairs, open repairs, EVAR, amputations, infra-inguinal bypass surgery, carotid endarterectomy) in Lincolnshire reflecting the broader configuration across the East Midlands.

Commissioning recommendations were made for specialised vascular services in 2010 however, the full recommendations have not been implemented and therefore do not provide the optimal model of service configuration for vascular services in the region, in particular in Lincolnshire.

Scope of the review

The Clinical Senate review panel is asked to review the available evidence (Appendix One) and make recommendations for the future provision of vascular services to the population of Lincolnshire.

When reviewing the case for change and options appraisal the Clinical Review Panel should consider (but is not limited to) the following questions:

- Will these proposals deliver real benefits to patients?
- Is there evidence that the proposals will improve the quality, safety and sustainability of care?
- Do the proposals reflect up to date clinical guidelines and national and international best practice e.g. Royal College reports?
- Do the proposals reflect the goals of the NHS Outcomes Framework
- Do the proposals reflect the rights and pledges in the NHS Constitution
- Do the proposals meet the current and future healthcare needs of their patients,
- Is there a clinical risk analysis of the proposals, and is there a plan to mitigate identified risks?
- Do the proposals demonstrate good alignment with the development of other health and care services?

- Do the proposals support better integration of services?
- Do the proposals consider issues of patient access and transport? Is a potential increase in travel times for patients outweighed by the clinical benefits?
- Will the proposals help to reduce health inequalities?
- Does the options appraisal consider a networked approach - cooperation and collaboration with other sites and/or organisations?

The Clinical Review Panel should assess the strength of the evidence base of the case for change and proposed models. Where the evidence base is weak then clinical consensus, using a voting system if required, will be used to reach agreement. The Clinical Senate Review should indicate whether recommendations are bases on high quality clinical evidence e.g. meta-analysis of randomised controlled clinical trials or clinical consensus e.g. Royal College guidance, expert opinion.

Timeline

To be completed by end of August 2014

Reporting arrangements

The clinical review team will report to the clinical senate council which will agree the report and be accountable for the advice contained in the final report.

Methodology

The review will be undertaken by a combination of desk top review of documentation and a review panel meeting to enable presentations and discussions to take place

Report

A draft report will be made to the sponsoring organisation for fact checking prior to publication

Comments/ correction must be received within 5 working days.

The final report will be submitted to the sponsoring organisation by end of August 2014

Communication and media handling

Communications will be managed by NHS England communications team with support from the Clinical Senate's Communication Manager

Resources

The East Midlands Clinical Senate will provide administrative support to the 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.

Accountability and Governance

The clinical review team is part of the East Midlands Clinical Senate accountability and governance structure.

The East Midlands 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.

Functions, responsibilities and roles

The **sponsoring organisation** will

i. provide the clinical review panel with the case for change, options appraisal and relevant background and current information, identifying relevant best practice and guidance. 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 (e.g. NHS Constitution and outcomes framework, Joint Strategic Needs Assessments, CCG two and five year plans and

commissioning intentions). 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.

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, 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.