9 July 2013	**ITEM: 8**
Health and Well-being Overview and Scrutiny Committee	
Vascular Services Update	
Report of: NHS England Commissioning Team	
Wards and communities affected: all	**Key Decision:** Non-key
Accountable Head of Service: N/a	
Accountable Director: N/a	
This report is public	

1. RECOMMENDATIONS:

1.1 To Consider and comment on the report.

2. INTRODUCTION AND BACKGROUND:

2.1 The Vascular Society of Great Britain and Ireland (VSGBI) published Provision of Vascular Service Standards in 2012 and outlined a new approach and framework for improving the results of elective Abdominal Aortic Aneurysm (AAA) repair. These standards have been adopted by the Department of Health and are being rolled-out nationally.

2.2 The VSGBI have a clear objective to halve the UK elective surgery mortality rate for AAA to 3.5% by 2013. A key recommendation from the guidelines is that hospitals undertaking fewer than 100 elective AAA repairs over three years should not continue to offer these procedures, as this is the level needed to develop and sustain clinician expertise for better patient outcomes.

2.3 They are also clear that the most complex procedures should be carried out by dedicated vascular surgeons working across specialist centres, with dedicated facilities where complex surgery takes place (to be known as arterial centres) and other local hospitals where routine care will continue (known as non-arterial centres); these hospitals will come together to form a specialist network serving a given population. The majority of patients will still receive their care (including non-emergency or complex surgery) at their local hospital and these services are not being altered as part of the proposals. The changes will therefore mostly affect a relatively small number of emergency or complex cases that will need to be treated in the arterial centres. Patient choice will prevail in all cases of non-emergency treatment.

2.4 Through implementing these standards new networks will be created which will operate as a single service across two (or more) hospital sites. They are also clear that the most complex procedures should be carried out by dedicated vascular surgeons in specialist centres.

East of England review of vascular services:

2.5 In March 2011, the Primary Care Trusts (PCTs) in the east of England region engaged the former Midlands and East Specialised Commissioning Group (SCG) to lead the work needed to review and establish effective joint emergency and elective vascular surgery networks for the region. The work had three main objectives:

1. To improve outcomes.
2. To implement best practice for vascular surgery as described by the VSGBI.
3. To ensure that all services are compliant with the quality requirements to support the national AAA screening programme.

2.6 A vascular steering group was set up in July 2011 to lead the review of current services and to ensure a broad representation from expert clinicians and commissioners, to patients and patient representatives who have used the services. The steering group was required to make recommendations for any changes that might be required to meet the three core objectives. As part of the review work, the group commissioned an independent clinical review of services. During summer 2012 an extensive period of engagement was carried out to discuss the required changes in vascular surgical services. The aim was to highlight the need for change, to explain how recommendations for change had been reached and to invite comments.

2.7 There was overwhelming support for the changes to services required to implement the VSGBI's standards across the east of England, from clinicians and the public alike.

2.8 Following the period of engagement, agreement was reached in September 2012 to designate arterial centres in Norwich, Cambridge, Bedford and Colchester, however it was agreed that the process would be extended in Essex and Hertfordshire to determine the final network recommendations in Essex (excluding north Essex) and Hertfordshire.

2.9 The additional time was used to assess viable options for networks in these areas and in particular to address the impact of any changes on co-dependent services such as stroke, renal and cardiac.

The review process: where are we now?

2.10 Between September and December 2012, the SCG undertook an options appraisal, working with Trusts and Commissioners (PCT and Clinical Commissioning Group representation as appropriate) to:

- Identify the potential options

- Develop criteria and weighting
- Evaluate the options
- Make recommendations on future reconfiguration of vascular services, and in particular the designation of arterial centres.

2.11 The criteria and weighting were developed and agreed by the Project Board, and were based on the Provision of Vascular Services 2012 standards, on the draft national service specification, and the views of the public and stakeholders reflected in the public engagement in the summer of 2012.

2.12 In addition the Project Board was informed by external clinical advice and clinical engagement groups which included representation from clinicians across Essex and Hertfordshire. The Project Board made their recommendations in December 2012, subject to additional external scrutiny by Gateway and by the National Clinical Advisory Team (NCAT).

External reviews (Gateway and NCAT)

2.13 In February 2013 the project group's recommendations were reviewed by an external panel of experts from Gateway and NCAT.

The key themes from NCAT were:

- The evidence base for the changes is robust and supports a service reconfiguration.
- Robust network arrangements need to be put in place to ensure that renal patients are not disadvantaged in Hertfordshire.
- The co-location of vascular surgical services with inpatient cardiac surgery and cardiology requires careful consideration.
- Further external visits should take place to assess the Trust estate in each area (these visits have now taken place).
- Formal network structures will need to be established.

2.14 The key recommendations from the Gateway team related to ensuring effective transition of the project, and ensuring a clear decision making process post April 2013.

3. ISSUES, OPTIONS AND ANALYSIS OF OPTIONS:

3.1 The recommendations for Essex

Having carried out a full options appraisal we have made some recommendations for the configuration of networks across mid/west Essex and south Essex:

- **Chelmsford/Harlow network** – it is recommended that Chelmsford is the main arterial centre and Harlow is a non-arterial centre.

- **Southend/Basildon network** – it is recommended that Southend is the arterial centre and Basildon as a non-arterial centre, **although this is subject to the outcomes of the Essex review into which hospitals should become Hyper Acute Stroke Units.**

(A Colchester/Ipswich network has already ratified and implemented with Colchester as the arterial centre and Ipswich as the non-arterial centre).

3.2 This will mean an established network delivering round the clock care, with vascular surgeons from the Lister and Watford Hospital working together to provide a service for patients that will improve outcomes and survival.

Co – located services

3.3 The most significant services interdependencies are hyper acute stroke services, cardiac and renal services. Clearly there is also a strong relationship with a range of other services e.g. diabetes, trauma. The only mandated co-located specialties identified in the national service specification are interventional radiology and critical care.

3.4 It is clearly essential that the pathways for renal patients are developed and both Southend and Chelmsford have inpatient renal units and dialysis.

3.5 In relation to cardiac services, a number of arterial centres are not co-located with a cardiac centre, and from the perspective of the arterial centres this has not created difficulties. The recently published vascular service specification indicates that cardiac surgery is interdependent but not co-located.

3.6 To take the specific example of Basildon, the Trust would retain 9-5 vascular consultant presence, when support to the cardiothoracic centre (CTC) would be routinely available. In addition, Southend has offered a second on-call arrangement to the CTC for any emergencies which are agreed to be very low in number.

3.7 For stroke services, hyper acute stroke units are recommended in Colchester, Southend and Chelmsford (and will be designated at Stevenage and Watford). The Essex proposals are therefore consistent for stroke and vascular services

The current recommendations are consistent with the national service specification

4. REASONS FOR RECOMMENDATION:

4.1 Essex HOSC has indicated that they do not envisage a requirement for further consultation given the extent of engagement to date.

4.2 The vascular reconfiguration has linked closely to the stroke reconfiguration in Essex and it has been decided to wait until the outcome of the reconfiguration in Essex before any recommendations on vascular can be implemented.

The reasons for this are:

- A commitment was given to stakeholders and providers that the outcome of the stroke configuration would form a part of the considerations in relation to the vascular reconfiguration.
- The options appraisal criteria include hyper acute stroke unit dependencies.

4.3 It is expected that a decision on the stroke reconfiguration will be announced in autumn 2013.

APPENDICES TO THIS REPORT:

- To read our previous update on the vascular designation and the process that has been undertaken so far, please click here

- If you have any questions or would like us to come and meet with you to discuss the project further, please don't hesitate to get in contact with:

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