Buckinghamshire Health and Adult Social Care Committee Briefing Note: Vascular Services for Thames Valley

Version Control

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1. Introduction

1.1 Vascular disease relates to disease of the arteries, veins and lymphatics. An audit in 2014 of a multi-disciplinary group of vascular clinicians in the Thames Valley network demonstrated that over 60% of their time is spent on performing minor elective procedures, providing clinical advice, service development and teaching. Less than 40% of time is spent on emergency or elective major procedures.

1.2 The major procedures, and the commissioning approach to them, are described in A04/S/a NHS Standard Contract Specialised Vascular Services (adult). Key requirements for provision of this service are:

- All Trusts that provide a vascular service must belong to a vascular network with clear governance arrangements
- All arterial surgery will be provided at a vascular centre.
- A vascular centre needs to have vascular surgeons and interventional radiologists available 24/7 and have on-call rotas to support this with a minimum of 6 vascular surgeons and 6 vascular interventional radiologists. This can be provided through a networked arrangement.
- Vascular surgeons to only treat patients with vascular disease.
- Day case and first line diagnostics to be provided locally, where appropriate.
- Arterial centres must do a minimum of 50 CEA procedures annually.

1.3 This prescription of services is supported by the Vascular Society as the way to ensure services are safe and sustainable for patients. The Vascular Society of Great Britain and Ireland (VSGBI) and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) state that the best outcomes for patients are achieved in specialist vascular units with dedicated vascular teams available 24 hours a day, 7 days a week.

1.4 NHS England commission this service through its Specialised Commissioning function.

1.5 In 2013, Specialised Commissioning asked all Trusts in Thames Valley to complete a self-assessment. Buckinghamshire Healthcare Trust (BHT) completed it and stated that their specialised vascular services were non-compliant with the service specification. This was confirmed by Specialised Commissioning.

1.6 Specialised Commissioning formally asked the Strategic Clinical Network (SCN), NHS England to lead a review of services that were non-compliant and were under commissioner derogation.

1.7 An SCN review (2014) of progress since 2010 was conducted which highlighted that Phase 1 and 2 had largely been completed, which included the networked provision of services for Wexham Park Hospital and Royal Berkshire Hospitals NHS Foundation Trust (RBH FT) as non-arterial centres. Phase 3 was about integration of BHT into the network. This remained to be done.

1.8 Since services needed to be provided from compliant centres, alternatives to Oxford were also considered.

1.9 A public consultation, Better Healthcare in Bucks, was undertaken by NHS Buckinghamshire and a HOSC (Health Overview and Scrutiny Committee) response, delivered in 2012, which included a discussion on the provision of networked vascular services.

2. What is going to change immediately?

2.1 From April 2016 patients from Buckinghamshire who seek specialist vascular surgery (other than carotid endarterectomy) will be offered this procedure at the John Radcliffe Hospital, Oxford.

2.2 In line with the Better Healthcare in Bucks HOSC (April 14, 2012) recommendation, the majority of pre- and post-operative procedures will be done locally to provide ease of access to patients. This includes outpatient appointments, ultrasound and radiology investigations as well as follow-up appointments and investigations.

2.3 This has built on significant work done to build consensus between the clinical teams at Oxford University Hospital NHS Foundation Trust (OUHFT) and Buckinghamshire Healthcare Trust (BHT) and the development of a shared vision.

3. What still needs to change and why does it need to change?

3.1 The Better healthcare in Bucks consultation excluded surgery to prevent strokes caused by carotid artery disease (carotid endarterectomy or CEA) from the centralisation of services at a specialist centre in Oxford. The recommendation from the HOSC was that this would be reviewed 3 years post consultation (ie from 2015).

3.2 Specialised commissioning (NHS England – South) state that they would not support commissioning services from a non-compliant centre when there is a compliant centre providing the service within the geography, which has the capacity to undertake the work.

3.3 An option appraisal paper was taken to the Thames Valley (TV) Clinical Senate Council in September 2015 for a recommendation. The TV Clinical Senate exists to provide a source of strategic, independent clinical advice and leadership on how services should be designed to provide the best overall care and outcomes for patients. It has patients, local authorities, education, health representatives from providers and commissioners and the Academic Health Sciences Network as Council members.

The options presented to the Senate Council were:

a. BHT to continue to provide vascular services as a stand-alone unit
b. BHT to become a non-arterial centre in the TV network
c. BHT to become a non-arterial centre in A N Other network

3.4 The Clinical Senate Council reviewed the proposal in line with the NHS England assurance process guideline and confirmed that it supported the recommended option that BHT become part of the TV network with OUHFT as the arterial centre and outpatient care provided at all hospitals in the network.

3.5 There is an overwhelming body of evidence supporting the centralisation of CEA surgery. 'The Provision of Services for Patients with Vascular Disease 2015' (POV15) produced by the Vascular Society is used to support the planning and commissioning of vascular services by Specialised Commissioning in NHS England. The strong recommendation is that all specialist vascular procedures that require in-patient stay should be done at a centre where there is 24/7 consultant cover. This is an issue of patient safety.

3.6 POV15 states that "the Vascular Society believes that every patient has the right to consult with a vascular surgeon close to their local hospital, but they may have to travel to obtain access to more complex 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."

3.7 POV15 also states that 50% of patients with vascular disease present urgently or as an emergency. The delivery of a 24/7 service is therefore a central challenge. A minimum of six specialists is required for a rota and this is likely to increase to 10 consultants when the system moves to full 7 day services.

3.8 NICE (National Institute of Clinical Excellence) (CG68) state that patients with symptoms that require a carotid intervention, should have their surgery within 14 days. The aim is to reduce this to 7 days to cut still further the chance of patients having a stroke whilst waiting for surgery. This is listed as a target in the Specialised Vascular Services Specification. Meeting this target will require access to vascular lists 5 to 7 days a week; something that is provided at OUHFT, but logistically impossible at BHT.

The latest published data from the National Vascular Registry and available on NHS Choices web site is given below. This is for the year from 01.10.2013 – 30.09.2014.

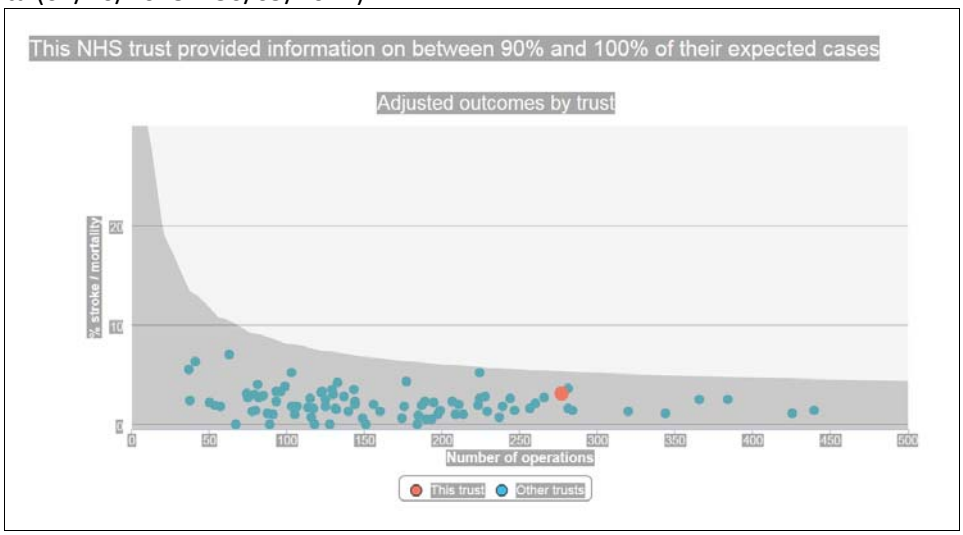
Trust	Code	Median wait (days)
Buckinghamshire Healthcare NHS Trust	RXQ	17
Oxford University Hospitals NHS Trust	RTH	14

More recent data produced by both hospitals, but not published, over the period 01.01.2012 – 31.12.2015 shows a more broadly comparable service. The efforts that BHT has made in relation to the reduction to surgery time have yielded good results.

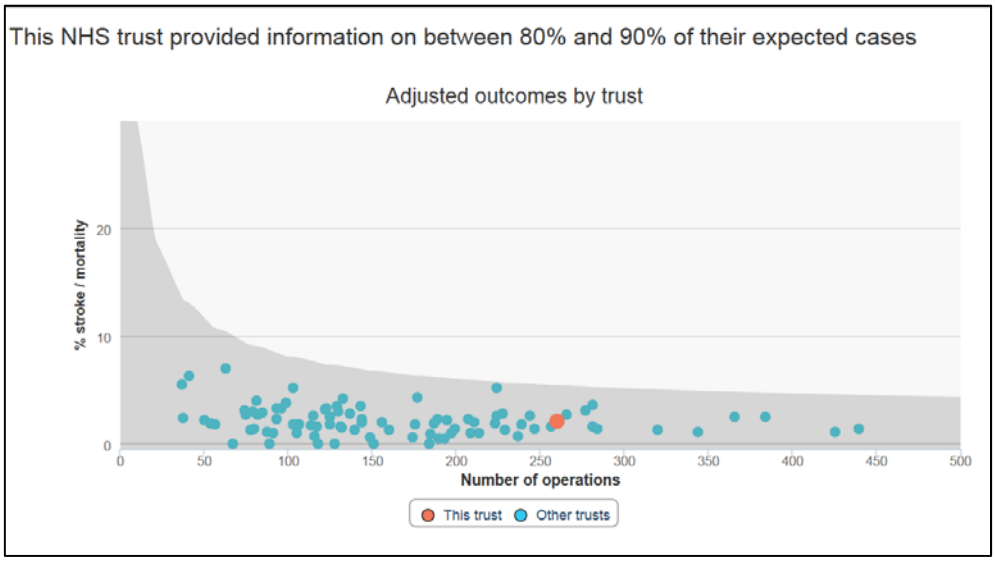
Trust	Code	Median wait (days)
Buckinghamshire Healthcare NHS Trust	RXQ	14
Oxford University Hospitals NHS Trust	RTH	15

3.9 The mortality data associated with CEA surgery for both Trusts fall within the funnel plots of normal expected results and within very close proximity to one another. A like-for-like comparison is difficult as there are different thresholds for performing CEA surgery at BHT and OUHFT.

BHT mortality data for CEA surgery – Data Source: National Vascular Registry – most current data (01/10/2013 – 30/09/2014).



OUHFT mortality data for CEA surgery – Data Source: National Vascular Registry – most current data (01/10/2013 – 30/09/2014).



3.10 The average length of stay for patients with CEA surgery is 1-2 days. With other major arterial work moving to OUH there is no designated specialist vascular consultant on-call rota to serve this patient group out of hours.

3.11 The 60% of non-specialised surgical input from the vascular surgeons will not be changed. The lessons learned from the centralisation of services in earlier phases of this programme will be applied to BHT, namely the appropriate provision of vascular surgical expertise locally to ensure that patients and staff at BHT get the level of expert support they require. POV15 suggests that non-arterial centres should have vascular referrals seen within 48 hours. Clear pathways for the management of urgent referrals and vascular emergencies will also need to be in place.

3.12 The number of patients per year who have CEA surgery at BHT is between 59 and 100. These patients would need to travel to the OUHFT for the surgical procedure and would have their pre- and post-operative care delivered at BHT.

3.13 OUHFT have modelled the capacity required for the additional patients that would use their service when this change is instituted and using the NHS IMAS modelling tool have demonstrated that this would not result in any deterioration in service. They have committed to ensuring timely access to surgery.

4. The role of patients and the public in this development?

4.1 The vascular network has benefited from a patient representative who has been involved with this programme of work since 2010. As a result of his continuous involvement, he has been able to provide significant input to the group.

4.2 The Clinical Senate undertook a series of Senate Assembly events, one of which, held on Jan 30th, 2015, was on vascular provision across the Thames Valley. In commissioning the review, the Senate identified the need to take a whole system view across the geography, to encompass the following:

- Services will be sustainable
- Services will be accessible and of a high quality in terms of patient experience
- Any proposed service change clearly articulates the benefits to patients

The meeting had a very wide stakeholder attendance, including three patients, two of whom were patient leaders.

The models of service provision was assessed in relation to :

- Patient Experience
- Quality
- Sustainability
- Accessibility

4.3 The recommendations included acknowledgement that specialised surgery needed to be concentrated in centres, and that Oxford and Frimley would provide arterial services and 7 day on call rotas of vascular surgical consultants and interventional radiologists. This is in place.

4.4 There was also a recommendation around ensuring that the network was developed around patient pathways and that pre-operative and rehabilitation services be delivered locally.

4.5 The TV Vascular Network, with strong leadership and involvement from our patient representative, is developing a programme of patient experience and outcome measures. This entails both quantitative measures in the form of a questionnaire and qualitative interviews with patients. This will help both to shape the services offered and to monitor the services post reconfiguration.

4.6 The questionnaire will seek feedback from patients across the network on their experiences of their care and self-reported outcomes of their care. This will be posted to patients 4 -6 weeks post discharge and is planned to start in May 2016. To ensure parity of care across the network, the questionnaire will be sent to all patients treated for vascular disease in all of the hospitals in the network.

4.7 Qualitative interviews will also be arranged with patients across the network to capture their experience of care and self-reported outcomes in greater depth. Patients, whose pathway or condition is of interest to the network, such as repatriated patients, will be purposively sampled across these interviews.

4.8 This proposal has been developed following discussion with patient engagement experts and evidence presented in academic literature and from 'What matters to patients' from the King's Fund (2010). A review date for this programme has been set for September/October 2016 to evaluate the feedback and its implications for the network.

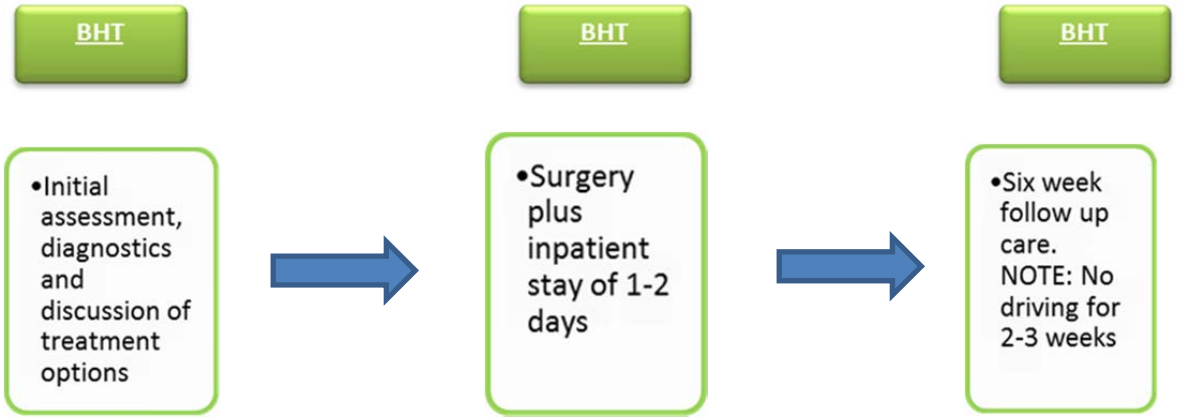
5. What is the level of impact on patients?

5.1 An important principle on which this is work is based is that patient will only be asked to travel for procedures where there is a clear evidence of benefit in doing so – namely for complex procedures. All other services will continue to be delivered locally.

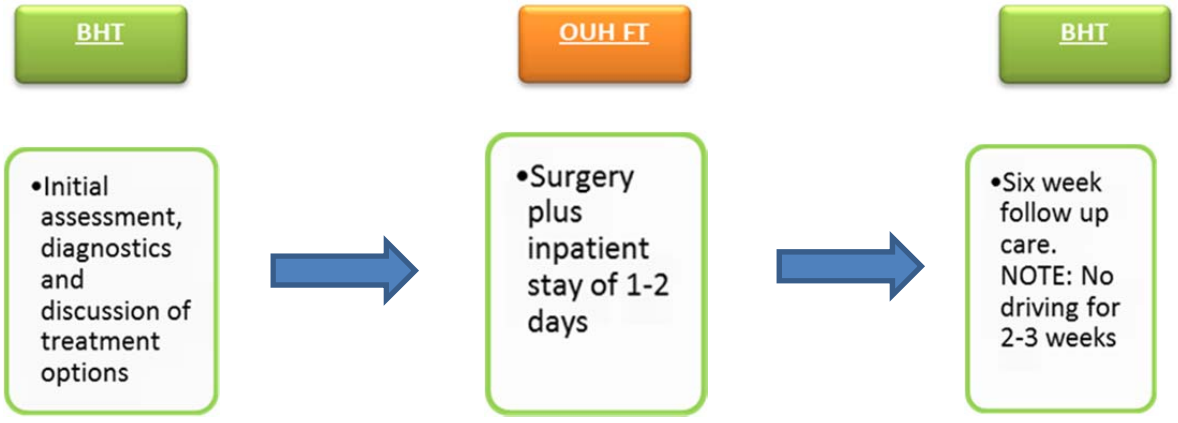
5.2 Patients will be able to rely on the availability of a wider clinical team 24 hours a day, 7 days a week. They will have access to inpatient care from a centre that complies with best practice guidance.

5.3 Patients will receive their pre-operative care and their follow-ups in their local hospital. The current and future pathways are listed below.

Current CEA Pathway



Future CEA Pathway



5.4 The Department of Vascular Surgery at the John Radcliffe Hospital has a triage facility on the vascular ward which allows for urgent referrals to be seen by the on-call registrar the day they are referred with symptoms of stroke/transient ischaemic attack (TIA) / amaurosis fugax (temporary blindness). Once investigations have been carried out and treatment plan agreed with the patient, patients are booked on to the next available theatre list for surgery.

5.5 Patient/carer travel

The distance between High Wycombe and Oxford is under 27 miles. The route is largely on the M40 motorway and takes 31 minutes without traffic (Google maps). By public transport the route from High Wycombe centre is Bus 737 to Oxford Brookes which takes approximately 41 minutes. From there it is a 0.8m walk to the hospital. Buckingham, at the north end of the patch, to Oxford is 25 miles by car or 1h 30minutes by public transport.

6. Benefits realisation

6.1 The patient experience and outcome work being undertaken by the network will form a significant plank of the benefits realisation plan. The network will report back to the HASC six months after reconfiguration.

6.2 The amalgamation of the BHT and OUHFT carotid units will create one of the biggest carotid centres in the country. Evidence shows that clinical outcomes are improved with increasing volumes of procedures.

6.3 Services will be sustainable and resilient with adequate on-call 24/7 cover as mandated for a high quality service.

6.4 Median time to surgery to be monitored and reported back to the HASC six months after reconfiguration.

FAQs

1. **What is the impact of this change on stroke services in BHT?**
   The BHT stroke unit is a high performing unit and has good working relationships with the Bucks vascular surgeons. The planned proposals would have no impact on this as the quality of this interaction and referral pathway would be unchanged. The main difference would be that for patients, once surgery is felt to be the correct treatment plan, they would be admitted to the OUHFT rather than BHT for this surgery. A small number of patients would be admitted to level 6A at the OUHFT the day before surgery. This would be done on clinical grounds.

   Local investigations, reviews and multi-disciplinary team meetings would be unchanged. The ease of access to an opinion for the stroke team would need to be retained. (At present this is done via a phone call or a face-to-face review). Shared standard operating procedures would need to be used to ensure that decision making was of a consistent nature.

The SCN is providing additional funding to the vascular network to support clinical leadership to develop and implement standard processes and systems and clear governance processes for the network.

2. **Does this destabilise BHT and what is the impact of this change on the viability of BHT?**
   The challenge is how we provide safe, sustainable non specialist services as close as we can to where the patients live. The sustainability of district general hospitals is important for the delivery of high quality care locally. Discussions have begun with the Thames Valley Clinical Senate to help address this and ensure that acute hospital services are designed to maximise safety, patient outcomes and experience and sustainability.

   Retention of some specialised services does not help deliver sustainability of a district general hospital. The cost of providing specialist consultant cover 24 hours a day, 7 days a week for a smaller than proposed population base reduces the ability to provide high quality secondary care services .

3. **What is the potential impact on interventional radiology services at BHT?**
   Surgery to prevent stroke caused by carotid artery disease (carotid endarterectomy) is provided by vascular surgeons, not interventional radiologists. The move of CEA will have no impact on interventional radiology.

   Interventional radiologists provide a wide range of elective and emergency interventional procedures; only a proportion of these are vascular. Elective vascular work comprises peripheral arterial intervention and EVAR (Endovascular aneurysm repair), and the majority of elective vascular work, including pre-procedural and post-procedural imaging, will remain in BHT. Only the EVAR procedure will be moving to Oxford.

   The move of the EVAR procedure to OUHFT is line with the recommendations of VSGBI and NCEPOD (see para 1.3) as OUHFT provides dedicated vascular interventional radiology available 24 hours a day, 7 days a week. From April 2016, EVAR procedures will no longer be performed at BHT. Instead the procedures will be performed in Oxford. The BHT surgical consultants will join the specialist vascular surgical unit in Oxford and continue to provide EVAR, with the support of the six interventional radiology consultants in Oxford.

   There is a precedent for this model in phase 2 of the Thames Valley Vascular Network with the move of EVAR work from the Royal Berkshire Hospital Foundation Trust to OUHFT.

4. **How would this financially impact BHT?**
   The impact on BHT of financial stability is expected to be minimal. Attempting to retain or develop "sub specification" specialist services at BHT will not help the sustainability of the hospital and may well hinder it.

5. **What are other potential unintended consequences?**
   It is important to have sufficient vascular presence at the non-arterial centres to ensure that patients have equity of access to care across the Thames Valley. Lesson learnt to date

suggest that there needs to be daily vascular presence at each hospital to assist with diabetic foot clinics and inpatient reviews. This has been factored in to the agreement between the OUHFT and BHT.

No further unintended consequences are anticipated.