



**Clinical Senate  
Yorkshire and the Humber**

*“An independent source of strategic clinical advice for Yorkshire and the Humber”*

# **Clinical Senate Review**

**for**

# **Yorkshire and the Humber**

# **Vascular Services**

**Part 2**

January 2017

Clinical Senate Reviews are designed to ensure that proposals for large scale change and reconfiguration are sound and evidence-based, in the best interest of patients and will improve the quality, safety and sustainability of care.

Clinical Senates are independent non statutory advisory bodies hosted by NHS England. Implementation of the guidance is the responsibility of local commissioners, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of access. Nothing in the review should be interpreted in a way which would be inconsistent with compliance with those duties.

Yorkshire and the Humber Clinical Senate  
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Date of Publication: December 2016

## Version Control

Document Version	Date	Comments	Drafted by
Draft version 0.1	21 November 2016	Based on Working Group teleconferences, discussion with commissioners and Council discussion	J Poole
Draft version 0.2	28 <sup>th</sup> November 2016	Amended following Council and Working Group comment	J Poole
Draft version 0.3	2 December	Amendment from the Chair	J Poole
Draft Version 0.4	16 <sup>th</sup> January	Amended following comment from the commissioners and Council discussion	J Poole
Final Version 1.0	17th January	Formatting for the final version	J Poole
Final Version	24 <sup>th</sup> January	Final minor comments from commissioners	J Poole

## **1. Chair's Foreword**

- 1.1 The Yorkshire and the Humber Clinical Senate thanks commissioners for the invitation to work with them on their proposals for a service model for vascular services across Yorkshire and the Humber. This builds upon our report published in April 2016 which considered the earlier stages of this work. I would like to thank the expert clinicians who have worked with us in both stages of this review.
- 1.2 In our consideration of the question, we have continued to focus on providing impartial clinical advice on the long term sustainability of the services. I hope that this report provides a balanced clinical overview on the proposed configuration of the services and assists commissioners in moving forward to achieve the changes required.

## 2. Summary of Key Recommendations

- 2.1 The Senate supports the model of all elective and emergency arterial care being provided in an arterial centre linked to one or more non-arterial centres, as set out in the national service specification.
- 2.2 The Senate recommends that:
- i. To comply with the national service specification standards and develop a long term sustainable vascular surgical service, the number of arterial centres within Yorkshire and the Humber needs to be reduced.
  - ii. Commissioners need to support their direction of travel with a clear set of criteria for how they have reached their recommendations on the location of the arterial centres. This criteria needs to be applied equally across the current arterial centres to demonstrate the transparency of decision making.
  - iii. Commissioners need to more clearly articulate the range of procedures to be undertaken in the arterial and non-arterial centres as stated within the national service specification.
  - iv. Commissioners undertake further work to understand the workforce implications of their direction of travel.
  - v. Commissioners revisit the population figures to ensure that their recommendations on arterial centre locations can be fully supported by population data and that this work also considers the residual flows of population across the boundaries of Yorkshire and the Humber within that work.
  - vi. Commissioners consider the recently published outcome data and address the issues raised by this data in their future proposals.
  - vii. Commissioners support their proposals with early discussions with the Clinical Commissioning Groups (CCGs) to ensure intermediate care and community services are in place to support the effective operation of the arterial centre.
  - viii. Commissioners consider their proposals within the context of the STPs and demonstrate the fit of their proposals with other re-organisations like urgent and emergency care and hyper acute stroke.
  - ix. Major Trauma Centres (MTCs) require an arterial centre to be located within the MTC. Arterial centres of themselves do not need to be located within a MTC.
  - x. Any performance issues within the vascular service located at a MTC needs to be addressed during the transition process.
  - xi. Commissioners address in the documentation the ability of the arterial centres in the reorganised service to make the investment required.
  - xii. Commissioners engage with a wider sample of patients and their families in the next stages of engagement.
- 2.3 The Senate is limited in its ability to comment on the proposed location of the arterial centres due primarily to the absence of the criteria of assessment and due to the need for commissioners to address the range of other factors discussed in this report in more detail. Based on the information provided:

- i. **Within South Yorkshire.** The Senate agrees that the population figures as presented and the inability of both Trusts to meet all minimum activity requirements would support the change to one arterial centre within this geography. The Senate is unable to support the proposals outlined for a single vascular specialist service delivered across 2 arterial sites for a 3 year period. The direction of travel needs to be clearly presented as a single arterial centre.
- ii. **Within West Yorkshire.** The Senate is supportive of the direction of travel of 2 arterial centres within this geography supported in a network arrangement with non-arterial centres.
- iii. **Within Humber Coast and Vale.** The Senate is supportive of the decision to maintain 2 arterial centres on this geography.

### 3. Background

#### Clinical Area

- 3.1 Vascular disease relates to disorders of the arteries, veins and lymphatics. Conditions requiring specialised vascular care include: lower limb ischaemia, abdominal aortic aneurysm (AAA), stroke prevention (carotid artery intervention), venous access for haemodialysis, suprarenal and thoraco-abdominal aneurysms, thoracic aortic aneurysms; aortic dissections, mesenteric artery disease, Reno vascular disease, arterial/ graft infections, vascular trauma, upper limb vascular occlusions, vascular malformations and carotid body tumours.
- 3.2 Specialised vascular services are those commissioned by NHS England and include all vascular surgery and vascular interventional radiology services but exclude varicose veins and inferior vena cava filter insertion.
- 3.3 A minimum population of 800,000 is often considered the minimum population required for a centralised vascular service. This is based on the number of patients needed to provide a comprehensive emergency service, maintain competence among vascular specialists and nursing staff, the most efficient use of specialist equipment, staff and facilities and the improvement in patient outcome that is associated with increasing caseload.
- 3.4 All arterial surgery should be provided at a vascular centre meeting the following core standards<sup>1</sup>:
  - Leg amputations should be undertaken in the arterial centres
  - 24/7 in-patient arterial surgery and vascular interventional radiology services with an on call rota vascular medical team comprising of a minimum of 6 vascular surgeons and 6 vascular interventional radiologists

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<sup>1</sup> A04/S/a 2013/14 NHS Standard Contract for Specialised Vascular Services (adults)

- Minimum of 10 AAA emergency and elective procedures per surgeon per year/ 60 per centre
  - Minimum of 50 carotid endarterectomy procedures per centre per year.
- 3.5 The overall purpose of the vascular services project is to commission and implement the optimum model of service provision for vascular services across Yorkshire and the Humber, addressing any identified issues of inequality of access and within available resources, from providers who are able to meet the full NHS England service specification for vascular services.<sup>1</sup>
- 3.6 Commissioners consulted with the Senate early in 2016 to discuss their early thoughts with regard to the future service model considering the national service specification, draft vascular standards and a stocktake of the service developed by Public Health England.
- 3.7 Since our April 2016 report commissioners have concluded their visits with the provider Trusts, undertaken initial engagement with the public and developed a direction of travel for the clinical configuration of the services.
- 3.8 Vascular services are currently provided in the following trusts across Yorkshire and the Humber:
- Sheffield Teaching Hospitals NHS Foundation Trust (STHFT)
  - Doncaster and Bassetlaw Hospitals NHS Foundation Trust (DBHFT)
  - Leeds Teaching Hospitals NHS Trust (LTHT)
  - Bradford Teaching Hospitals NHS Foundation Trust (BTHFT)
  - Calderdale and Huddersfield NHS Foundation Trust (CHFT)
  - York Teaching Hospital NHS Foundation Trust (YTHFT)
  - Hull and East Yorkshire Hospitals NHS Trust. (HEYHT)
- 3.9 The direction of travel stated by commissioners is:
- **South Yorkshire and Bassetlaw** -a single vascular specialist service delivered across 2 arterial sites (at DBHFT and STHFT) with a single team led by joint governance and leadership. Complex arterial workload to be delivered at a single site within 3 years
  - **West Yorkshire** - 2 specialist arterial centres for West Yorkshire.
  - **Humber Coast and Vale** – no change. 2 specialist vascular services would continue at YTHFT and HEYHT

### Role of the Senate

- 3.10 The Senate has been asked to identify any clinical risks, issues, opportunities or concerns on the work undertaken to date in this review or with the proposed direction of travel and to provide a clinical view on the future configuration of vascular services across the region.

3.11 The specific question the Senate has been asked to address is:

*Considering the progress and work undertaken to date on this service review, the Senate is asked to consider the direction of travel for clinical configuration of services, supported by the NHS England Regional Leadership Group, addressing the following questions:*

- i. Based on the submission of evidence, is the Senate supportive of the proposed clinical direction of travel and proposed configuration of services to ensure sustainability of vascular services and deliver improved outcomes for the population of Yorkshire and the Humber?*
- ii. Advise on any clinical concerns or adverse impacts relating to this proposed direction of travel*
- iii. Provide clinical recommendations to mitigate any adverse clinical impacts and ensure the safe and sustainable transition of services to the proposed configuration.*

### **Process of the Review**

3.12 The Working Group involved in the first part of the review in April 2016 all confirmed their willingness to engage in the second part of this review in early September. The Terms of Reference for this review were agreed on 31<sup>st</sup> October.

3.13 The Senate Working Group held a teleconference to aid their discussions on 8<sup>th</sup> November and commented also via email discussion. A discussion was arranged with the commissioners for the 15<sup>th</sup> November to provide opportunity to explore the issues in further detail. The Senate Council met on 17<sup>th</sup> November and discussed the vascular proposals in detail. A final teleconference was held with the Working Group on 21<sup>st</sup> November and the report was drafted following these discussions. The Senate Council ratified the draft by email following their Council discussion. The final draft was provided to the commissioners for comment on the 30<sup>th</sup> November 2016.

## **4. Evidence Base**

4.1 This is an area rich in detailed guidance, underpinned by strong evidence. In considering its recommendations, the Senate has drawn upon the recommendations and the published evidence. The evidence is referenced in the April 2016 Senate report.<sup>2</sup>

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<sup>2</sup> [Yorkshire and the Humber Clinical Senate - Published advice and recommendations](#)

## 5. Recommendations

*Based on the submission of evidence, is the Senate supportive of the proposed clinical direction of travel and proposed configuration of services to ensure sustainability of vascular services and deliver improved outcomes for the population of Yorkshire and the Humber?*

- 5.1 The Senate is supportive of the model of all elective and emergency arterial care being provided in an arterial centre linked to neighbouring hospitals which would provide non arterial vascular care and with outpatient assessment, diagnostics and vascular consultations undertaken in these and other local hospitals. This is the model clearly set out in the national service specification.<sup>1</sup>
- 5.2 The range of procedures and services to be provided at the arterial centres and non-arterial centres are also clearly set out within the specification and the Senate recommends that commissioners develop their model of service on this basis and more clearly articulate this in their documentation. Some non-vascular interventional radiology procedures like nephrostomies, gastro-intestinal bleeds and obstetric bleeding complications may move to the arterial centre and the ability of the non-arterial site to maintain a range of interventional radiology supported services needs to be considered by commissioners.
- 5.3 In order to comply with the national service specification standards and develop a long term sustainable vascular surgical service, the Senate is supportive of the reduction in the number of arterial centres within Yorkshire and the Humber. The evidence provided by commissioners supports this conclusion.
- 5.4 The Senate advises however that commissioners need to support their direction of travel with a clear set of criteria for how they will reach their recommendations on the location of the arterial centres. The stocktake document prepared by commissioners discusses the service issues in terms of the ability of the current arterial centres to meet the arterial centre core standards, to meet the population minimum of 800,000, the geography the service supports, the outcomes of the service and the co-dependent services. These issues, however, are not translated into a clear set of criteria on which proposals are being made within the Regional Leadership Group (RLG) document. The Senate recommends that a clear set of criteria is agreed and applied equally across the current arterial centres before further progression of this work. This should also include the ability of the arterial site to maintain an emergency endovascular aneurysm repair (EVAR) service by appropriately trained staff. The criteria will ensure transparency of decision making and it will demonstrate the clear clinical narrative that supports the direction of travel. The ability to demonstrate equity in the decision making is key.



- 5.5 The Senate acknowledges the difficulties in obtaining the workforce data but recommends that commissioners undertake further work on this to understand in more detail:
- the current workforce of vascular surgeons and interventional radiologists
  - the impact of the proposals on that workforce, we recommend that this includes an assessment by the clinicians about their willingness to move their practice to the new arterial hub,
  - whether the direction of travel can be supported by the trainee numbers
  - The wider workforce of vascular nurses, sonographers and allied medical specialties
- 5.6 The Senate recommends that commissioners revisit the population figures, particularly the differences between the self-declared populations and the Public Health England (PHE) figures to ensure confidence in the data and to ensure that their recommendations on arterial centre locations can be fully supported by population data. 800,000 is the minimum population required to support a long term sustainable arterial centre. The residual flows of population across the Yorkshire and the Humber boundaries between Lincolnshire, Nottinghamshire and Teesside need to be fully considered within this further work. Commissioners may also wish to draw upon the Office of National Statistics data on the predicted population increases.
- 5.7 Since the documentation has been prepared there has been further outcome data published.<sup>3456</sup> The Senate recommends that commissioners need to fully consider this and address the issues raised by this data in their future proposals.
- 5.8 The Senate has considered the interdependency of the Major Trauma Centre with the arterial centre and recommends that a MTC needs to be co-located with an arterial centre; arterial centres of themselves do not need to be located within a MTC.<sup>7</sup> There are 3 MTCs within Yorkshire and the Humber and the Senate supports the direction of travel which maintains the arterial centres at these 3 sites.

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<sup>3</sup> Surgical outcomes of Trusts and individual operators: Data published 5<sup>th</sup> September 2016  
<https://www.vsqip.org.uk/surgeon-outcomes>

<sup>4</sup> <https://www.vsqip.org.uk/contents/uploads/2013/11/Outcomes-after-Elective-Repair-of-Infra-renal-Abdominal-Aortic-Aneurysm.pdf>

<sup>5</sup> National Vascular Registry Annual Report 2015  
<https://www.vsqip.org.uk/content/uploads/2015/12/NVR-2015-Annual-Report.pdf>

<sup>6</sup> Provision of Services for Patients with Vascular Disease 2015  
[https://www.vascularsociety.org.uk/\\_userfiles/pages/files/Resources/POVS%202015%20Final%20version.pdf](https://www.vascularsociety.org.uk/_userfiles/pages/files/Resources/POVS%202015%20Final%20version.pdf)

<sup>7</sup> The Clinical Co-dependencies of acute hospital services, SEC Clinical Senate Dec 2014

- 5.9 Since we originally worked with commissioners on these proposals in early 2016 we have seen the development of Sustainability and Transformation Plans as the main vehicle for planning service change. The vascular proposals for Yorkshire and the Humber cover 3 STPs and there is little reference in the documentation from commissioners on the fit of their proposals with the wider STP planning. It is noted that the commissioner plans do maintain at least 1 arterial centre within each STP. From a planning perspective it could be argued that an ideal solution would be the location of 1 arterial centre within each STP footprint, co-located with the Major Trauma Centre, increasing this to 2 arterial centres if this is required to support the population.
- 5.10 The Senate recommends that the impact of the arterial centre proposals on other STP led re-organisations like urgent and emergency care and hyper acute stroke, for example, need to be considered in greater detail within the documentation provided. We accept that some STPs are further in their decision making than others but the integration of decision making on these services is not demonstrated in the documentation.
- 5.11 The Senate recommends that as part of the planning of the service model, commissioners need to consider the need for good intermediate care, community and social services to support the effective operation of the arterial centre. There needs to be as much planning into the discharge of patients from the arterial centre as the effective planning of services within the centre. It is not evident, currently, that specialised commissioners are supporting their proposals with discussion with the CCGs to ensure effective planning of the whole patient pathway. It is also noted that there is reduced funding in social care<sup>8</sup> which makes these early conversations even more essential.
- 5.12 The ability of the arterial centres in the reorganised service to make the investment required is also not considered within this documentation and the Senate recommends that this also needs consideration in this early planning stage.
- 5.13 In our earlier consideration of this service, commissioners confirmed that they would be engaging with the public and we are pleased that the commissioners have held patient and public engagement events between July and August. It is evident from the public engagement report supplied to the Senate that there is more work to do to help the public to fully grasp the issues. It was also noted that 2 of the trusts were unable to supply any patients for the engagement work, whereas another trust managed to engage with 17 patients. The breadth and depth of patient engagement is currently lacking and we support the need to engage a wider sample of patients and their families in the next stages of engagement. We also support the recommendations from the School of Health and Related Research (SchARR) to

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[http://www.local.gov.uk/documents/10180/7632544/1+24+ASCF+state+of+the+nation+2016\\_WEB.pdf/e5943f2d-4dbd-41a8-b73e-da0c7209ec12](http://www.local.gov.uk/documents/10180/7632544/1+24+ASCF+state+of+the+nation+2016_WEB.pdf/e5943f2d-4dbd-41a8-b73e-da0c7209ec12)

provide more detailed documentation for the public to help them to understand the issues.

- 5.14 In the absence of the criteria discussed and the recommended further work detailed above, the Senate has made the following observations:

**South Yorkshire Proposals:**

- 5.15 The Senate agrees that the population figures as presented, the inability of both Trusts to meet the minimum activity per surgeon and the inability of the Doncaster service to meet the minimum activity as a centre, would support the change to one arterial centre within this geography.
- 5.16 The Senate is unable to support the proposals outlined for a single vascular specialist service delivered across 2 arterial sites for a 3 year period as this model is not supported by the national service specification. Historically both of the Trusts have shown a lack of engagement in local discussions which has contributed to the current issues. The Senate understands the need to address the differences in clinical culture on both sites and supports commissioner intentions to maintain the best clinical practice for this service. The Senate considers it unhelpful however to state that the 2 arterial sites will continue for 3 years. Commissioners could make it clearer that the recommendation is for this to be a single arterial centre which we acknowledge will take time to achieve. The proposals for this geography need to be supported by the application of the decision making criteria and with the issues listed above addressed by commissioners.
- 5.17 When considering the services currently provided at the 2 centres, the data suggests that Doncaster has the more progressive clinical model and had the MTC been located at Doncaster the Senate would have supported this Trust as the location of the arterial centre. There are factors that need to be addressed as part of the direction of travel if Sheffield is to become the single arterial centre for this geography. These factors include a better understanding of the data which suggests that there have been fewer EVAR grafts performed in Sheffield than one would expect when compared to the total numbers of AAA patients and in addition we recommend development work to clarify the relationship between the interventional radiology and vascular services within that Trust. Supported team development may help to achieve this.

**West Yorkshire Proposals:**

- 5.18 It is noted that Leeds Teaching Hospitals Trust, the site of the major trauma centre, is unable to expand to become the single arterial centre for this population.
- 5.19 The Senate is supportive therefore of the direction of travel of 2 arterial centres within this geography as currently 2 of the 3 arterial centres are unable to meet the population minimum, the minimum activity for the centre and per surgeon.
- 5.20 Bradford Teaching Hospitals Foundation Trust and Calderdale & Huddersfield Foundation Trust currently operate as 1 service across 2 sites. This model is not supported by the national service specification and the Senate supports the proposal

that this arrangement changes to the model outlined within the service specification of an arterial centre supported in a network arrangement with a non-arterial centre. There is an excellent working example of this arrangement in the West Yorkshire geography between Leeds and Mid Yorkshire Trusts.

- 5.21 The Senate notes that Bradford Teaching Hospitals Foundation Trust is a renal centre and the presence of a renal centre does support this trust as the location of the arterial centre. Commissioners need to clearly articulate the decision making criteria to support the decision on the location of the second arterial centre in West Yorkshire and ensure that all factors have been considered in the decision. This will ensure confidence when demonstrating which current service can provide the most sustainable service in the long term.

#### **Humber Coast and Vale Proposals:**

- 5.22 The Senate supports the decision to maintain Hull, a major trauma centre, as an arterial centre and on the basis of the information provided the Senate also supports York as an arterial centre. Both Hull and York services meet the minimum activity for the centre and per surgeon and meet the population minimum in their self-declared population figures. It is also noted that there are geographically remote parts of Yorkshire that are supported by the York service. Our concerns about the population data are discussed in paragraph 5.6 and this needs to be addressed by commissioners. The proposals for this geography also need clear assessment against decision making criteria.

#### ***Advise on any clinical concerns or adverse impacts relating to this proposed direction of travel.***

- 5.23 Our clinical concerns relating to this proposed direction of travel are articulated in our response to the first question but can be summarised as:
- The lack of clearly developed criteria, supported by the data, applied to all current arterial centres to provide a clear narrative on the decision making that has led to the proposed direction of travel
  - The need to have a better understanding of the population, including cross boundary flows and the workforce implications
  - The need to address the outcome data within the direction of travel
  - The recommendation of a 1 centre 2 site approach in South Yorkshire for a 3 year period. Although we recognise the commissioner reasons for this, to allow for the differences in clinical culture on the 2 sites to be overcome, commissioners should be clearer that the service will operate as a single arterial centre
  - The lack of consideration of the whole patient pathway including discharge into the community
  - The lack of discussion on the fit of these proposals with other re-organisations
  - The lack of discussion on the investment available to support the model in the arterial centres that will require expansion. This includes beds, potentially ICU and workforce

*Provide clinical recommendations to mitigate any adverse clinical impacts and ensure the safe and sustainable transition of services to the proposed configuration.*

- 5.24 The Senate is supportive of the need to reduce the number of arterial centres within the Yorkshire and Humber geography to ensure a long term sustainable and high quality service for our population. If commissioners are able to demonstrate within the documentation that the above points are considered and addressed this would mitigate the concerns expressed by the Senate.

## 6. Summary and Conclusions

- 6.1 The Senate supports the model of all elective and emergency arterial care being provided in an arterial centre linked to one or more non-arterial centres as set out in the national service specification. The Senate recommends that in order to comply with the national service specification standards and develop a long term sustainable vascular surgical service the number of arterial centres within Yorkshire and the Humber needs to be reduced.
- 6.2 The Senate advises however that commissioners need to support their direction of travel with a clear set of criteria for how they will reach their recommendations on the location of the arterial centres. This criteria needs to be applied equally across the current arterial centres to demonstrate the transparency of decision making.
- 6.3 The Senate also recommends that the direction of travel would be strengthened with commissioners better demonstrating their understanding of the workforce implications, population figures, recently published outcome data and the fit of proposals with other re-organisations.
- 6.4 Based on the information provided at this time, the Senate supports the direction of travel for a single arterial centre within South Yorkshire, 2 arterial centres within West Yorkshire and the maintenance of 2 arterial centres within Humber Coast and Vale.

# APPENDICES

## Appendix 1

### LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

#### Council Members

Professor Chris Welsh, Senate Chair

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

Dr Ben Wyatt, GP, Brig Royd Surgery, Ripponden

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

#### Assembly Members

Peter Allen, Citizen Representative

#### Co-opted Members

Ruth Chipp, Vascular Nurse Specialist, City Hospitals, Sunderland

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

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

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

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

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

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

## Appendix 2

### PANEL MEMBERS' DECLARATION OF INTERESTS

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



## COUNCIL MEMBERS DECLARATION OF INTERESTS

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

Sewa Singh, Medical Director, Doncaster & Bassetlaw Hospitals NHS Foundation Trust, Jon Hossain, Consultant Vascular Surgeon & Deputy Post Graduate Dean, Health Education England – Yorkshire and the Humber, Jon Ausobsky, Consultant General Surgeon, Bradford Teaching Hospitals NHS Foundation Trust, Mark Millins, Lead Paramedic for Clinical Development, Yorkshire Ambulance Service NHS Trust, Dr Pnt Laloë, Consultant Anaesthetist, Calderdale & Huddersfield NHS Foundation Trust. Their conflicts of interest were due to their employment in a position of authority at a provider Trust whose vascular services were under consideration as part of this review. The Chair restricted or excluded their participation in Council debate

## Appendix 3

# CLINICAL REVIEW

  

# TERMS OF

  

# REFERENCE

**TITLE:**

**YORKSHIRE AND THE HUMBER VASCULAR SERVICES REVIEW – part 2**

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

**Terms of reference agreed by:** Vicki Broadley, Senior Supplier Manager

**Date:** October 2016

## 1. CLINICAL REVIEW TEAM MEMBERS

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

**Citizen Representative:** Peter Allen

**Clinical Senate Review Team Members:**

Name	Job Title
Chris Welsh	Senate Chair
Peter Allen	Patient Representative
Dr Claire Cousins	Lead Consultant Interventional Radiologist, Cambridge Univ. Hospitals FT
Mr Simon Hardy	Consultant Vascular Surgeon, East Lancashire Hospitals FT
Dr Paul Evers	Vascular Consultant, Taunton & Somerset Hospitals FT
Dr Stephen D'Souza	Consultant Interventional and Vascular Radiologist and IR Lead, Lancashire Teaching Hospitals NHS Trust
Rebecca Bentley	Nursing Professional Lead & Non Medical Prescribing Lead, Bradford District Care FT
Dr Ben Wyatt	GP, Brig Royd Surgery, Ripponden
Dr Sally Franks	GP, Dr Penn & Partners, Leeds
Andy Swinburn	Associate Director of Paramedicine, East Midlands Ambulance Service
Ruth Chipp	Vascular Nurse Specialist, City Hospitals, Sunderland
Mr Stephen Gilligan	Clinical Director Critical Care, Consultant in Anaesthesia & Intensive Care

## 2. AIMS AND OBJECTIVES OF THE REVIEW

### Question:

Considering the progress and work undertaken to date on this service review, the Senate is asked to consider the direction of travel for clinical configuration of services, supported by the NHS England Regional Leadership Group, addressing the following questions:

- i. Based on the submission of evidence, is the Senate supportive of the proposed clinical direction of travel and proposed configuration of services to ensure sustainability of vascular services and deliver improved outcomes for the population of Yorkshire and the Humber?
- ii. Advise on any clinical concerns or adverse impacts relating to this proposed direction of travel
- iii. Provide clinical recommendations to mitigate any adverse clinical impacts and ensure the safe and sustainable transition of services to the proposed configuration.

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

- Identify any clinical risks, issues, opportunities or concerns on the work undertaken to date on this review
- Identify any clinical risks, issues, opportunities or concerns with the proposed direction of travel
- Provide a clinical view on the future configuration of vascular services across the region

### Scope of the review:

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

## 3. TIMELINE AND KEY PROCESSES

**Receive the Topic Request form:** not applicable

**Agree the Terms of Reference:** 26<sup>th</sup> October 2016

**Receive the evidence and distribute to review team:** 30th October 2016

**Working Group Teleconferences:** 8<sup>th</sup> and 21<sup>st</sup> November 2016

**Teleconference with commissioners:** 15<sup>th</sup> November 2016

**Draft report submitted to commissioners:** 30<sup>th</sup> November 2016

**Commissioner Comments Received:** 14<sup>th</sup> December

**Senate Council ratification;** by email before end November 2016

**Final report agreed:** end December 2017

**Publication of the report on the website:** January 2017

#### **4. REPORTING ARRANGEMENTS**

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

#### **5. EVIDENCE TO BE CONSIDERED**

The review will consider the following key evidence:

- Y&H Vascular Stocktake 2015
- Y&H Vascular Senate Report April 2016
- Y&H Vascular Public and Patient Engagement Report September 2016
- Vascular Services Data Briefing October 2016
- Health Education England Y&H workforce briefing September & October 2016
- North of England Regional Leadership Group Service Review paper October 2016
- Correspondence from West Yorkshire & South Yorkshire provider trusts on the direction of travel will be shared with the senate following receipt (expected by 4 November 2016)

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

#### **6. REPORT**

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

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

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

## 7. COMMUNICATION AND MEDIA HANDLING

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

## 8. RESOURCES

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

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

## 9. ACCOUNTABILITY AND GOVERNANCE

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

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

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

## 10. FUNCTIONS, RESPONSIBILITIES AND ROLES

The **sponsoring organisation** will

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

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

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

**Clinical Senate council will:**

- i. appoint a clinical review team, this may be formed by members of the Senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
- ii. endorse the terms of reference, timetable and methodology for the review
- iii. consider the review recommendations and report (and may wish to make further recommendations)
- iv. provide suitable support to the team and
- v. submit the final report to the sponsoring organisation

**Clinical review team will:**

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

**Clinical review team members will undertake to:**

- i. commit fully to the review and attend all briefings, meetings, interviews, and panels etc. that are part of the review (as defined in methodology).
- ii. contribute fully to the process and review report
- iii. ensure that the report accurately represents the consensus of opinion of the clinical review team
- iv. comply with a confidentiality agreement and not discuss the scope of the review or the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the Clinical Senate Manager, any conflict of interest prior to the start of the review and /or materialise during the review.

**END**

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## Appendix 4

### BACKGROUND INFORMATION

The evidence provided for this review is listed below:

- Y&H Vascular Stocktake 2015
- Y&H Vascular Senate Report April 2016
- Y&H Vascular Public and Patient Engagement Report September 2016
- Vascular Services Data Briefing October 2016
- Health Education England Y&H workforce briefing September & October 2016
- North of England Regional Leadership Group Service Review paper October 2016
- Correspondence from South Yorkshire provider trusts on the direction of travel