1 Background

Vascular surgery deals with a variety of acute and life threatening conditions, including rupture of abdominal aortic aneurysms and narrowing of the carotid arteries, leading to stroke and peripheral arterial disease. There are also roles for vascular surgery supporting other major sub-surgical specialties e.g. major trauma, neurosurgery and cardiac surgery.

There is increasing evidence to ensure higher volume hospital centres for vascular surgery services, to achieve a critical mass of patients enabling clinicians to populate dedicated rotas and to improve outcomes. It is widely accepted that there is good evidence of the relationship between the volume of work undertaken by individual surgeons and the outcomes for patients requiring vascular intervention.

There is also increasing evidence and demand for specialised interventional vascular radiology, and there is a large and increasing repertoire of procedures that can be undertaken without the need for open surgery with equally good, or better outcomes for some groups of patients. To enable delivery of these specialist vascular interventional radiology procedures, dedicated rotas to ensure 24/7 care are required.

2 What are non-cardiac vascular services?

The main groups in non-cardiac vascular services include:
- Abdominal Aortic Aneurysm
- Carotid Stenosis
- Peripheral Arterial Disease

2.1 Abdominal Aortic Aneurysm (AAA)

AAA occurs when the abdominal aorta is weakened and stretches to a diameter of 3cm or greater in the abdominal section. There were around
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6,000 deaths in 2009 in England and Wales caused by rupture of an AAA. Most deaths are in men aged over 65 for whom rupture of an AAA is responsible for 2.1\% of deaths.

AAA can be treated by open surgery or endovascular approaches. A national population-based screening programme is being rolled out, offering screening to men aged 65 and over. An ultrasound scan is offered to men in their 65th year. Older men are not invited, but can self-refer. The aim is for the national screening programme to be fully implemented across the whole of England by March 2013.

2.2 Carotid Stenosis

Carotid disease is a narrowing of the carotid artery. Blockages cause symptoms called Transient Ischemic Attacks (TIAs) and can lead to strokes. They are mainly treated by carotid endarterectomy (surgical removal of the plaque). This is a surgical procedure, although stenting (an interventional radiology procedure) is sometimes used. These procedures correct the narrowing in the carotid artery. National Institute for Health & Clinical Excellence (NICE) guidelines recommend that patients with symptomatic moderate to severe blockages should have endarterectomy within 48 hours, and no later than 2 weeks, from the onset of symptoms.

2.3 Peripheral Arterial Disease (PAD)

PAD refers to the obstruction of arteries mainly in the lower extremities. It can cause critical ischaemia (loss of blood supply), which requires urgent revascularisation to avoid amputation. A more severe version is acute ischaemia. This is usually due to sudden blood loss caused by a blood clot. These patients require emergent revascularisation to avoid limb loss. Diabetic patients are particularly at risk of limb loss. They require specialised multidisciplinary care to maximise foot health and reduce risk of amputation.

2.4 Non-cardiac vascular services also include varicose veins, lymphoedema, vascular emergencies, renal access and diabetes and have interdependencies across a number of other specialties including: cardiology, cardiac surgery, dermatology, clinical laboratory services, nephrology, neurology, plastic surgery, neurosurgery and other surgical disciplines.

3 The Vascular Society Vision

There are significant drivers for change in the provision of vascular surgery in England.

3.1 The Provision of Vascular Services (POVS) document produced by the Vascular Society in 2009 is already out of date and will be revised and published by the end of 2011 (See Appendix 1);
3.2. Changes to the POVS document are driven by data showing that outcomes from large centres are better than those from small centres;

3.3. The National Abdominal Aortic Aneurysm Screening Program (NAAASP) has set standards for the provision of aortic aneurysm surgery by hospital Trusts;

3.4. The European Working Time Regulation (EWTR) renders rotas more onerous than 1:6 untenable;

3.5. Separate specialty status will lead to a reduction in the number of UK Vascular Surgeons, both at Consultant and trainee level. Vascular surgery is likely to become more Consultant delivered with lesser trainee input in service delivery. As a consequence Consultants will need to work within larger groups to make this possible.

4. Case for change

4.1.1 National guidance

A number of factors have prompted the NHS to assess the provision of non-cardiac vascular services. Some of these include:

- The implementation of the NAAASP – national specification being drafted;
- Reference to the implementation of the NAAASP in the NHS Operating Framework for 2011/2012;
- Recent publication of UK mortality rates following AAA surgery. The UK has the highest AAA mortality rates in Europe.
- Publication of ‘A report of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) 2005’ – recommended reducing the number of surgeons and anaesthetists involved to reduce the numbers caring for small volumes and ensure sufficient volumes for expertise required;
- VSGBI’s Quality Improvement Framework (QIF) for AAA 2009 - All organisations participating in the AAA screening programmes must achieve sign up to the AAA QIF which states 24/7 on site cover (due to be signed off November 2011) (original AAA QIF 2009 allowed for 24/7 by network).
- VSGBI QIF (May 2009) – centres performing less than 20 cases per year of AAA repair should stop as that is the minimum number to demonstrate safety (British journal surgery 2007; 94:395-403. Br J Surg 2008: 95: 64-71). (VSGBI QIF 2011 requires a minimum of 32 AAA repairs. There is significant evidence that the minimum

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1 Abdominal Aortic Aneurysm: a service in need of surgery? A report of the National Confidential Enquiry into Patient Outcome and Death (2005)
number of AAA repairs should be 50. Large centres in the UK report in excess of 200 AAA repairs per annum.

- Implementing the Department of Health guidelines on carotid endarterectomy within 48 hours of onset of symptoms.\(^4\)
- National Stroke Strategy
- NICE guidance on Endovascular stent-grafts for the treatment of AAA (2009) TAG 167 – EVAR (endovascular aneurysm repair) should only be performed in specialist centres by clinical teams experienced in the management of AAAs;
- AAA Quality Improvement Programme standards e.g. Framework for improving the results of elective AAA repair (to halve elective mortality rate for AAA surgery in the UK to 3.5% by 2013);
- British Society of Interventional Radiology (BSIR) – vascular accreditation (to add in key recommendations re vascular Interventional Radiology). (BFCR(11)6 Standards in vascular radiology; BFCR(11)3 Standards of practice and guidance for trauma radiology in severely injured patients; BFCR(10)12 Improving paediatric interventional radiology services; BFCR(10)11 Self-review of practice for clinical radiologists undertaking interventional procedures; BFCR(08)13 Standards for providing a 24-hour interventional radiology service);
- Royal College of Surgeons
- Royal College of Radiology
- Renal Association
- DH report on Interventional Radiology;
- European Working Time Directive impact on surgical and interventional radiology rotas.

Nationally the recommendation is that a case for change should be considered if there is variation in outcomes following aneurysm surgery, evidence linking volume and outcome for specific procedures, unequal access to treatment for AAA, unequal access to interventional radiology, particularly out of hours, current and future workforce issues. All these factors are relevant in NHS Sussex.

There is a strong case to remodel vascular services to fewer more specialised centres or networks providing high quality vascular services. This involves both vascular surgeons and vascular interventional radiologists. Commissioners need to ensure good follow up treatment to AAA screening to realise the benefits of screening and ensure robust provision of an emergency vascular service.

A vascular specialist Interventional Radiologist (IR) is a radiologist who has sub specialised in both IR and sub-specialised in “vascular” IR. The types of vascular procedures involved include:

- Endovascular aneurysm repair (aortic, popliteal, other)
- Iliac artery angioplasty (balloon widening)/stenting;
- Superficial femoral artery angioplasty/stenting;
- Popliteal /crural (below the knee) vessel angioplasty;
- Subclavian artery angiography and stenting

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- Carotid artery angioplasty/stenting
- Embolisation of arterio-venous malformations (abnormal connections between arteries and veins)
- Embolisation of bleeding/aneurysmal visceral arteries

The maximum number of sessions an IR would undertake per week would be four to avoid over exposure to radiation and to maintain reporting skills. There are no specific procedure volumes as there are for a vascular surgeon. There is a need to ensure sufficient vascular IRs are trained in EVAR to fulfil the on call rota requirements. The key issue about vascular IR is co-location with a dedicated vascular surgeon in case of complications.

5 Why is there a need to change the way services are provided?

- Nationally there is evidence linking volume and improved outcomes for specific procedures;
- The procedures included are all elective and emergency inpatient arterial surgery to be performed at one site (not just AAA surgery) and interventional radiology. For the Chichester population, the estimated number of patients who will fall under these categories is approximately 100 inpatients and 150 interventional radiology day cases per year.
- The procedures excluded are non-arterial day cases (varicose veins) and most renal access surgery, outpatients, investigation and diagnostic work-up.
- The intention of ensuring sites of higher volume is to maximise critical mass and economy of scale benefits. This will allow such sites to meet with national quality standards.

6 Local Reviews

6.1 NHS South East Coast (SEC) Health Care Needs Assessment (HCNA) for Abdominal Aortic Aneurysm Services (May 2011)

Gaps in service provision identified by the HCNA:
- There is no formal vascular network across Sussex;
- Not all Sussex hospitals currently providing AAA repairs have 24/7 vascular consultant cover either on site or through network arrangements;
- Not all patients appear to be treated by a vascular specialist (either surgeon or interventional radiologist);
- Not all organisations provide a full range of vascular treatments;
- Open Surgical Repair (OSR) and endovascular aneurysm repair EVAR (non surgical) skills and expertise is not available at all Sussex sites or around the clock (a combined service would harness such benefits).
6.2 South East Coast (SEC) Strategic Health Authority (SHA) Quality Board July 2011

In July 2011, the SEC SHA Quality Board requested that NHS Sussex Cluster consider the following key issues and recommendations from the SEC HCNA report:

- Develop a Sussex wide vascular network
- Commission appropriate volumes of AAA repairs in view of the volume/outcome effect and potential target volumes
- Develop a service specification which:
  - identifies appropriate levels of activity including numbers of EVAR;
  - ensures any Trust providing AAA repairs has 24/7 onsite on call cover
  - ensures vascular surgeons have a separate vascular on call rota (whilst sustaining the general surgical rota)
- Vascular interventional radiology and vascular surgery on call rotas should form part of the same network
- Ensure continued and complete submission of data to National Vascular Database (NVD)
- Commissioners and providers to monitor data on regular basis
- Trust data should be reviewed to ensure patients are being treated by vascular specialists, particularly in emergency procedures.

In SEC SHA, Kent and Medway have an established vascular and interventional radiology network with centralised vascular surgery at Medway Maritime and Kent and Canterbury. Surrey has had a Vascular Working Group for 10 years and is reviewing vascular services in light of co-dependency issues (e.g. South Central review; trauma planning).

6.3 NHS South Central Safe and Sustainable Review –

A review of vascular services was undertaken in autumn 2010 in South Central (which includes Southern Hampshire). The review did not include NHS Sussex or NHS Surrey. The review’s clinical recommendations were that:

- A network is established between Southampton and Portsmouth vascular services, with all emergency and planned complex vascular surgery being carried out at Southampton.
- The longstanding relationship between Basingstoke and North Hampshire NHS Trust and Frimley Park Hospitals NHS Trust vascular services should continue, with all emergency and planned complex vascular surgery being carried out at Frimley Park Hospital
- Day case, diagnostic and outpatient vascular services should be supported in local hospitals.
- A South Central engagement document was released in September 2011 explaining this, and that consultation would then commence by December 2011.

An additional proposal emerged during September 2011 from Portsmouth, suggesting that vascular surgery is retained at Queen Alexandra Hospital.
in Portsmouth and that this provides emergency and planned care for the Portsmouth population and the population of Chichester, utilising clinicians from Chichester. A bid to this end was issued by Portsmouth. However, the bid is not supported by the Lead Clinicians at St Richard’s Hospital, Chichester, who have made clear that they will be working in Brighton.

Co-ordination between South Central and Sussex (see below) reviews is an imperative to avoid confusion and a suboptimal arrangement of services being implemented. Discussions about the catchment population between South Central and Sussex became joint, from the commissioner perspective, during June 2011 (at the time of the Sussex external review).

6.4 NHS Surrey

Surrey is not currently reconfiguring its services to a single site model. There is a two site option in NHS Surrey of Ashford & St. Peter's Hospitals NHS Foundation Trust (FT) and Frimley Park Hospital NHS FT which has worked well for 13 years with some services available at SaSH.

- West Surrey is covered by the West Surrey Vascular Network, which includes Frimley Park Hospital NHS FT, Ashford & St Peter’s NHS FT, Royal Surrey County Hospital NHS FT and Basingstoke & North Hampshire NHS FT. There has already been some centralisation of vascular services. No in patient vascular work is undertaken at the Royal Surrey County Hospital NHS FT. Following the South Central review, Frimley Park Hospital NHS FT has been commissioned to provide vascular services for the north Hampshire population. AAA repairs will no longer be undertaken at Basingstoke & North Hampshire NHS FT. Since April 2011 Ashford & St. Peter's Hospitals NHS FT has provided a vascular service to the Epsom population (previously covered by St George’s Healthcare NHS Trust, London. This network was visited early in 2011 by the Vascular Society and various Royal College representatives to review the current service configuration. NHS Surrey is now awaiting a paper on the current service model against a single site option and will be making recommendations from this.
- There is very little patient flow from the north west of West Sussex into this network. The West Sussex AAA Screening programme already includes the Crawley & Horsham populations.
- East Surrey: this is covered by SaSH, which is part of St George’s Healthcare NHS Trust Vascular Institute Network.

6.5 Sussex external review of vascular services

An external review of vascular services was undertaken in Sussex during June 2011 by members of the Vascular Society of Great Britain and Ireland, with the working report recommendations made available in August 2011. This review utilised the forthcoming national guidance as its benchmark, due for ratification, by the Vascular Society in 2011 (See Appendix 1).

The terms of reference for the external review were:
• Benchmark and evaluate existing vascular services against standards proposed by the Vascular Society of Great Britain and Ireland.
• To develop a strategy for the provision of a safe and sustainable service that meets these standards.
• Focus on optimum patient outcomes, safety, affordability and sustainability.

The reason for an external review was to ensure:
• Robust analysis of local services against national guidance to inform planning;
• Transparency;
• Fairness between provider organisations.

There are aspects of good practice and evidence of good outcomes from vascular services in Sussex. However, there are gaps in compliance with national guidance. To deliver a Sussex-wide service, compliant with national guidance, intended to ensure the best outcomes of care, the recommendation of the external review is for a single vascular centre based in Brighton.

Sussex is a large geographically elongated county so the hospital chosen would need to lie centrally. Brighton is a teaching hospital with a major trauma centre which lies centrally in Sussex.

The solution recommended should:
√ Satisfy the guidelines in the Provision of Services document produced by the Vascular Society, and should take into account the anticipated revisions to the those guidelines due for publication towards the end of 2011.
√ Take account of the evidence favouring the move to vascular treatments being conducted in large centres.
√ Satisfy the requirements of NAAASP.
√ Provide care that is equal to, or better than that already offered for all residents in Sussex, irrespective of location.
√ Be safe, affordable, sustainable and provide optimal patient outcomes going forward
√ Take into account the geography with respect to travel (Vascular Society recommend a specialist vascular surgical centre is available within one hour of a person’s residence).
√ The NHS South Central Review has proposed a two centre solution at Southampton (including Portsmouth and Winchester) and Oxford. The review accepted the inclusion of Basingstoke in the West Surrey Vascular Network.

A single centre in Brighton would satisfy all the requirements of the NAASP, the Vascular Society, EWTD and separate specialty status provided the Royal Sussex County Hospital:
   a. Can accommodate three times its current vascular surgical and interventional radiology activity;
   b. Can accommodate a minimum of six vascular surgeons working from the hospital;
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c. Can guarantee to provide a daily weekday attendance of at least one vascular surgeon at every peripheral hospital in the group (Chichester, Worthing, Eastbourne, Haywards Heath and Hastings);
d. Ensure a 24/7 interventional radiology service;
e. Continues to provide inpatient care of vascular patients, venous and amputation surgery, and a service to the diabetic population in Chichester, Worthing, Haywards Heath, Eastbourne and Hastings; and,
f. Continues to provide outpatient vascular clinics in Chichester, Worthing, Eastbourne, Hastings and Haywards Heath.

There is full support by the acute provider organisations in NHS Sussex of the recommendations of the external review by the VSGBI as laid out above.

The Sussex Vascular Review noted the issues raised by the Portsmouth Hospitals NHS Trust about the creation of a vascular centre in Portsmouth to provide services that would include the Chichester population. However, the Sussex Review still recommended that vascular surgery is concentrated on a single centre in Brighton with networked outreach to units in Chichester, Worthing, Haywards Heath, Eastbourne and Hastings.

7 Current service provision

Each of the three acute Trusts in NHS Sussex comprises two hospital sites. Vascular surgery is performed in four of the six hospitals; these are St Richard’s (Chichester) and Worthing (Western Sussex Hospitals NHS Trust); Eastbourne (East Sussex Healthcare NHS Trust (ESHT)) and Brighton (Brighton and Sussex University Hospitals (BSUH)). No arterial surgery is performed at Haywards Heath (BSUH) or Conquest Hospital, Hastings (ESHT). Outpatient services are available on all sites.

There is some arterial work carried out at East Surrey Hospital, Redhill (SaSH). East Surrey hospital serves a population of 420,000. There is some vascular surgery on site, but the Vascular Surgeons and Interventional Radiologists work both at SaSH and at St George’s Healthcare NHS Trust i.e. have joint appointments. There is no 24/7 vascular surgery or interventional radiology on site cover. SaSH provides vascular surgery for Sussex residents locally and by transferring them to St George’s Healthcare NHS Trust. Arterial Surgery provision for SaSH is reviewed and planned jointly between NHS Surrey and NHS Sussex.

Appendix 2 provides a summary of current activity by providers for 2010-11 for all Sussex residents for the specialist vascular surgical procedures under discussion.

8 Options for specialist service provision for NHS Sussex

Whether there is a vascular surgical base at Queen Alexandra Hospital (QAH), Southampton University Hospitals Trust (SUHT) or Royal Sussex County Hospital (RSCH), part of BSUH, in light of the South Central and
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Sussex reviews, all scenarios mean that there will no longer be arterial vascular surgery at SRH, part of WSHT. There will though remain day case surgery, diagnostic work up and follow up.

The reasons for not developing SRH as a vascular centre for South Central and Sussex include:
- Need to invest in more vascular surgeons (two currently)
- Need to invest in more interventional radiologists (three currently)
- No 24/7 vascular surgical cover on site
- No 24/7 interventional radiology on site
- No specific vascular ward
- No dedicated theatre specification endovascular suite for EVAR (use C-arm in theatre), nor any EVAR on site. (EVAR is a form of interventional radiology technique).
- No vascular laboratory on site
(Source: Sussex Vascular Review Aug 2011)

The current volumes of activity at SRH do not comply with and deliver national guidance to improve outcomes of care.

Since the Sussex Vascular Review, one of the three vascular surgeons at SRH, has announced his retirement at the end of March 2012. This means that there will only then be one full time vascular surgeon and one part time vascular surgeon at SRH at that time, which in turn means that 24/7 arterial vascular surgery cover for SRH will no longer be available at SRH from April 2012. The change for SRH provision is acknowledged within the Sussex Vascular Review.

In addition, the status quo for Worthing and Eastbourne is not permissible because it neither meets with the minimum volumes laid out in the national guidance, nor provides the required out of hours cover and is therefore not an option.

Portsmouth will be reviewing its bid to assess the potential for providing the Portsmouth and Chichester population, without the assumption of using SRH clinicians.

Service configuration proposed for NHS Sussex will therefore be
- One specialist vascular surgical and endovascular care centre for NHS Sussex at Brighton in line with the Sussex Vascular Review

There will then be patient choice to be referred to other specialist vascular surgical centres, which in Hampshire would be at Southampton (and potentially Portsmouth, depending on whether or not it can fulfil the South Central vascular service specification), and the outcome of the forthcoming consultation and in the North of West Sussex the proposed solution for SaSH.
9 Model of Care

- Specialist vascular surgical and endovascular care at designated 24/7 site for emergency and inpatients – includes all salvageable amputations and arterial surgery and arterial vascular interventional radiology;
- Consultant vascular surgeons dedicated to vascular surgery i.e. no commitments to the general surgery rota
- 1 in 6 on site on call rota for both vascular surgeons and vascular interventional radiologists (“on site” – means that the on call cover is dedicated to that site rather than being resident on call).
- A volume threshold of 50 for AAA procedures per annum divided between open and endovascular repair (choice of procedure to follow best available evidence at the time because evidence and cost effectiveness for endovascular and open repair keeps changing) and an annual volume of 35 carotid endarterectomy (CEA))
- Inpatient vascular surgery at linked District General Hospitals (DGHs)(daycase where clinically appropriate) – agreed to be renal access, varicose veins and amputations (not salvageable limbs)
- Outpatient clinics at all linked DGHs.
- Follow up protocols
- All elective procedures reviewed preoperatively in the specialist vascular multi-disciplinary team, including a vascular surgeon and a radiologist as a minimum with vascular anaesthetist.
- All elective arterial patients reviewed by a vascular anaesthetist prior to admission.
- Appropriate patient consultation and information with support of clinical nurse specialists.
- Measurement and audit of practice.

Anticipated length of stay:
- Any interventional radiology procedures: No overnight stay. All will be discharged home.
- Elective AAA: two to four days at the Hub. The majority will then be discharged home. The rest will require a period of rehab in the Spoke.
- Carotid endarterectomy: Mostly one overnight stay then discharged home. A minority will require an extra period of neuro-rehab in the Spoke.
- Limb bypass surgery: Two to four days in the Hub. An additional three to five days in the Spoke. Discharge will be to home or rehab.

10 Travel

Currently 7 to 10 people are treated in Chichester for ruptured AAAs per annum. This low figure is due to the long running AAA screening programme. These patients will need to be admitted directly to the hub. There is ample evidence to show that such patients can travel for up to
one hour with no adverse effect on their outcome. Some references include:


11 Process

For Sussex to develop a Vascular & Interventional Radiology Implementation Plan that

- Delivers 24/7 on site emergency vascular surgery and endovascular care for the population of NHS Sussex;
- Ensures a platform for a robust AAA screening and repair service;
- Ensures a first class, high quality, safe, standardised and resilient vascular service across NHS Sussex, delivering world class outcomes for patients, catering for local need;
- Services should be provided as close to the patient’s home as possible where clinically appropriate.
- There should be equality of access to therapy and rehabilitation services across Sussex for vascular patients.

12 Actions required:

- Establish a Sussex-wide vascular network (Inaugural meeting 9th November – Terms of Reference Appendix 1);
- Secure a smooth AAA screening roll out. The business plan to extend screening for all of Sussex, not just the current West Sussex Screening Programme, has been agreed with implementation from April 2012.
- Ensure appropriate volumes of AAA repairs are commissioned within the 2012/13 Operating Plan round;
- Utilise the intelligence already available;
- Ensure all stakeholders identified;
- Develop and set standards (use national where possible);
- Identify the service configuration options and assess;
- Agree configuration of services;
- Agree engagement plan;
- Formal consultation if deemed necessary;
- Timeline for implementation
- Create plan for achieving transition
• Deliver reconfiguration of services

13 Public and patient engagement

Public and patient representative membership is being secured via existing linked managed clinical networks, via NHS Sussex Cluster Public Patient Involvement (PPI) engagement groups and via vascular service clinicians.

A Sussex vascular and interventional radiology (S&VIRN) network PPI group is being established. Four volunteers have come forward to assist in establishing this work, in line with the public and patient involvement strategy for all the Sussex managed clinical networks.

There will be two patient/carer representatives on the S&VIRN Board.

There will be additional patient engagement in other work such as provision of patient information to inform choice.

14 Recommendations

For HOSC members to be updated with progress in implementing national guidance for vascular arterial surgical and endovascular care services in NHS Sussex.

A verbal update on progress with timescales will be provided at the 24 November 2011 HOSC meeting

For HOSC members to decide on the engagement and consultation processes required if any.
Appendix 1

Sussex Vascular & Interventional Radiology Network
Draft Terms of Reference for Board for discussion 9th November

Purpose

To improve vascular services across NHS Sussex, by supporting commissioning to develop vascular services to meet the needs of the population that are value for money. In the first instance, this will require delivery of the recommendations of the Sussex Vascular Review including a drafted implementation plan by November 2011.

A key role is to inform the strategic development of vascular services across the Network, informed by the Sussex Vascular Review and the SEC Health Care Needs Assessment for AAA screening. This will include overseeing the development of clinically effective patient pathways.

To achieve this, the Network will:
- Bring together local organisations to address issues and achieve maximum gain;
- Support innovation and the sharing of best practice and experience;
- Bring patient views to bear on service redesign and work programme
- Focus on the interface between organisations;
- Ensure that value for money is achieved;
- Assess the need of the Sussex populations to inform the commissioning process.

Quality –

Provide the highest quality vascular service to patients of NHS Sussex to ensure an accredited vascular & interventional radiological service for the area.

Equity –

Ensure all patients have access to comprehensive services and treatments across the network geography

Standards –

Develop and implement agreed clinical and managerial standards and patient pathways that are based on best evidence and/or VSGBI recommendations when available. By audit, quality assurance and peer review ensure that the standards are met. Reflect any variance to these standards in service planning, provision and organisation.

Monitoring -

Agree an effective means for agreeing an integrated system for quality assessment and improvement.
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Develop a network wide clinical governance strategy, quality assurance and peer review mechanism for vascular & interventional radiology services.

Planning –

Be an effective planning organisation for service provision, taking into consideration local population needs and issues and national guidance including technical advances.

Develop implementation plans for delivery of specialist vascular and interventional radiology services for NHS Sussex on the basis of the Sussex Vascular Review recommendations, including service configuration, including developing modern capacity for providing vascular intervention in line with national targets for providing treatment and responding to patient choice.

Plan the coherent development of the full range of vascular & interventional services, linking specialist and local services for preventing, diagnosing and managing the treatment of acute and chronic vascular disease whilst promoting equity within the Network.

The Network will support NHS Sussex and its provider organisations to deliver the Sussex Vascular Review recommendations.

The network will ensure that a work force strategy is developed and implemented

Service Development –

Deliver the evidence-based clinical strategy recommended by the Sussex Vascular Review and SEC HCNA for AAA screening for treating vascular disease across the entire patient journey, ensuring that agreed changes in clinical practice are implemented and shared throughout the Network.

Ensure good practice and learning is spread across the Network with roll out across the cluster of national and local best practice.

Promote and support service innovation.

Commissioning –

Engage, advise and inform with those involved in commissioning services to deliver agreed priorities in vascular services in NHS Sussex, seeking the agreement of the commissioning leads to improve service capacity consistent with those priorities.

The Network will provide commissioners with:
- expert guidance on the development of services.
- the development of local guidelines and pathways
- updates on quality standards including where providers do not fulfil these standards;
• information of any significant issues facing their services.
• annual and locally tailored commissioning intentions.
• information on commissioner performance against national targets and standards.

Participation –

Encourage participation from all areas of the multidisciplinary team providing these services

Ensure public and patient engagement and involvement within the network.

Workforce –

Develop a modern, skilled workforce that is compliant with the VSGBI recommendations and is able to provide high quality, effective vascular disease service that meets national guidance, as documented in the Sussex Vascular Review, and address particular problem areas for recruitment and retention of staff, working closely with the workforce leads within the cluster, SHA and nationally. This will require a workforce strategy to be developed and implemented to ensure transition of arterial vascular surgery to BSUH with outreach day case and outpatient model with linked Trusts.

Relationships to other services –

Establish links with other Clinical Networks, for example, the Trauma, Diabetes, Renal, Cardiac, Stroke, to discuss areas of common concern, including disease prevention and treatment. This will include the early identification and treatment of diabetes, renal and coronary heart disease, with local mechanisms for monitoring patients.

Establish links with health communities outside Sussex to take account of their needs and strategies in planning future services.

Communication –

Ensure good communication lines with all members of the board and the wider stake holder community involved in vascular services.

Patient and carer engagement

Involve patients through patient representation on the board and encourage the development of a larger patient forum to advise and input thorough the patient representatives.

The Network will gain the views of patients and carers by involving them in its structures and by under taking specific pieces of work to seek their views
Accountability

The Chair of the Sussex Vascular & Interventional Radiology Network Board will be accountable to the (? Sussex Executive Group or Chief Executives of the acute Trusts, NHS Sussex and the Strategic Health Authority) for the network’s annual work programme and will report back to this community at regular intervals about progress in achieving the agreed objectives.

The Network Board will establish clinical advisory and other project groups (eg AAA screening; lymphoedema) to review and make recommendations on specific areas of work or developments, ensuring representation and engagement from across the Cluster organisations.

Proposed Network Board Membership

- Chair - TBA
- Clinical Lead – this could be for each Trust (and then put in place network clinical lead)
- Lead Vascular surgeon
- Specialised Commissioning Group representative
- CCG Commissioning lead representative (unless agreed that this is via the Cluster Medical Director rep)
- Network manager or network lead clinician – stroke
- Network management lead - vascular
- Provider CEO or their authorised representative – ESHT, WSHT, BSUH, SASH
- CSU representative
- Lead nurse/AHP representative
- Sussex Cluster Medical Director
- Sussex Cluster Exec Management Representative
- Interventional radiology lead – clinical/managerial
- Rehabilitation representative
- SECAMb
- Patient representatives x2
- AAA screening PH lead representative

It may be necessary to delegate attendance to appropriate senior deputies. Should this arise the deputy must have a key role in vascular services and bring the full authority of the person/organisation they are deputising for.

Terms of Business

The Network will meet bi-monthly.

The Network will be quorate with X members present.

Minutes of all meetings will be available to all stake holders. Administration support will be provided by the Sussex Managed Clinical Networks Office.
Bi-monthly highlight reports will be provided to the CCGs and SEG.

Acknowledgement

These draft Terms of Reference are based on an amalgamation of the Kent and Medway Vascular and Interventional Radiology Network and North East London Vascular Network.
Appendix 2 – Activity (Sussex Residents)

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<td>Amputation</td>
<td>Elective</td>
</tr>
<tr>
<td></td>
<td>Non-Elective</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
</tr>
</tbody>
</table>

The hospitals likely to provide a service to the population