



# **Kent and Medway Vascular Services Review**

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### **Kent and Medway JHOSC report: 8 January 2016**

Version number: 2

First published: 8<sup>th</sup> January 2016

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The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

## 1 Introduction:

### 1.1 What Are Specialist Vascular Services?

Vascular disease affects veins and arteries. It may cause blood clots, artery blockages and bleeds which can lead to strokes, amputations of limbs and conditions that might threaten life if left untreated.

NHS England South (South East) commission specialised treatment in Kent and Medway, Surrey and Sussex under the national specification for specialised Vascular Services.

Specialised vascular services are types of treatment for:

- aortic aneurysms – a bulge in the artery wall that can rupture (treatment may be planned or as an emergency)
- carotid artery disease, which can lead to stroke
- arterial blockages, which can put limbs at risk.

The types of treatment that might be required include:

- complex and potentially high risk bypass surgery to the neck, abdomen or limbs
- balloon or stent treatment to narrowed or blocked arteries
- blood clot dissolving treatments to the limbs
- stent grafts of varying complexity to treat aneurysms.

All these treatments are highly specialised and need a skilled team available 24 hours a day, every day of the year, to provide this service and support patients.

This review has looked at both emergencies and planned specialist vascular treatment. It includes both patients treated in Kent and Medway hospitals and people living in Kent and Medway who go to London for their treatment.

This review has not looked at varicose vein surgery, heart disease, heart surgery or the management of the common types of stroke.

The national service specification was published in 2013 following concerns about the outcomes for patients in England and Wales receiving vascular services. The standards within the specification were developed through a national specialised Clinical Reference Group (CRG) and reflect the best practice guidance of the National Vascular Society 2012

The key aim of the specification and guidance is to improve outcomes, so that patients with vascular disease benefit from the lowest possible disability and mortality rates, for both elective and emergency care. The clinical evidence underpinning the specification and guidance recognises the relationship between treating adequate numbers of patients and improved patient outcomes.

As a result of the implementation of the national specification there have been marked improvements in outcomes for vascular patients across the country.

## 1.2 What Does the National Specification Say?

It sets out that specialist vascular services need:

- To work within a hub and spoke clinical network where one hospital (the hub) provides all the inpatient surgery and the other hospitals (spokes) provide outpatient and diagnostic services in collaboration with the hub and, where appropriate, some day case surgery
- To serve a minimum population (800,000) to ensure staff see enough different types of cases
- 24 hour access to specialist care, including six vascular surgeons, six interventional radiologists and specialist nurses, with sustainable on call rotas.
- To provide access to cutting-edge technology, including a hybrid operating theatre for endovascular (minimally invasive) aortic procedures and a dedicated ward for vascular patients
- To have the right mix of highly skilled, specialist staff who each carry out enough specific procedures (known as core index procedures) to maintain and improve their skills, ensuring consistent safe quality care.

Our review has assessed vascular services for people in Kent and Medway against the best practice standards set out in the national service specification.

## 1.3 What is the Current Position Across Kent and Medway?

About 900 people a year in Kent and Medway need specialist vascular services. In Kent and Medway, it is provided by Medway NHS Foundation Trust (MFT) in Gillingham and East Kent Hospitals University NHS Foundation Trust (EKHUFT) in Canterbury. Most people from the west and far north of the county - Tonbridge, Tunbridge Wells, Sevenoaks, Dartford, Gravesham and Swanley - receive their care in London, predominantly at St Thomas' Hospital. This arrangement has developed, over the past 5/6 years as a result of links between doctors at different hospitals, and clinical and patient choice.

## 2 Kent and Medway Case for Change

### 2.1 How Do the Current Inpatient Centres Do Against the National Standards?

- The service provided by St Thomas' Hospital in London is fully compliant with the national clinical guidance and best practice specification.
- The services across Kent and Medway, while delivering on a number of the key standards, are not fully compliant with the national clinical guidance or best practice specification.

- The main issues are that they are not treating a large enough population, are carrying out too few or borderline numbers of core index procedures and have too few staff, particularly consultants.

## **2.2 The Main Areas of Non-compliance Are:**

- The lack of a vascular network across Kent and Medway. Although the different stages of patients' care locally (before, during and after their hospital stay) seem to work well, there is little evidence of the two units in Kent and Medway formally collaborating. It is less clearly understood across East Kent and Medway how things work for those patients who go to London.
- The number of people served by both East Kent Hospitals University NHS Foundation Trust (EKHUFT) and Medway NHS Foundation Trust (MFT) is below the 800,000 minimum which is recommended by the Vascular Society.
- At both trusts, the total number of some of the core index procedures is either borderline or below the recommended numbers.
- The number of consultants is currently lower than required so there is concern about being able to staff the vascular surgical and interventional radiology rotas 24/7 at both sites
- The outcomes for the Kent and Medway centres are within the current acceptable levels but in some cases are outside of the recommended targets and they vary across the county.

NHS England South (South East) have been granted “a derogation” meaning that services in Kent and Medway can continue, even though they do not fully meet the national specification, while we work with the clinical specialists, patients and carers to find a solution that can fully meet the specification and provide sustainable service going forward.

## **3 The Review Process**

The aim of the review is to ensure that quality, safe and sustainable vascular services can be delivered now and into the future.

The review has considered and scoped the current provision of specialised vascular services for Kent and Medway residents and is identifying solutions that can deliver the national specification, the Vascular Society guidance and improve outcomes for patients.

The review process is overseen by a Vascular Review Programme Advisory Board, which is clinically led and includes both external and local clinical experts in vascular care.

The Review Board is supported by a clinical reference group (CRG) providing clinical advice and expertise, both from the current providers and also from the vascular society.

### **3.1 The CRG Has Developed a Vision for Vascular Services for Kent and Medway Residents**

Vascular services are a specialised area of healthcare which, evidence has shown, will benefit from organisation into larger centres covering a population that will facilitate significant volumes of activity in all areas of service, with a robustly staffed workforce able to deliver services 24 /7, 365 days of the year.

There is an opportunity to ensure that excellence in patient care and outcomes can be provided and that resource is always available for the vascular service to continue to improve on the type and standards of care provided. In Kent and Medway, the opportunity exists to develop this.

Establishing a vascular service of excellence will offer the opportunity for a much improved and comprehensive service to patients. In particular, the right model of care could deliver the opportunity to provide more local care to Kent and Medway residents and the type of care could include more complex procedures.

Such a centre(s) will be better able to embrace new technology and innovation in practice. A regional centre(s) of excellence is most likely to facilitate a change in patient flows. Such a centre (s) is most likely to be able to attract the highest calibre workforce and offer sustainability.

The training boards will look to centres of excellence to be involved in training the future generation of vascular clinicians. This not only benefits the service but invests in the future provision of excellence in patient care. A suitably sized centre (s) with the appropriate population could offer opportunity for quality audit and research.

The vision of the clinical teams in Kent and Medway is to develop and deliver a model of care for vascular services that offers all of these benefits.

### **3.2 External Clinical Scrutiny**

This is in place via the South East Clinical senate that has reviewed the Case for Change and will review the findings of the programme board and its subsequent recommendations.

### **3.3 Alignment to the national/local Emergency and Urgent Care strategy**

The Vascular review has been cognisant of the emerging Kent and Medway strategy on the Urgent and Emergency care landscape in line with the national picture.

\*\* Appended to this report is a summary of this work to date. The vascular review will ensure that the key recommendations of the national work are reflected in the options for specialist vascular services.

### 3.4 Communication and Engagement

The review is also supported by a communications and engagement plan, which sets out how the review will ensure effective engagement and communications throughout the process. This has included Listening Events held between July and August 2015 the findings of which have been used to shape the Case for Change and the options appraisal process.

The review will continue to engage both the public and patients as the process develops in particular to influence and shape the patient pathway.

## 4 Progress to Date

Both the Kent and Medway Overview and Scrutiny Committees were notified of the Case Change and agreed to the establishment of a JHOSC.

The participants at the Listening events reported a **positive experience of vascular services both in Kent and Medway and in London.**

There were 64 attendees at the Listening events, 12 individuals were Medway residents and the remainder were Kent residents

The attendees recognised the Case for Change and noted that having access to a specialist vascular team or centre was most important and reassuring in a life threatening situation. Having good access to such a service in Kent and Medway was vital.

The key priorities noted by the public include:

- The ability to make choices
- Adequate Information and communication, both to make choices and throughout the patient journey
- The need for high calibre staff with the specialist skills, and capacity to deliver the service 24/7
- The best treatment possible as quickly as possible, particularly in an emergency and smooth access to elective care
- The need for support particularly following amputations, when people return home
- Joined up working between services and disciplines, working within a clinical network, including improving the ability to recognise vascular disease.

## 5 Option Development and Appraisal.

The detailed option appraisal has to date considered a number of key areas. These will be built upon through development of the clinical model and include:

- **Travel/Access:** considering ambulance travel times across Kent and Medway and into London based on 60 minute travel times and impact on the ambulance trust. Reviewing public transport facilities/times.
- **Patient demand:** assessing the numbers of patients requiring specialist inpatient and day patient vascular care, noting the numbers of patients attending London units.
- **Co-dependencies:** assessing the impact on other clinical areas and the need for co-located services.
- **Vascular interventional radiology (minimally invasive interventions performed endoscopically by radiologists):** ensuring that this service is co-located and viable and assessing the impact on non-vascular interventional radiology work.
- **Workforce:** confirming the workforce requirements, including on call rotas for specialist 24-hour vascular care. Assessing the current gaps and options for delivering seven-day services. Reviewing workforce training and supply and possible workforce options. Assessing competencies across the vascular pathway.
- **Public health:** assessing population growth and demand, Identifying key demographic influences and impacts on service configuration.
- **Financial planning:** assessing current financial envelope/flows for Kent and Medway. Identifying cost implications of options including increased transfers, additional facilities, workforce implications, implementation costs.

Agreement has been unanimously reached by the Programme Board members that specialised vascular services should remain in Kent and Medway.

Early assessment notes that continuing with the status quo will **not** address the current gaps against the national specification or address the sustainability issues.

The CRG has considered a long list register of options in line with the specification and agreed that there were two options that needed further clinical development/review to establish if these could address the key issues.

The clinical leads were tasked to develop the clinical models and then the CRG determined if these could address the case for change and therefore require detailed appraisal.

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These options included;

**Option 1** a two centre arterial hub with spokes model working within a network.

**Option 2** a single Kent and Medway arterial hub with spokes working in a network across Kent and Medway.

The findings of the CRG are:

- **Option 1:** will not deliver the required volumes without significant repatriation and will struggle to meet the required consultant numbers. The CRG could not support this model going forward.
- **Option two:** this reflects the national best practice model and will meet the requirements of the national specification.

The CRG have recommended to the programme board that a single Kent and Medway hub and spoke model working in a network is the only model that should be taken forward.

The Programme board (PAB) has accepted the findings of the clinical reference group, this reflects the priorities noted in the Listening Events. The PAB and is keen to hear the views of the JHOSC.

The CRG is currently developing the clinical model further building on the clinical requirements, best practice and the public's priorities taken from the listening events.

The public /patient feedback to date highlighted the importance of:

- Workforce and the possibility of attracting the best specialists to Kent
- Speed of access to and availability of specialist care
- Considering the specifics of local populations when planning and designing options for vascular services as the review goes forward
- Recognising that patient/clinical choice is important
- The population growth in Kent and Medway, particularly in Dartford.

A clinical/public/patient workshop is planned early February to consider and test the pathway.

The programme board is keen that the JHOSC is involved in shaping this model/pathway and members will be invited to attend this event.

## 6 Next Steps and timeline

### 6.1 Development of the Clinical Model

The Clinical Reference Group will develop the clinical model illustrating the patient pathway. This will include assessment of the key indicators and impact areas and inclusion of the public priorities.

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The model will be tested against national best practice models and reviewed by the South East Clinical Senate.

Feedback from the JHOSC will inform and influence the clinical model recommended to NHS England south specialised commissioning.

### 6.2 Approval of the Programme Board Recommended Option and Clinical Model.

The programme board will make its final recommendations to NHS England Specialised Commissioning in March 2016.

Procurement advice is being sought to clarify the appropriate procurement route to commence early April 2016.

Implementation will depend upon the mobilisation plan required and may take on an incremental process with a target of the end of the 16/17 financial year (March 2017).

## 7 Proposed Timeline

<b>Key actions</b>	<b>By who</b>	<b>By when</b>
<b>Development of the clinical model</b>	CRG Supported by patient and public and JHOSC engagement	Approval by PAB; March 2016
<b>Development of Clinical model</b>	Stakeholder event to test and develop the clinical model and describe the patient pathway K&M JHOSC meetings	February 2016  Jan and Feb 2016
<b>Detailed Appraisal of the option ( inc EA)</b>	Led by Programme director; business case to PAB	March 2016
<b>Recommendation of option and clinical model</b>	Programme board	Approval by NHS England south March/April 2016
<b>Procurement process</b>	Confirm requirements and commence process	End March 2016

## 8 Recommendations to the JHOSC

- To consider and comment on the proposed clinical model of a single Kent and Medway arterial hub with spokes working in a network across Kent and Medway
- To decide if any further information is required.
- To refer any relevant comments to NHS England (South East) and request they be taken into account during the development of the clinical model and further stakeholder engagement as applicable.

## 9 Appendices

### 9.1 Appendix 1: Briefing on the development of the Kent and Medway Emergency and Urgent care strategy.

1. CCGs in North Kent, West Kent and Medway are working together to develop strategic commissioning intentions for acute care. Similar work is also progressing in East Kent between the CCGs and East Kent University Hospitals Foundation Trust. as part of a wider strategic 'whole system review' programme that is also looking at the future pattern of community, mental health and primary care services, together with the interface with social care services, across east Kent. Whilst the regulation of the healthcare market remains the responsibility of Monitor and the Trust Development Agency, CCGs have a responsibility to ensure the reasonable healthcare needs of their population can be met. This CCG responsibility can only be achieved if there are viable healthcare providers in place who are able to deliver the commissioning requirements of the CCGs. As such, CCGs have a strategic responsibility to ensure the viability of healthcare providers.
2. The objectives of this work in North Kent, West Kent and Medway are to develop a set of strategic commissioning intentions that outline the changes required by CCGs in acute hospital providers. The aim of these changes will be to:
  - Address documented quality concerns (e.g. identified by Monitor, Trust Development Agency, Care Quality Commission...)
  - Ensure delivery of key performance targets as specified in the national prevailing NHS contract
  - Support ongoing workforce and financial stability
3. Changes in the demographics of the local population mean that the model of care needs to develop to meet the associated changing demand placed upon services. Demand for healthcare is expected to be greater in terms of future predicted volumes of people but also different according to changing needs. There are a number of factors that need to be considered when looking at how the Kent and Medway population is going to change. In 2011 the base population for Kent and Medway was calculated as 1,731,400. By 2031 this is projected to increase to 2,024,700, an increase of 293,300 that is equivalent to a 17% rise (circa 42,000

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for Medway / 251,000 for Kent).

4. In particular, the percentage of old people, who are living longer with multiple co-morbidities, is changing and by 2021 it is projected there will be a:
  - 25.5% increase in number aged 65 years +
  - 34.1 % increase in the number aged 85 years +
5. The projected 17% increase in the local population also includes population increases as a result of a planned 158,500 additional dwellings that are expected between 2011 and 2031. These developments will have a skewed impact on different areas. In particular, there are significant developments planned in Dartford, Ebbsfleet and Ashford (as well as significant housing development in Bexley, South-East London, which are not factored into the housing numbers referenced above but whose residents would look to Darent Valley Hospital as their local acute provider).
6. The current acute healthcare arrangements, when considered against the projected changes in the population, are not sustainable either from a financial or workforce perspective. which in turn could affect quality This points to a need to move to a model of care that sees more people empowered to manage their own healthcare , and to receive more care in out-of-hospital settings, and places less reliance on hospital based care. With regard to workforce there are already significant challenges recruiting to certain key clinical and specialist posts and the impact of this is already being felt. This adds to quality concerns, which are a further issue driving change, and result in a number of key performance targets not being delivered.
7. Issues in primary care, including the lack of sustainability of some practices predicted rates of GP retirement, and issues around business viability, can also not be ignored. These point to the need for a clear, coherent and mutually compatible strategic direction across providers within the wider Kent and Medway health and social care systems.
8. In setting out to determine the strategy for acute hospital based care the delivery of acute emergency care is a key consideration and a starting point. The NHS England Emergency and Urgent Care Review identified that hospitals with emergency centres are able to receive, assess, treat and refer all patients (both adults and children) with urgent and emergency care needs. These hospitals include:
  - an emergency department, under the continuous supervision of a team of consultants in emergency medicine (not necessarily continuously present, but are available to attend within 30 minutes); and
  - some facilities and beds to admit and investigate patients' illnesses and injuries as well a range of outpatient and supporting services.
9. When the NHS England review is considered against the current configuration of acute hospitals in Kent and Medway, which is considered later in this document, it is suggested that three types of emergency defined in the national review centre can be identified:
  - Emergency centres with an emergency medical take only (such as that provided at the Kent and Canterbury Hospital and Maidstone Hospital)

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- Emergency centres with emergency surgical and medical takes
  - Emergency centres with emergency surgical and medical takes, with some more specialist services
10. An emergency centre with specialist services has all the features of an emergency centre, but also includes twenty-four hour-a-day, seven-days-a-week access to some more specialist services (all supported on-site by level three critical care (the highest level for the most seriously ill patients) and interventional radiology). Such facilities should include a grouping of identifiable specialist services that support a network, current examples include:
- major trauma management including neurosciences, plastic surgery, burns;
  - primary percutaneous angiography for ST-segment elevation myocardial infarction (Primary Percutaneous Coronary Intervention (pPCI)) ie very specialist cardiology services;
  - stroke thrombolysis;
  - emergency vascular surgery; and
  - specialist paediatric services.
11. Kent and Medway CCGs are reviewing the above list to see if there are additional specialist services that clinicians and clinical commissioners believe should only be provided once or twice across Kent and Medway.
12. In North Kent, West Kent and Medway, CCGs are progressing work on acute strategic commissioning intentions on the basis that where current accident and emergency departments exist at the main hospitals, there will continue to be some form of emergency department clinicians and clinical commissioners believe as described in Point 9. It is envisaged that the main changes that might be required are around the consolidation of the more specialist services and moving to a model of care that places a greater emphasis on care being delivered outside of acute hospital settings.
13. In east Kent the East Kent Strategy Board has been newly established by local health and care commissioners to spearhead a new drive to determine how best to provide health and care services to the population of east Kent. This programme of work is wide-ranging as it involves all health and care organisations within east Kent and will take a 'whole system' approach to transforming the local health and care economy.
- Comprising all organisations involved in the planning, provision and delivery of health and care services in this area, the Board is an advisory board with a clinical chair. Its membership includes the chief executives and most senior clinicians and leaders of east Kent's NHS and care services. The Board will oversee a work programme and advise local health and care commissioners whose role it is to plan the future pattern of services across east Kent.
14. The Board has not yet considered or tested any options for change and no decisions about how services might be organised in the future have been made. Hearing the views of clinicians and support staff, patients, their families and carers and the wider public is integral to this transformation programme and the

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Board has pledged to engage widely before any decisions are made about the future pattern of services.

15. CCGs hope to meet in the near future with the Kent Health and Social Care Overview and Scrutiny Committee and the Medway Health and Social Care Overview and Scrutiny Committee. to update them further and to listen to and understand their views and perspective on this work.

**9.1 High level decision making process:**

