Kent and Medway Vascular Services Review
JHOSC Briefing October 2018

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Purpose of Paper:	To update the JHOSC on the K&M Vascular review process and the interim option appraisal

Executive Summary

This briefing is to advise the Kent and Medway Joint Overview and Scrutiny Committee (JHOSC) of progress of the K&M Vascular review and to seek a view on the recommendation noted.

Specialist Vascular care is provided within Kent and Medway by two acute Trusts (East Kent Hospitals Foundation NHS Trust (EKHUFT) and Medway Foundation NHS Trust (MFT)). Neither of these Trusts are currently fulfilling either the requirements of the national specification for this service or the guidance from the Vascular Society. They predominantly serve patients from the east of the county with Guys and St. Thomas' hospitals (GSTTH) in London receiving patients from the west and north of Kent. GSTTH is fully compliant with the national specification and with the Vascular Society guidance.

NHSE commissioned a review of the service within Kent late 2014 to make recommendations for resolving the non-compliance and ensuring a safe, high quality sustainable service for Kent and Medway residents going forward.

A case for change was developed and agreed and an options appraisal process undertaken and a joint overview and scrutiny committee established between Kent County Council and Medway Unitary Authority early 2015 to oversee and review the process.

There has been a range of public engagement events throughout the review informing both the case for change, the options appraisal and the model of care. A clinical reference group has underpinned the review with members of both EKHUF and MFT, with representation from GSTTH and other acute hospitals in Kent. The reference group also includes external clinical advice from an external interventional radiologist and a vascular surgeon (representing the Vascular Society).

The review process has identified a clinical model, based on best practice, of a single in-patient arterial centre in Kent and Medway supported by a number of spokes and one of those to be an enhanced spoke unit. The proposal as agreed by both Trusts and clinicians is for the arterial centre to be in east Kent. The current patient flows into GSTHH from the west and north of the county will not be impacted by this decision unless it is patient choice to receive their care in Kent and Medway (it is anticipated that a centre of excellence within Kent and Medway will encourage more patients to attend this service).

Both Trusts have formed a network (as per Vascular Society recommendations) and have developed a business case for the development of this model. This will include detailed

pathway modeling, transitional arrangements and the final site configuration recommendations.

In May 2018 the K&M vascular network identified concerns and raised these with the review Programme Advisory Board (PAB). These concerns focused on the interim period until the final decision is approved and the service established. Namely, the East Kent Transformation Programme is likely to take five to seven years to implement and a final solution for vascular, if in east Kent, will need to align to the timeline. It was questioned whether it was appropriate to wait for this period of time before making changes to vascular services or whether an interim solution was required.

The network was unable to reach a consensus on the interim model and arrangements and requested that a commissioner decision was made with regard to both the need and site of any interim arrangement. Therefore, in July/August 2018, the PAB undertook an options appraisal process which included a self assessment from both Trusts and a review of the findings form the review processes to date.

A panel from NHSE specialised commissioning, the review SRO, the K&M STP and external clinical advice have made a recommendation for consideration by NHSE specialised commissioning based on the available information. This recommendation will be considered by Specialised Commissioning South who will undertake the necessary due diligence between now and the end of November 2018 in order to reach an 'in principle' decision. If approved, this will require the development of a detailed business case following completion of key lines of enquiry that will then require approval via organisational governance processes.

The recommendation to specialised commissioning at this stage is that:

- Due to the likely timeline for a final solution being a minimum of 5 to 10 years the panel assessed it is unacceptable for no interim arrangements to be put in place to stabilise both the service and deliver improved outcomes for K&M patients.
- This recommendation is supported by the Getting it Right First Time (GIRFT) review of both services in 2018 with an ongoing requirement to make improvements now and the recent CQC findings at EKHUFT that strategic changes should not delay improvements being made to service delivery.
- Therefore a recommendation is made to put an interim solution in place.
- The panel assessed the available information and determined that East Kent provided the most suitable interim option for the inpatient Arterial Centre supported by an enhanced spoke at Medway.
- If agreed 'in principle' key lines of enquiry will be identified that will inform a business case, clearly evidencing the requirements to deliver against this recommendation

The following are of note:

- This business case for both the final solution of a single arterial centre and for the proposed interim solution will require approval by NHSE specialised commissioning.
- Specialised Commissioning South will consider the recommendation for the interim solution with a timeline for an 'in principal' decision by the first week of December 2018.
- If this direction of travel is approved public consultation is anticipated as the interim solution will be in place for a number of years and is likely to be a significant service change. The interim and final changes will impact of circa 200 patients per year regardless of the site approved.
- The JHOSC had been appraised and consulted on the process to this point
- The K&M Vascular network has a clinical forum established and the development of this interim model will be led through this group.

Current position

1. The Kent and Medway Vascular Review commenced in December 2014 in response to a commissioner led derogation[1] for both Trusts providing vascular surgery within Kent and Medway (East Kent Hospitals University NHS Foundation Trust (EKHUFT) at the Kent and Canterbury Hospital (K&CH) and Medway Foundation NHS Trust (MFT)). This review was led through establishment of a programme approach under the governance of a multi-stakeholder Kent and Medway Vascular Programme Advisory Board (PAB).

2. There are approximately 900 patients per year who receive inpatient specialist vascular surgery and on average 530 of those are treated within Kent and Medway. This is split across EKHUFT and MFT, with EKHUFT seeing more patients as the Trust is the provider of the AAA (abdominal aortic aneurysm) screening programme and hence planned AAA repairs are currently undertaken within the Kent and Canterbury Hospital site in Canterbury for patients from all parts of Kent and Medway. In addition to the specialist vascular services delivered by EKHUFT and MFT, a proportion of patients from the north and west of the county travel into South London to Guys and St. Thomas' Hospitals Trust for their surgery. This accounts for around 30% of the total activity.

3. The review identified a number of issues and developed a clear case for change which has been agreed by the PAB membership and presented to the Joint Overview and Scrutiny Committee (JHOSC). The case for change identified the inability of the two Kent and Medway Specialist Vascular provider Trusts, East Kent Hospital Foundation Trust (EKHUFT) and Medway Foundation Trust (MFT) to deliver against either the national specification for specialist vascular services or the guidelines from the national Vascular society for Great Britain and Ireland. The assessment illustrated that workforce is a key limiting factor for both trusts alongside the population numbers to deliver the required activity volumes for the core index procedures. There is a clear recognition that the sustainability of the services and improvement of patient outcomes is severely limited by these and other key issues.

4. Key gaps in compliance identified include;

    - The lack of a vascular network across Kent and Medway.
    - 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.
    - That the total number of some of the core index procedures undertaken is either borderline or below the recommended numbers within both Trusts.
    - The number of consultants is currently lower than required and the sustainability of consultant led 24/7 vascular and interventional radiology (IR) rotas (as required) is challenging. Indeed at the current time there is no guarantee that a patient with an emergency presentation will see a consultant with the requisite skills.

[1] NHS England has committed to ensure all patients requiring treatment from a specialised service have access to the same standard of service and the same clinical policy wherever they live. This approach was subject to consultation in later 2012 / early 2013. Detailed service specifications for specialised services, including vascular, were developed and these detail what NHS E as the commissioner requires from a service in terms of clinical practice, evidence base, quality standards and access criteria. Where providers were unable to move to the agreed common standards by April 2013, NHS England put in place time limited exceptions (or derogations) allowing providers to continue providing essential quality services for their patients whilst working to meet the new rigorous and coherent service specifications. The vascular services in Kent and Medway continue to be unable to meet the specified NHS England standards, hence remain in "derogation".

5. More recently, building on the case for change, a Getting It Right First Time (GIRFT)[2] review in 2018 identified a number of key issues for both of the Trusts (as reported at Kent and Medway PAB 29.3.18):

    - A hub and spoke model is required
    - Volume and outcomes to be addressed
    - The timelines for carotids and aneurysms (carotid endarterectomy (CE) and AAA surgery) to be addressed
    - Timelines to ward an issue
    - There is a need to focus on lower limb improvements
    - There are significant differences between both sites:

Outcomes	MFT	K&CH
AAA; 60 per year required	53	98
Carotid Endarterectomies; 40	24	78
Timeline to treatment for CE; 14 days max (7 days best practice)	33%	86%
Average LoS	18	8
National screening timeline	62 days (max 87)	44 days (max 50)

6. The lack of ability to deliver the national recommendations and to have sufficient levels of activity negatively impacts on the Trusts' ability to recruit and retain staff. This position is unlikely to alter until there is a decision on the future of Kent and Medway vascular services and the issues of low activity volumes addressed.
7. The assumption that the population from the north and west of the county which currently uses South London services could be redirected into Kent and Medway services was not supported through the review. This was due to both historical patterns of clinical behavior and patient choice, supported by current commissioners. The review concluded that if a centre of excellence were present within Kent and Medway then this may impact positively on both of these issues.
8. The recommendation of the review was to create a Vascular Network across Kent and Medway with a single arterial centre (e.g. to undertake the higher risk and complex procedures) supported by non-arterial centres with one operating as an enhanced non-arterial centres (e.g. a hub and spoke model). This model would be available to all Kent and Medway residents but no commissioning changes would be made to alter the current flow into south London.
9. This recommendation has been accepted by both Trusts and by Guys and St. Thomas' hospitals who provide services for the west and north of the county currently. This has also been supported through public engagement and the JHOSC.
10. A Kent and Medway Vascular Network has been established between EKHUFT and MFT and has developed a draft business case for consideration by NHS England Specialised Commissioning. Following detailed work with both clinical communities and patients the recommendation within the business case is for the arterial centre to be within EKHUFT and the non-arterial centre within MFT (subject to consultation if required).

[2] **GIRFT** is a national programme, led by frontline clinicians, created to help improve the quality of medical and clinical care within the NHS by identifying and reducing unwarranted variations in service and practice through benchmarking clinical services with their peers.

11. In line with the Keogh review of urgent and emergency care (2013) we would expect vascular services to be located on the site of a major emergency centre (MEC). The future location of the major emergency centre in East Kent will be determined through the East Kent Transformation Programme and be subject to public consultation. Currently two options are under development: Option 1 which see the MEC at the WHH in Ashford; and Option 2 that sees the MEC at Canterbury. Thus, the location of the inpatient arterial hub, if this is to be in east Kent, will be determined by the outcome of the East Kent Transformation Programme and the proposed consultation process.
12. All the options in East Kent see a major capital development at one of their main sites. Experience from elsewhere demonstrates that the process of securing capital, developing the pre-consultation business case, gaining agreement to consult and then consulting with the public and relevant stakeholders themselves, approval by the CCGs of a preferred option, development / sign-off of a Full Business Case and then finally undertaking the build will take between **five and ten years**, with seven representing good progress in most circumstances. The current EK urgent and emergency care pre-consultation business case is being modeled on a seven-year plus time period.

Interim solution

13. Due to the length of time it will take to put in the long-term timeline associated with the East Kent Transformation Programme, the need has been identified for interim solutions for a range of services (where there is a strong case for change and / or concerns about the sustainability / viability of services). Vascular is one such service and during the interim period, while the final site is both agreed and implemented, the Kent and Medway Vascular Network has been charged with ensuring the following four critical deliverables are in place across the network.
    i. A joined-up approach to multidisciplinary teams / meetings, i.e. operating as a single approach across both services rather than within individual organisations
    ii. Maximization of use of resources
    iii. Improved and consistent outcomes for all Kent and Medway patients
    iv. A single surgical consultant on call rota
14. Despite some progress towards collaborative working with shared multidisciplinary teams / meetings (MDTs and MDMs) starting to take place there has been no progress on delivering a single on call rota or making significant progress on improving outcomes across Kent and Medway patients.
15. In the intervening period of the review there has been insufficient improvement on the key areas of non-compliance for either Trust and the outcomes for the core procedures remain unchanged.
16. Following a discussion at the PAB in May 2018 it was confirmed that despite the network Board being established and clinical relationships being built, there was little chance of improving or sustaining outcomes or creating a single on call rota without putting an interim model in place and the next section of this document explores the rationale for putting in place an interim solution.

Case for change for an interim model

17. The key issues within the original case for change remain and limited progress has been made in addressing them.
18. Whilst there has been some improvement in staffing this is insufficient and does not fulfill best practice requirements. There are concerns regarding the sustainability of the current workforce. There has been little progress against improving outcomes for patients and

this is unlikely to change if the current service provision remains until the final solution is implemented.

19. Vascular inpatient activity continues to be delivered at both hospital sites and despite the network being established neither unit is compliant with the national service specification (NSS), i.e. remain in derogation. This is consistent with the original case for change and relates particularly to low consultant numbers and low total numbers of population served.

20. The key issues currently include;

- The current timeframe for implementing a final disposition of vascular services in east Kent is likely to be an absolute minimum of five years, with seven years representing good progress and up to ten years is possible. During this time there is unlikely to be any progress on addressing the issues evidenced in both the case for change and GIRFT review. As such it is unlikely that the services will be able to preserve or enhance clinical outcomes within a reasonable time frame for patients.
- The lack of an agreed interim model perpetuates the current tensions between the two clinical teams impacting on making real progress on collaborative working. This negatively impacts on the ability to deliver the required clinical improvements (as noted by GIRFT) and the objective of improving. This, and the uncertainty of the timeline for implementation of the final model outlined in the point above, continues to impact of recruitment and retention and this is unlikely to stabilize without clarity.
- Despite some progress towards working collaboratively there remains absence of a current clinical consensus around an interim operational model and this is impacting on implementation of well-established best practice guidance.
- Both Trusts are under considerable pressure with their wider operations including the urgent and emergency care pathways and there is a risk that this may impact on the vascular services if they are not stabilised in this interim period.
- The JHOSC are anxious to understand why the agreed changes have not been formally agreed and implemented (and through this improvements to patient outcomes being delivered).

21. In summary, NHS England has identified that:

i. The K&M Vascular network has confirmed that they remain committed to the agreed long-term model and their preferred site for the arterial centre is within east Kent. They are unable to address the case for change and subsequent recommendations without an interim option being agreed (i.e. the network has been unable to find an agreed interim arrangement that addresses the case for change and delivers the GIRFT recommendations).

ii. The implementation of the final model is unlikely to be earlier than five years minimum and most likely to be seven years plus. This was assessed by external clinical advice, the regional medical Directors, Specialised commissioning and the STP as unacceptable in relation to improving clinical outcomes for patients in Kent and Medway. It was strongly felt that an interim solution needed to be identified and implemented that delivers benefits to patients.

iii. Recruitment and retention in this period of uncertainty is challenging, this is a specialist clinical area where staff have a number of choices and will be unlikely to choose an unstable area and/or an area where clinical outcomes are not optimal.

iv. There is a considerable risk that delaying implementation for a number of years (as likely) will further destabilise the existing service and workforce.

22. In conclusion, the risk of destabilisation of the existing service and workforce whilst awaiting implementation of the final solution is considerable. Awaiting a long-term model to deliver the required clinical improvements and deliver best practice for patients is

assessed as unacceptable.

23. On the basis of the above NHS England, with the support of the STP, has proposed that an interim model is required and an options appraisal of the interim model needed to be undertaken.

Interim Model Options Appraisal

24. NHS England, supported by the providers and the STP, has identified four potential options for the interim solution. The options have focused on the delivery of the arterial centre on one of the two existing sites (K&CH or MFT) and the remaining site to operate as the non-arterial spoke. Table 1 details the four options.

Table 1; Possible interim options

Option 1	Maintain current arrangements and accept the risks relating to workforce and improved quality
Option 2	Maintain the services on both sites and establish a shared on-call rota
Option 3	Interim single arterial centre on the K&C site and non-arterial centre on the MFT site
Option 4	Interim single arterial centre on the MFT site and non-arterial centre on the K&C site

25. Initially the network considered the interim solutions but were unable to reach an agreement on the preferred option and have advised the PAB that this requires a commissioning decision. Therefore, NHS England, as the lead commissioner and supported by the PAB, has undertaken a table top exercise reviewing the interim options against the evaluation criteria within the business case.

26. In evaluating the interim options, the PAB has drawn upon the review of the clinical models that identified the long-term solution (i.e. the proposal for a single arterial centre to be located in east Kent). This has included adhering to the key principles of the original review, namely:

- Minimum population numbers served to enable the minimum numbers of core index procedures able to be performed
- Delivery of the required number consultant vascular and IR consultants to deliver a 24/7 rota
- Dedicated vascular facilities including wards and hybrid theatre(s)

27. It should also be noted that within the original review:

The Kent and Medway Clinical Reference Group, which supported the PAB in undertaking the original review of the long-term solution, agreed that the option of sharing a consultant rota across two sites was not clinically safe or sustainable. The Vascular Society has supported this model only in exceptional circumstances which are not relevant within Kent and Medway.

- Minimum population requirements and patient flows were reviewed. Following lengthy discussions, the PAB agreed that the existing flows of the west and north of the county into London were fit for purpose and should not be altered through commissioning decisions as part of the review. Any patient flow changes should be due to patient and clinical choice which may occur if a new Kent and Medway service became a centre of excellence.
- Detailed analysis of travel times and access was also reviewed including travel time modeling undertaken both externally and by SECAmb. Agreement was reached that there is no specific travel time target as key is the need for clear transfer protocols

between non-arterial centres and the arterial center. SECAmb noted that travel times were also dictated by individual patient clinical presentation. Therefore, the review recommended that an hour travel time form the time of referral to a specialist vascular unit was to be used as a guide not a target. The review of the patient flows indicated that access within the recommended travel and clinical assessment time is not an issue for patients accessing either site (i.e. east Kent or Medway), This remains relevant for any interim model.

28. Whilst the above relate to the review of the long-term options, it was felt the above three points were relevant in relation to identifying an interim solution. Therefore, the issue of access / travel times and the patient flows / volumes has not been reviewed as part of the identification of an interim option. This would undermine already approved principles and be counter to the outcome of that appraisal process. Clinical adjacencies have been reviewed in relation to the adjacencies to A&E and are considered in the options appraisal by the panel.

29. A number of key additional elements were identified that were felt to require consideration during the process for identifying an interim option. These included:

    a. Is the current position sustainable from a quality, finance or workforce perspective, namely:

        i. If the outcomes cannot be improved during an interim arrangement due to the lack of a single rota, is it acceptable to continue with variable outcomes for Kent and Medway residents through the current arrangements within the two services / will an interim solution improve outcomes for patients across Kent and Medway?

        ii. What are the financial impacts of an interim solution?

        iii. What are the workforce implications of an interim solution?

        iv. Which option provides the best chance of achieving a sustainable service that can deliver improved outcomes across Kent and Medway?

    b. Capacity; the ability of either Trust/site to take on the activity with minimum disruption and to manage within the Trust pressures currently

    c. Overall deliverability of the plans set out by the Trusts, namely:

        i. The ability to deliver within a reasonable time frame,

        ii. The degree of change required within the site

        iii. Ability to deliver within the capacity restraints and service challenges currently in place in both Trusts?

        iv. Which option can be delivered within the earliest safest timeframe?

    d. Clinical safety; the impact of clinical adjacencies and management of additional demand within the clinical demands of the unit at the time

    e. Strategic fit; the impact of wider strategic plans and the long-term solution agreed by the Board

30. It was recognised that engagement with providers was a vital component of the process to identify an interim solution. Therefore, each trust has been asked to consider their ability to deliver an interim option. This included reviewing the key additional elements noted above and self assessing against these.

31. Both Trusts currently operate a single IR rota that supports both vascular patient and non-vascular urgent /emergency care. In either scenario it is proposed that the resident IR team at the arterial centre will continue to support both patient cohorts. This requires consideration of the IR requirement and provision at the non-arterial centre. Discussions are underway to identify an agreed model however a shared rota across Kent and Medway is not a popular choice with a number of IR consultants. Further detail has been

requested with regard to delivery of the Interventional radiology service (IR) this includes consideration of both vascular and non-vascular IR.

32. **Therefore, further work is required in settling the future disposition of IR services, and an initial response has been sought from the Trusts.** A detailed risk assessment will in due course be required to ensure safe and consistent delivery of both vascular and non-vascular IR using the network approach currently in place across the existing Kent and Medway non-vascular sites (Darent Valley Hospital (Dartford), Maidstone Hospital, Pembury Hospital (Tunbridge Wells), Queen Elizabeth the Queen Mother Hospital (Thanet) and William Harvey Hospital (Ashford)).
33. An assessment meeting was held on the 31st August 2018. Membership of the panel and contributions to the decision making included:
    i. An external consultant vascular surgeon and Vascular Society representative
    ii. The Kent and Medway STP Programme Director
    iii. NHSE Specialised Commissioning
    iv. NHE England, Medical Director (South East) and Review Programme SRO
    v. NHS England, Regional Medical Director Specialised Commissioning (South).
34. Both Trusts self assessments and responses were duly considered, alongside the findings of the original clinical models work by the PAB clinical reference group and the most recent GIRFT findings.
35. The initial assessment indicated that an **interim option is required** due to the significant period it will take to implement the final model. To delay improvement or risk deterioration of current clinical outcomes for patients across Kent and Medway was not regarded as acceptable by any panel member. Previous JHOSC meetings have clearly identified concerns re delay in resolving this issue and the need to progress to improve outcomes for patients and ensure a sustainable K&M service. The move to a single arterial centre, in line with the sought-after long-term solution, was felt to have demonstrated a range of quality and sustainability benefits (i.e. moving the Kent and Medway services out of “derogation”). Waiting for these benefits to be delivered through the implementation of the long-term service model for east Kent, was felt to leave a large portion of the Kent and Medway population with a service level below the mandated quality standard for an inappropriate length of time. This led the group to discard the “as is” option (i.e. Option 1).
36. The group further reviewed the information available in relation to Option 2 to 4.
37. **On the basis of the information available the recommendation is that this should be on the Kent & Canterbury site.**
38. The key points leading to this decision include that this option:
    i. is assessed as having the best capacity and clinical ability to deliver the interim solution with minimum disruption (the current capacity at the K&C site for both beds and ITU space with no significant capital investment was a key consideration)
    ii. this option is also likely to minimise any impact of emergency vascular care on the existing A&E pressures
    iii. puts the interim service within the trust that is the favoured option for delivering the long-term solution
    iv. recognises current outcome data that indicates better outcomes from the K&C based service
    v. ITU capacity and costs and potential time to reconfigure associated with creating an interim solution at MFT limit the option of MFT as the arterial centre

39. The concern of stakeholders in relation to the co-adjacency of emergency vascular services and an emergency department were discussed (i.e. recognising that consultant led emergency care is not provided at the K&CH). It was noted that the NHS England review, led by Sir Bruce Keogh (2013) into urgent and emergency care recommends the location of vascular services within a major emergency centre (MEC), as proposed in the long-term solution for Kent and Medway (as outlined earlier in this paper). This is an issue for an interim move to the current K&HC site, which does not have a consultant-led emergency department on site. However, the panel were advised that whilst this is the optimum position (i.e. co-location of a vascular service on a site with a consultant-led emergency department) there is precedent for vascular arterial centres to be located on sites without an emergency department and, through robust development of patient pathways, these have been able to meet the required quality standards. It was also noted that the existing arrangements in K&CH have been in place for a number of years with no impact on patient outcomes; indeed K&CH outcomes are confirmed as good. The panel agreed that this was not a determining factor for choosing an interim solution but that the preferred long-term solution remained co-location of the inpatient arterial centre in a MEC (i.e. alongside a consultant-led emergency department). This concern would however require careful consideration by the clinical members of the network to establish comprehensive clinical pathways.

40. All options had a number of inherent risks. Those associated with Option 3 will need to be addressed as part of the process going forward. The initial risks identified are outlined in Table 3.

Table 3: Initial risk assessment:

Risk	Initial mitigation
Staff unwilling to move to the preferred site	• Assess ability of existing networks to facilitate effective transfer of clinical staff between service locations • Assess risk and ability of preferred site to manage activity safely with existing staff • Assess ability to recruit additional staff externally for the interim model
Inability to deliver both a vascular and non-vascular IR rota	• Assess risk for vascular and non-vascular patients • Assess ability to deliver activity from within the preferred site IR establishment • Put in place agreed clinical protocols for urgent and emergency IR and surgical access on the non-arterial site
Cohesion of the network and robustness of joint working across the arterial and non-arterial site	• OD plan for the network including engagement work commissioned
Challenge on an interim move by key stakeholders	• Ensure clarity re the need for an Interim model • Ensure clarity re this being an interim move with consultation for a long-term solution to be undertaken • Engagement with the JHOSC and key stakeholders prior to implementation

Process next steps

41. **The recommendation identified in this paper will go to NHSE Specialised Commissioning in October 2018 for approval in principle**. This decision to be taken by the end of the first week in December 2018. During this period a number of key lines of enquiry may be addressed to further inform this decision.

42. **If approved in principle, NHSE specialised commissioning will further identify key lines of enquiry to inform a business case**. This will include the requirement for EKUHFT to work in partnership with MFT across the network, outlining the viability of the proposal and including an implementation plan for the interim solution (with a timeline for delivery and detailed assessment of the risks and benefits).

43. A range of specific issues were identified, which will need to be identified in the business case:

    a. Clear clinical protocols for managing both emergency and urgent vascular assessment and intervention on the non-arterial hospital sites across Kent and Medway (excluding Darent Valley Hospital, Maidstone Hospital and Pembury Hospital who are supported by the London pathway)

    b. Review models for rehabilitation and repatriation, and establish clinical protocols

    c. A robust IR rota and pathway to support non-vascular patients at the non-arterial sites across Kent and Medway (excluding Darent Valley Hospital, Maidstone Hospital and Pembury Hospital who are supported by the London pathway)

    d. An implementation plan that includes timelines, risk mitigation actions and costs

    e. Consideration of the ability to repatriate appropriate patients to the non – arterial centre for recovery/rehabilitation

    f. A workforce plan outlining required staffing and how this requirement will be met

    g. Clarity on any financial investment and or risk required with the interim proposal.

44. Public consultation plan to be developed with regard to implementing an interim option

45. The K&M Vascular network to ensure that the clinical members are fully sighted and engaged to developing the interim model. It is key to the success of both the interim and long-term model that the network is strengthened and develops a network approach to the model of care supporting both patients and staff within the service.

Public and stakeholder engagement.

46. Public engagement events have been considered due to both the length of time since previous engagement events but also due to the delays in delivering a final solution. In the event of an interim solution being approved a formal consultation may be required due to the length of duration of any interim solution.

47. A formal consultation plan is being developed and will be shared with the JHOSC and will be aligned to the likely East Kent Consultation as appropriate.

48. A K&M vascular network event was held on the 20th September with detailed discussions on the process and recommendations for an interim model. There continue to be concerns with regard to the clinical pathways required to ensure safe sustainable services and the impact on interventional radiology. This is particularly key for non-vascular interventional radiology. The network will continue to develop clinical pathways and protocols to address these concerns and the business case for the interim model will be required to address any clinical concerns before it can be approved.

49. Feedback from the JHOSC in October 2018 to be conveyed to Specialised Commissioning. The JHOSC members to be advised of the decision and any additional requirements as identified by Specialised Commissioning as part of both the initial in principle decision making and the formal decision. Regular updates on progress of an interim model , if approved to be provided to the JHOSC.

50. The JHOSC is asked to;

- Note the report and discuss the recommendations
- Advise on the recommendations and next steps
- Advise on the proposal for consultation with regard to the interim option