SCOPE : VASCULAR DISEASE

Name of Service: VASCULAR DISEASE

Does the scope reflect version 3 of the Specialised Services National Definitions set?

The scope reflects the Specialised Services National Definitions set (version 3), with the proviso that many services that were originally considered non-specialised in the SSNDS (version 3), are now classified as specialized. This reclassification reflects the change in speciality status, service provision and reconfiguration, which has occurred throughout the UK since the publication of SSNDS version 3.

Since the SSNDS (v3) vascular surgery has been granted status as an independent speciality (16th March 2012), with a separate curriculum, SAC and examination. Training will encompass provision of vascular services with little or no component of general surgery. In the future consultants in vascular surgery will not be able to offer additional service provision in general surgery and will concentrate solely on provision of vascular surgical services.

In parallel with the move to specialist status, there has been significant reconfiguration and centralization of vascular services in the past 5 years. Reconfiguration has been driven by commissioners professional advice (Provision of Vascular Services 2012), the need to improve patient outcomes and the initiation of the National Abdominal Aortic Aneurysm Screening Programme (NAASP).

The changes in speciality status and service reconfiguration were anticipated by SSNDS (v3). This document suggested that some services, which were at that time considered non-specialised, would become specialized:
"However over the next few years vascular disease surgery services are likely to be concentrated in fewer hospital sites which may eventually numberless than 50. In support of this it should be noted that there is now good evidence - see Section6, reference: Holt PJ et al - that for aortic aneurysm surgery, outcomes improve as volume increases. (A treatment threshold of about 30 aortic aneurysms per annum would equate to around 50 hospitals covering the whole of England; currently there are well over 50 hospitals providing a service.) The majority of members of the Vascular Society of Great Britain and Ireland specialise and only treat vascular disease"

The change in classification is reflected below in the suggested scope for commissioning vascular disease:

Non-Specialised Radiology: · diagnostic angiography, magnetic resonance imaging (MRI), computer tomography (CT), ultrasound and duplex · angioplasty, stenting and thrombolysis for occlusive disease · management of deep vein thrombosis (DVT) and pulmonary emboli including inferior vena cava (IVC) filter implantation · embolisation for haemorrhage control, tumours and fibroids **Specialised Radiology** · stent grafting for abdominal aortic aneurysms · thoracic aortic stent grafts for aneurysms, trauma, dissection, etc. · carotid stents · management of vascular malformations · angioplasty and stents to manage coarctation of the aorta.
Non-Specialised Vascular Surgery (Elective)
· diagnostic angiography, interpretation of computer tomography (CT), ultrasound and duplex
· amputations
· treatment of diabetic foot conditions
· thoracoscopic sympathectomy and hyperhidrosis treatment.
Non-Specialised Vascular Surgery (Emergency)
· treatment of iatrogenic vascular injury
Specialised Vascular Surgery (Elective)
· carotid endarterectomy for stroke prevention
· bypass procedures to the upper limb and neck
· bypass procedures for aorto-iliac and lower limb occlusive disease
· infrarenal abdominal aortic aneurysm repair (including endovascular repair)
· peripheral and visceral aneurysm repair (including open and endovascular treatments)
· treatment of popliteal artery entrapment
· vascular reconstruction following operations for cancer resection
· treatment of aortic arch and thoraco abdominal aneurysms (including complex endovascular therapy with fenestrated, branched endografts)
· treatment of aortic dissections
· thoracic aortic stent grafts for aneurysms, trauma, rupture, dissection, etc
· open or endovascular surgery for thoracic and thoracoabdominal aortic aneurysms (ruptured or electively)
· 1st rib resection for thoracic outlet syndrome
· surgery for carotid body tumours
· treatment of infected aortic grafts
· treatment of mid-aortic syndrome
· complex revision arterial surgery
· treatment of vascular malformations
· deep vein reconstruction

· treatment of difficult aneurysms by:
o fenestrated and branched aortic stenting
o laparoscopic aortic surgery
o robotic vascular guidance
· paediatric vascular surgery (included in Definition No. 23, Specialised Services for Children for commissioning purposes).
Specialised Vascular Surgery (Emergency)
· treatment of ruptured or leaking abdominal aortic aneurysms (either by open surgery or endovascular techniques)
· treatment of acute limb ischaemia – both surgical and endovascular
· treatment of vascular trauma including life threatening bleeding from any source.
· interventions for DVT

Does the scope reflect existing service specifications and policies, where they exist? Please list any considered.

Vascular services encompass a wide range of conditions but the majority of patients undergo specialized treatment for aortic aneurysms, carotid disease or lower limb atherosclerosis. These conditions have been addressed within guidelines and policy documents. The scope reflects the following service specifications and policies:

a. **Provision of Vascular Services 2012 (POVS**): the most recent iteration of POVS from the Vascular Society of Great Britain and Ireland. Sets down policy for delivery of vascular services and service specification.
b. **NICE guidelines. Endovascular stet grafts for abdominal aortic aneurysms 2009**
c. **NICE guidelines. Endovascular stent graft placement in thoracic aortic aneurysms and dissections. 2005**
d. **NHS AAA Screening Programme Quality Criteria**: sets down an 800,000 population requirement for screening programme and intervention centre
e. **National Collaborating Centre for Chronic Conditions. Stroke: national clinical guideline for diagnosis and initial management of acute stroke and transient ischaemic attack (TIA). London: Royal College of Physicians, 2008**: suggests standards for vascular intervention after stroke or TIA
f. **NICE clinical guidance. Lower limb peripheral arterial disease. 2012**
g. **Regional reviews into vascular services**: there are a number of regional reviews into vascular service delivery. Some are completed and some under construction. The London Health Programmes Cardiovascular Review is cited as an example of the need to utilize service reconfiguration and centralization to improve patient outcomes.
h. **AAA Quality Improvement Programme (http://www.aaaqip.com/aaaqip/index.html)**
i. **Healthcare Quality Improvement Partnership UK Carotid endarterectomy audit (http://www.hqip.org.uk/national-carotid-interventions-audit)**

Does the scope reflect any agreed professional standards, both those listed in the SSNDS and those developed since their publication? If the service is a paediatric service, does it reflect the clinical relationships set out in *Commissioning safe and sustainable specialised paediatric services: a framework of critical inter-dependencies*? Please list those developed since publication.

The scope reflects the agreed professional standards for the delivery of vascular services. **Provision of Vascular Services 2012 (POVS**) defines service specification and policy for vascular surgical services. This document, published by the Vascular Society of Great Britain and Ireland is endorsed by the following societies: Association of Surgeons of Great Britain and Ireland, British Society of Interventional Radiology, British Society of Endovascular Therapy, Circulation Foundation, General Surgical Specialist Advisory Committee, Irish Association of Vascular Surgeons, Rouleaux Club, Society of Academic and Research Surgery, Society of Vascular Nurses, Society for Vascular Technology of Great Britain and Ireland, Vascular Anaesthesia Society of Great Britain & Ireland

Does the scope reflect national policy direction, where this exists? Please list the names of policy/ies reflected.

a. The scope reflects the agreed professional standards for the delivery of vascular services. **Provision of Vascular Services 2012 (POVS**) defines service specification and policy for vascular surgical services. This document, published by the Vascular Society of Great Britain and Ireland is endorsed by the following societies: Association of Surgeons of Great Britain and Ireland, British Society of Interventional Radiology, British Society of Endovascular Therapy, Circulation Foundation, General Surgical Specialist Advisory Committee, Irish Association of Vascular Surgeons, Rouleaux Club, Society of Academic and Research Surgery, Society of Vascular Nurses, Society for Vascular Technology of Great Britain and Ireland, Vascular Anaesthesia Society of Great Britain & Ireland.
b. The scope reflects policy from the NAAASP, which has set policy and quality standards for delivery of the NAAASP (http://aaa.screening.nhs.uk/)

Does the scope result in fewer than 50 providers (if the service is for all ages) and fewer than 20 providers for children‟s services? If not, explain the reason for this.

Vascular services are undergoing change at present. Vascular surgery has been granted speciality status and most regions of the UK are going through vascular service reconfiguration. The NAAASP has been initiated with a population requirement for a catchment area of 800,000 for an intervention centre. The changes are centralising arterial intervention using a hub and spoke model. It is likely that there will be 50 or less arterial intervention centers following these changes.

The changes in speciality status and service reconfiguration were anticipated by SSNDS (v3). This document suggested that some services, which were at that time

considered non-specialised, would become specialized:
"However over the next few years vascular disease surgery services are likely to be concentrated in fewer hospital sites which may eventually numberless than 50. In support of this it should be noted that there is now good evidence - see Section6, reference: Holt PJ et al - that for aortic aneurysm surgery, outcomes improve as volume increases. (A treatment threshold of about 30 aortic aneurysms per annum would equate to around 50 hospitals covering the whole of England; currently there are well over 50 hospitals providing a service.) The majority of members of the Vascular Society of Great Britain and Ireland specialise and only treat vascular disease"

The scope for paediatric vascular services are less well defined and a specialized commissioning policy will need to be developed for this service. This service will be confined to less than 20 centers nationally

Is the scope based on factors that can be objectively measured? What are the objective measures?

The scope can be objectively measured as the arterial interventions may be identified using current HES data, which can quantify number of cases, crude outcome measures and the number of providers. In addition there are three independent sources of data that may be used to assess procedural outcomes and providers within the scope:

a. **AAA Quality Improvement Programme (http://www.aaaqip.com/aaaqip/index.html):** most recent report has quantified AAA outcome and concordance with HES data (Outcomes after elective repair of infra-renal abdominal aortic aneurysm – a report from the vascular society 2012)
b. **Healthcare Quality Improvement Partnership UK Carotid endarterectomy audit (http://www.hqip.org.uk/national-carotid-interventions-audit):** the 3rd audit report assesses UK outcome and practice
c. **Quality reports from NAAASP**

What are the consequences of introducing the scope? For example: including activity that is not specialised, excluding specialised activity that takes place outside of specialised centres, excluding activity that takes place in outreach clinics.

The scope for specialized commissioning of vascular disease refers exclusively to procedures performed in arterial intervention centres. It is unlikely that any procedures will be performed in clinics or any setting outside of high volume arterial intervention centres.

Are there any financial consequences of introducing the scope? For example, loss of income for providers that would no longer be considered to be specialised.

Please describe any political consequences of introducing the scope? For example, exclusion of providers who deliver a specialised service within an otherwise non-specialised setting or unhappiness amongst patient groups

Would the scope benefit or disbenefit particular CCGs? For example, if non-specialised activity was included because it takes place within a tertiary centre, would the CCGs that refer to that centre benefit. What would be the impact of the scope on technologies/drugs that are currently often commissioned through individual funding requests?

Please describe any complexities in introducing the scope. For example, if the service is not currently commissioned by SCGs, will it be very difficult to assess the current level of spend on the service?

Is this an „interim" scope? What could practically be done to refine the scope so that it better differentiated between directly commissioned services and those commissioned by CCGs?