ANNEX B

# Vascular Services Review
# Mid-Mersey Impact Assessment
# October 2011

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# Vascular Services Review
# Mid-Mersey Impact Assessment

## Introduction

1. This is the report of an Independent Panel convened to hear evidence from the Mid-Mersey Vascular network on the impact of implementing a recommendation of the Cheshire and Merseyside Vascular Services Review (The Review) not to designate Warrington Hospital as a Vascular Centre.

## Background

2. In 2010 the commissioners across Cheshire and Merseyside undertook a review of vascular surgery. Similar reviews have been or are being carried out across the country based upon standards set out by vascular specialists themselves. The aim of the review was to recommend a service configuration for vascular surgery that would meet the clinical standards as set out and provide the best possible access and care for the population served. The review covered the Cheshire and Merseyside area excluding people living, east of the M6 in Cheshire who are served by a Manchester Vascular Network and people in the south of Cheshire who will in future be served by a vascular network based in Stoke-on-Trent which includes Leighton Hospital in Crewe. Patients east of the M6 north of Warrington in areas such as Ashton, Leigh, Golbourne and Atherton are part of the Mid-Mersey Network.

3. The criteria chosen by the clinical panel to determine which trusts should be nominated as a centre were locally agreed. Across the country other local clinical teams have established their own criteria, some of the numbers of procedures required differ, however this was known at the outset of the review and set by the clinical panel.

4. The Review was tasked with ensuring that specialist doctors including vascular surgeons and interventional radiologists were available equally to everyone at all times. Achieving the availability of Interventional Radiology 24/7 was of particular importance, as increasingly the “gold” standard treatment for arterial occlusion and even haemorrhage in a range of specialties across a hospital involves interventional radiology. Royal College guidance (2008) BFCR(08)13 Standards for providing a 24-hour Interventional Radiology service highlighted the risk to patients that an absence of Interventional Radiology posed.

5. In addition the NHS is rolling out a screening programme to screen older men for abdominal aortic aneurysms. Men who are discovered to have the condition need specialist treatment to reduce their risk of dying from their aneurysm. At present, local vascular services are not set up to undertake a screening programme which would meet the standards required by the NHS. The review was asked to ensure this was taken into consideration.

6. The Project Review Board which was supported by a local clinical panel concluded that to achieve these aims services needed to be delivered from fewer (2) centres across the area. This was based on research that shows that the chances of survival and improved quality of life after treatment of arterial diseases are greatest when patients are treated by a highly trained specialist team carrying out large numbers of procedures and working in a large centre to which patients are referred, or, in an emergency transferred.

7. The review supported a proposal for a network North of the river Mersey centred on the Royal Liverpool and Broadgreen University Hospitals NHS Foundation Trust and incorporating Aintree University Hospital NHS Foundation Trust, and the Southport element of Southport and Ormskirk Hospitals NHS Trust. The location of the Southern Centre has not been determined by the Review Board in its recommendations. The review Board cited two possibilities and this has yet to be considered further by the Commissioners.

8. The Mid-Mersey Vascular Network original proposal for a centre based on their current catchment was not supported during the review and this was communicated by letter to the trusts involved. As a result the trusts felt it was important to carry out an impact assessment of the original decision not to have Warrington Hospital designated as a vascular centre.

9. An independent panel was convened by the commissioners (Primary Care Trust Cluster and Warrington Clinical Commissioning Group) to carry out the assessment.

**The Impact Assessment Process**

10. The panel met with the trusts for an initial meeting (the chair was not present for that meeting nor was Dr Gerry Murphy) to agree the Terms of Reference and agree the assessment process. The Panel then met with the Trusts for a whole day on three occasions (Dr Roberts was unable to attend the last meeting on 26th September) to consider evidence presented to them.

    The Panel Consisted of

| | |
|---|---|
| Mrs Helen Bellairs (Chair) | Independent Management Consultant |
| Dr Gerry Murphy | Consultant Interventional Radiologist |
| Dr Geoffrey Roberts | Director Geoff Roberts Associates Ltd<br>Cheshire Deputy Coroner |
| Professor Anthony Watkinson | Consultant Interventional Radiologist<br>Royal Devon and Exeter NHS FT<br>(Distinguished Fellow of the Cardiovascular & Interventional Radiological Society of Europe (CIRSE).<br>Past President of the British Society of Interventional Radiology (BSIR)) |

11. The panel was nominated by both the Trusts and the Commissioners (NHS Cheshire, Warrington and Wirral and the Warrington Clinical Commissioning Group) and its make up reflected the major concern that the Trusts had about the loss of major vascular work, the potential for a serious loss of Interventional Radiology to other services, alongside the loss of crucial immediate vascular surgical input in an emergency to other specialities. The panel was free to seek any other advice or input as necessary.

    The terms of reference were-:

    - Meeting with Clinical and Managerial staff at Warrington & Halton Hospitals and St Helens & Knowsley Trust to listen to their concerns, re the impact of losing vascular surgery and other arterial services.
    - Defining with staff the exact nature of the interventional radiology services that they believe would be in jeopardy as a result of non-designation, and the impact of this on the hospital and the population it serves.
    - Defining with staff the exact nature of the concerns in respect of Trauma Unit status and the Stroke Pathway.
    - Assessing the risk of these impacts occurring and their severity if they did occur.
    - Considering the risk in the context of reconfiguration of vascular services in Cheshire and Merseyside.
    - Considering the risk in the context of services received by the people of Warrington, Halton, St Helens and Knowsley.
    - Reporting to Warrington Health Consortium.

12. The impact evidence was presented in a series of clinically led presentations involving all specialities in Warrington who have concerns about the significant detrimental impact of the loss of arterial work (and therefore vascular surgeons and Interventional Radiologists) based at Warrington Hospital. They included-:

    - Consultant Vascular Surgeons
    - Consultant General Surgeons with colo-rectal interest.
    - Warrington and Halton Hospitals NHS Foundation Trust Audit & Governance Lead
    - Interventional Radiologists
    - Consultant Stroke Physicians
    - Consultant Diabetologists
    - Consultant Urologists
    - Consultant Gastroenterologists
    - Consultant Obstetrician & Gynaecologists
    - Consultant Trauma & Orthopaedic Surgeons
    - Consultant Intensivist & Lead Vascular Anaesthetist
    - Consultant Intensivist & Warrington and Halton Hospitals NHS Foundation Trust Trauma Lead
    - Warrington LINKs
    - Halton LINKs
    - A Service User who had a ruptured Aortic Aneurysm in Jan 2011
    - North West Ambulance Service

13. The evidence prented was also provided in written summary form throughout the process by the Warrington and Halton Hospitals NHS Foundation Trust.

14. St Helens and Knowsley Hospitals NHS Trust is currently served, for vascular services, by Warrington and Halton Hospitals NHS Foundation Trust and they focussed, in particular, upon the inevitable disruption to already working (10 years in the making) clinical relationships and partnerships. They also highlighted the increasing number of jointly provided services as the two trusts increasingly work together for strategic service development in the light of the Mid-Mersey QIPP.

15. The panel made clear at the outset that the purpose of the Impact Assessment was not to re-run The Review, but to explore the potential impact or unintended consequences arising from the implementation of a recommendation that did not include Warrington Hospital as a designated centre. We also made it clear that it was important that the Trust focussed on what made Warrington unique, as centralising services would always mean some trusts would cease to provide services in their own right and would become part of a network/outreach arrangement.

16. During the process the clinicians from both Trusts consistently and universally raised concerns about the review criteria, the evidence (or lack of it) for them, the lack of transparency of the review and the lack of a wider and deeper clinical and organisational engagement in the process. They also raised questions about why the process chosen by Cheshire and Merseyside differed from those used in other NW processes. They described the other processes as more inclusive, and suggested that across the northwest there were significantly different service models (hospitals sharing centre status with different elements of the arterial service under review being centred on different trusts) being proposed.

**The panel noted that this was a real and strongly held perception of the process and that it played a significant part in their strong desire to describe the impact the decision would have on Warrington and their anxieties about the detrimental effect on local services. The hospital clinicians felt that the impact assessment was the first time they had had a real opportunity to describe the service they offered and to be properly engaged in a process. The panel agreed to make this point in the report but stated they would be making no comments or observations about the review or service model in the report.**

**The Evidence and the Panels Views**

17. The evidence was presented by clinicians throughout the process. One of the things that struck the panel in particular was the passion and enthusiasm that all clinicians had for how they worked together as clinical teams within individual trusts, how they were reliant on each other for delivering high quality care and how joint working across the two trusts was essential to both their clinical strategies and

aspirations for improvements across a range of services for the population they served.

**There was a strongly evident and consistent level of trust between clinicians within the individual trusts across clinical specialties and across the clinical teams in the two trusts. The clinicians on the panel felt this was, even if not unique to the two trusts, very highly developed and embedded and unusual.**

18. An emerging Mid-Mersey clinical strategy incorporating both trust strategies and joint strategies where that made sense clinically and financially was held dear by both clinical groups and a list of these was shared with the panel.

19. This integration was particularly evident for vascular services where they have been working together for 10 years. The two trusts have been working on a strategy to develop the services further, expanding the Vascular Surgical rota to 1:6 (on hold because of the review) and establishing a (long overdue) joint 1:6 rota for Interventional Radiology from October 2011.The newly formed joint stroke service, evidence of which was presented to demonstrate this was functioning very effectively across the two trusts, is also key to the two trusts plans for joint working. The clinicians felt this was further evidence of the two trusts successful integration of services.

**The Panel acknowledged that joint working was relatively well developed compared with many other health communities and seemed well accepted by the clinical teams and supported by management. Whilst the panel felt that to disrupt an existing vascular network was counter to the way other services were developing between the trusts, the panel also acknowledged that it was unlikely that all service configurations would fit neatly into that model or any other. The clincians on the panel felt strongly that a possible solution that maintained these relationships should be sought if at all possible.**

20. It was a disruption to this relationship in the vascular service that particularly concerned the St Helens and Knowsley hospital team, they felt that they would be forced through unintended consequences to change their partnership to the Liverpool Network if Warrington was not designated as a centre. This would in their view happen because the distance from them to the other potential southern centre would not meet the travel criteria for patient access or the transfer times required in an emergency.

**The clinicians on the panel agreed that from the evidence presented they would almost certainly have to move to the Liverpool Network and agreed that the development of clinical relationships and trust took time and was one of the most difficult aspects of service change. If Warrington moved towards the Southern Network, and was not the centre the disruption of a successful working relationship with St Helens for vascular services was highly likely and**

**was an unintended consequence that was one of the most difficult to mitigate. All of the clinicians on the panel recognised that to get to the level of joint working currently in place would take a significant period of time (years).**

21. The North West Ambulance Service suggested that if emergency patients from Warrington had to travel either to Chester or to Liverpool the transfer time would significantly impact on their ability to meet their response standards locally. Their capacity in the Warrington area is already stretched because of the greater increase in activity in the area than elsewhere. They argue that there would need to be investment in their capacity to mitigate the loss of vehicles from the community. They argued this was potentially a greater problem in Warrington because of the more rapid increase in demand than elsewhere, and also cited the Warrington road system as uniquely likely to gridlock than anywhere else in the region. They were of the view this would be a significant impact on their service.

**Whilst accepting the transfer times shown by the Ambulance service and the demand figures presented, the panel did not feel that the capacity issue was an insurmountable problem, but wished to draw it to the attention of the commissioners as a potential consequence and cost not yet planned. The issue of gridlock was also acknowledged as challenging but the panel were not in a position to comment on the uniqueness or otherwise of this.**

22. The Trusts presented significant evidence about their service capacity including gold standard equipment that would be “wasted” leaving the trusts with unused capacity with a potential financial impact.

**The clinicians on the panel acknowledged that they did have equipment and capacity not currently available in other networks, and the panel acknowledged that this could have a financial impact on the trusts, in particular Warrington. The clinicians suggest that this could be mitigated with other service developments, but also by considering how changes to the proposed service model may be implemented, protecting the outcome improvements for Carotid Endarterectomy and Aortic Aneurysm Survival, whilst utilising state of the art equipment already in place in Warrington.**

23. By far the biggest concern for clinicians across the two trusts is the impact of the loss of in-house vascular services (a consequence of the service model as currently described and the centralisation of expertise) on how other specialties receive immediate urgent vascular surgical support. This perceived loss includes the immediate support for iatrogenic vascular injury in other surgical procedures, and specialities performing invasive procedures (interventional radiology and gastroenterology etc., the trust clinicians cited a number of potential deaths resulting from losing this immediate support citing the recent occasions where this saved lives and reduced morbidity.

**The panel recognise this as an issue as these patients are unlikely to be fit for transfer mid procedure. One panel member was particularly concerned that the lives at risk in these situations, equalled or outweighed those saved by the anticipated improvements in outcomes from centralising vascular surgery if there was not a guarantee of a vascular surgical presence in all trusts at least equivalent to current availability. The panel agreed that there was the potential to mitigate this by ensuring that the centre paid attention to the needs of trusts in the network, but equally the clinicians acknowledged that this does not always play out in reality. Commissioners would need to have a strong service specification to ensure that these arrangements were established and sustained. This would not be unique to Warrington and would need consideration across the board in any implementation plan.**

24. The trusts also described situations where if there was not readily and immediately available vascular surgical expertise they would need to consider transferring some trauma patients to other units. This included supracondylar fractures in children and lower limb trauma involving joints. The clinicians were concerned that they may be found culpable if they carried out treatment without on-site support from vascular services.

**The panel acknowledged this concern, and recognised that no clinician would embark upon a course of treatment with unacceptable risks, however again the guaranteed presence of a vascular surgeon and interventional radiologist at least equal to current availability could mitigate this concern. The panel acknowledged the potential paradoxical increase in fatalities which would fall under the Coroners jurisdiction as potential Article 2 deaths, and would recommend that commissioners consider these when making their final decision.**

25. The urologists described difficulties they perceived in maintaining their major cancer work (Warrington is designated as a Cancer Centre for Renal Cancer) without guaranteed support for their cancer lists where currently vascular surgeons are present in theatre or immediately available. They also expressed concerns about the loss of interventional Radiology for renal blockages and sepsis, the Upper GI clincians were similarly concerned about the role Interventional radiology plays in achieving biliary drainage in patients acutely and seriously ill with blockages. They are also increasingly turning to Interventional Radiology for the urgent treatment of GI bleeds in emergency situations. The potential for these patients to need to be transferred elsewhere would, they argued, undermine local services in a short time.

**The panel also acknowledged these concerns as valid but recognised that it was possible to mitigate this concern by ensuring availability of a vascular surgical and interventional radiology presence in working hours from the centre as described above.**

26. The vascular team were particularly concerned about the centres capacity to manage all compromised limbs due to diabetes and the desirability of disconnecting a well-established joint approach with diabetologists in both trusts,

resulting in a reduced response to an ischaemic limb. Travel was deemed to be a particular issue for this group of patients.

**The clinicians on the panel agreed that the sheer volume of such patients, potentially needing transport to centres was likely to be unmanageable. The clinicians on the panel felt that this would be a growing challenge, and that it was a reason for the commissioners to be very sure about the service model as currently described. The clinicians on the panel felt that a very large group of patients had the potential for disruption to their service in order to benefit a very small number of other patients from improved outcomes for Abdominal Aortic Aneurysms. The lack of personal transport amongst this group (and the large sections of the Warrington, Halton and St Helens population as a whole) was accepted as real issue that would need a solution. This was particularly raised by the patient group and LINKS. The issue of transport and unwillingness to travel for treatment demonstrated by this population was raised by the cancer network in its deliberations about service centralisation.**

**One panel member was particularly concerned that commissioners were convinced that the unintended consequence of increased morbidity and mortality in other patient groups, or even vascular patients transferring for longer distances, did not outweigh the improved outcomes described by the review. All of the numbers involved are relatively small but Warrington and the Ambulance trust estimated that there was potential for additional deaths. The clinicians acknowledged this concern and felt that the commissioners should make the evidence clear in any implementation plan.**

27. The anaesthetists, intensivists, vascular surgeons and interventional radiologists described current difficulties in accessing services in specialist centres now, and questioned the ability of the centres to take on the workload in a timely and responsive manner. Warrington has invested in a significant amount of capacity and technology in intensive care compared to others and this would be “wasted”.

**The panel recognised the issues raised but accepted that a suitably timed and planned implementation plan would mitigate this, and recognised that this would not be a short term plan particularly in the South. They also acknowledged the existing capacity challenges in the Royal Liverpool to respond to trusts outside the immediate area with their current and planned capacity, particularly Interventional Radiology and Intensive care, and felt they should be clearly addressed to avoid the access concerns in Warrington.**

28. One of the general and overriding concerns, shared by clinicians and managers of both trusts but most acutely by Warrington and Halton, was that a loss of vascular services would result in an increase in patients in all specialties who, over time as local guaranteed support waned, would need transferring to the vascular centres. This they believe is an unintended consequence on other services that improving outcomes for a small number of people with aneurysms has.

29. They believe such a dwindling of expertise and a drift of patients other than those initially intended towards the centres, would impact on most of the future service

developments that the two trusts aspire to, this would include trauma unit status (other trusts affected by the centralisation of vascular services do not have similar aspirations), cardiology interventions already planned and agreed by the commissioners local. They are also convinced that the continued recruitment of the best clinicians for local people will become more difficult as jobs became diluted and less interesting or attractive.

**The clinicians on the panel support this description as a common impact of service centralisation to date despite the best will at the outset. It was their experience that over time the quality of outreach support dwindles and that the centre consumes more and more of the available clinical time. Two centre jobs are not popular and whenever issues arise the outreach service is hit or is unreliable. The panel suggested that a very tough commissioner approach to ensuring that local hospitals were supported and that the support is sustained and reliable would be essential to mitigate this real danger. The clinicians believed whilst this issue was not exclusive to Warrington and St Helens and Knowsley as individual trusts, this did have the potential to impact more on them than others because of their aspirations for continued joint service development.**

30. Warrington in particular is justly proud of their contribution to surgical training**.** The loss of vascular services would impact on training in surgery and gradually other specialties. Warrington is currently one of the most popular training posts deemed to be of high quality by the deanery, and the clinicians believe this would cease to be the case with the loss of vascular registrars. Maintaining compliance with the EWTD would be compromised.

**The panel acknowledged this was an issue whenever services were centralised, the suggested it would need to be considered as part of any implementation plan.**

31. The loss of potential for developing the local Interventional Radiology service along the aspirational lines set out by both trusts was a major impact that the trusts described. They believe the loss of local vascular work would seriously hamper their ability to sustain the 1:6 rota they have established. Clinicians from a range of specialties all said that any (they believed almost certain) diminution in the service they have planned would significantly impact on current and future local service quality, they described a range of circumstances across a whole range of service specialties where readily available routine and urgent access to interventional radiology was not only desirable but was increasingly recommended by Royal Colleges as an essential component of a local service. This included, Gynaecology and Obstetrics, Upper GI, vascular access for haemodialysis, renal cancer treatment, and management of trauma to name a few.

**The panel agreed this would increasingly become a problem if there was not locally available Interventional Radiology. They commented that up until now this service was not well developed in the local area, but acknowledged that the current plans would give a minimal local access and any diminution would be of significant adverse impact. The panel suggested that consideration of the effect of altering Interventional Radiology provision on both vascular and non-vascular patients would need to be a vital part of any plans for implementing the centralisation of vascular services. A robust network of access to interventional radiology both during the working day and out of hours, providing local access as far as possible was essential in a hospital with the range of services found in these trusts.**

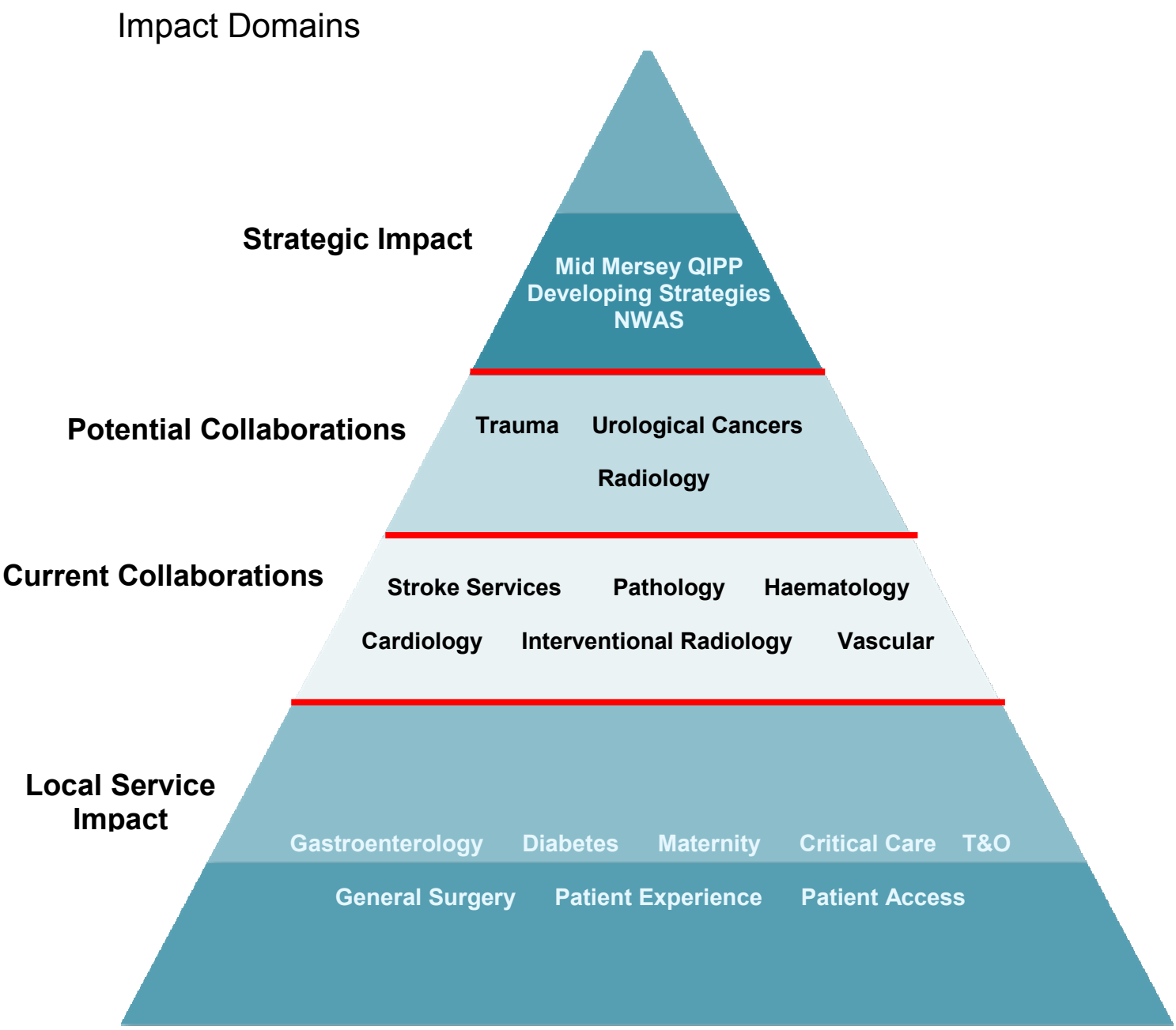
**The clinicians on the panel agreed with the view of local practitioners, that the recruitment of Interventional Radiologists would be very difficult going forward if vascular services were lost. The local lead for radiology stated that one of the provisos of recent appointments was that vascular services were part of the local provision. If this was not the case it is unlikely that the new appointments would take up post as there would be better and more attractive posts advertised by the centres. This could be mitigated however by the creation of a robust Interventional Radiology Network offering all consultants the opportunity for specialist work alongside local on call rotas. This would need to be addressed at the outset of any implementation process.**

**Summary**

32. The trusts presented a huge amount of evidence across the three days the diagram below summarises the areas of impact in four domains. The diagram below is an adaptation of the trust's own diagram showing the impact across four domains, the impact on current services, the impact on current joint working, the impact on identified future joint plans and the bigger strategic picture that QIPP brings.

33. Like many other trusts across the country Warrington and Halton Hospitals NHS Foundation Trust are naturally very concerned for the quality and range of services they provide for local people, and do not welcome attempts to interfere with them. St Helens and Knowsley Hospitals NHS Trust are equally concerned. Although the panel recognised and acknowledged the concerns raised, and the deeply held passion for the services they currently provide, it was largely felt that if Warrington is not designated as a centre, that Warrington and St Helens were not unique except in one regard, and that was their already functioning network between them and the degree of joint working and trust between the two groups of clinicians. Fears about impact on strategic plans such as designation as a Trauma receiving Unit are very real to the trust.

34. Some of their concern seems to arise from a lack of clarity about the detail of the service model, early sharing of the detail, including the availability, in local trusts, of the vascular and Interventional radiology expertise, would help.




35. The table summarises the impacts/risks as identified by the panel and described in the boxes above. The panel agrees that the risks are all, in principle, capable of being mitigated as the process moves forward. Commissioners and Trusts will need to work together, but with a strong implementation plan this is seen as feasible.

36. We have taken cognisance of the risk register presented by the trust and whilst we did not discuss the risk scores specifically, the panel recognises that in any complete risk register there would of necessity be the controls and actions to be taken to mitigate the risks. The narrative in the main section above covers this in some detail.

**Table of Risks**

| Risk | Potential Mitigation |
|---|---|
| Loss of Immediate Vascular Support to other services in an emergency including iatrogenic vascular injury | Strong service specification and network model to guarantee in-house presence of vascular surgeons at least equivalent to current arrangements during working hours and an on call rota that meets the needs of the whole area out of hours |
| Failure to Achieve Trauma Unit Status | The presence of Interventional Radiologists and Vascular Surgeons in hours and the guaranteed support for all units from out of hours rota. Good local support teams to enable local work will be essential as it is not just the consultant specialist that makes a successful team. |
| Additional Transfer times/distance for patients in emergency primarily ruptured aortic aneurysm and NWAS impact on general response time<br><br>Also additional travel for other vascular trauma or haemorrhage | Further work with NWAS re distances and transfer times and consideration of each vascular network coverage<br><br>Commissioner discussions about solutions for the impact on NWAS response times<br><br>Clarity about mitigating additional risks for patients requiring transfer for treatment other than Abdominal Aortic Aneurysms |
| Break up existing Mid-Mersey vascular network because location of centres in relation to trusts and therefore transfer | Exploration of a solution that enables current clinical relationships to be maintained in Mid-Mersey. Location of centres/units |

| Risk | Potential Mitigation |
|---|---|
| times and routes | need to be treated fairly |
| Loss of Interventional Radiology response within 60 minutes in emergency | Interventional Radiology Review Establishment of network that provides in hours and out of hours response ensuring clinicians serve local trusts regularly and have good working arrangements in all trusts in which they work. Preserving local arrangements as far as possible whilst ensuring all clinicians have access to specialist work. |
| Vascular injury to limbs ensuring Warm ischaemic time is not compromised by need to either transfer trauma of secure local vascular input | Securing a robust vascular rota as described above in and out of hours in all units with local presence or guaranteed capacity to transfer patients immediately |
| Loss of local Interventional Radiology Input to specialties or reduced local access<br><br>Upper GI<br><br>Urology<br><br>Obstetrics – aspitrations to develop IR in post partum haemorrhage<br><br>Nephrectomies for Cancer<br><br>Lower GI major resections<br><br>Gynaecology - fibroids | Interventional Radiology Review<br><br>Guaranteed in hour local access with out of hours rota to serve all trusts<br><br>Network that enables recruitment and retention of Interventional Radiologists that will maintain current local service and enable the service developments necessary to provide a high quality Interventional Radiology service across Cheshire and Merseyside<br><br>Loss of Local IR would potentially mean other cases would need transfer for treatment - commissioners need to consider the impact on capacity if this were to be the case |

| Risk | Potential Mitigation |
|---|---|
| Reduced use of equipment already purchased in Warrington primarily in theatres, in ICU, and Radiology | The service model may allow this to continue to be optimally utilised but this needs to be part of any final decision re location of centre |
| Concern about capacity for the 48 hour response for Carotid Endarterectomy for residents served by the two trusts | Commissioners need to be sure that there is capacity for this standard to be met through centralisation ensuring all residents get equa access. |
| Difficulty in recruitment of Interventional Radiologists to the joint posts/rota | The Interventional Radiology Review and the creation of a safe robust network that provides full range of Interventional Radiology to all trusts securing good jobs that make Cheshire and Merseyside the most attractive place to work |
| Surgical Training<br><br>EWTD | This needs to be explored as soon as possible with the Deanery and solutions found |

37. Mitigating the concern relating to Interventional Radiology will, the panel believe, need significant work prior to implementing the proposed changes to vascular services and the panel suggest that commissioners consider a full Interventional Radiology service review across Cheshire and Merseyside to ensure that the service is capable of fully meeting the needs of **all** trusts today, and builds in the planning for developments necessary to meet the future requirements of a robust and high quality Interventional Radiology Service serving the residents of Cheshire and Merseyside.

38. The panel felt that a solution that maintained that relationship as well as ensuring the best access for patients across Cheshire and Merseyside as a whole was something to be achieved if possible.

39. Whatever the configuration, it is important that any plans recognise the time it takes for integration and trust to build between organisations and clinical teams. The Implementation plan and process must include significant time for team building between trusts and whole clinical teams. This is a joining together into a network not a centre takeover and all partners and clinicians need to play an equal part in the development of an exciting new service.

40. Centralisation of services will always bring challenges and it is for the trusts and commissioners to recognise the impact/risks and work through the implementation process to mitigate them and ensure the best possible solution.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