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EDITORIAL

The CRG for Vascular Services

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The last decade has witnessed a number of changes in the delivery of vascular services nationwide. Vascular surgery attained speciality status in 2012, and is well recognised as an urgent and emergent speciality delivering time-dependent care for patients with aortic aneurysms, carotid surgery for stroke prevention and lower limb revascularisation for critical limb-threatening ischaemia. The National Vascular Registry (NVR), established in 2013, provides effective monitoring and reports on outcomes whilst also delivering a robust programme of quality improvement.[1] The National Abdominal Aortic Aneurysm Screening Programme was fully implemented in 2014,[2] and this coincided with a move towards centralisation of vascular services to a network model of care with elective and emergency arterial surgery concentrated in arterial hubs. In 2013, NHS England took full responsibility for all specialised commissioning which included all arterial surgery. Over the years, major vascular policy decisions make reference to the Vascular Clinical Reference Group (CRG), yet few clinicians are aware of who these groups are, who they are accountable to and how they are involved in organising, reconfiguring, delivering and monitoring of vascular services in England.

The Vascular Services CRG was first established in 2013 and currently sits in its fourth iteration as part of the Internal Medicine National Programme of Care (NPoC), one of six national programmes as part of Specialised Services commissioned by NHS England.[3] It is a 'lead and inform' CRG that covers the spectrum of arterial and deep venous interventions and aims to deliver the products of commissioning to contract services based on the Vascular Service Specification of NHS England.[4] The CRG advises Specialised Commissioning on achieving high quality care and aims to reduce health inequalities by championing the delivery of evidence-based, data-driven, patient-centred effective interventions and care pathways and promotes 'joined up' health services to avoid patients falling through gaps and reduces the risk of harm.[5]

The Vascular CRGs are appointed to a three-yearly term with a Chair, currently a vascular surgeon, and representatives from stakeholders that include clinicians from vascular surgery and interventional radiology, vascular nurses and allied specialties, a patient and public representative and a lead commissioner. The membership of the CRG, for the duration of the term, is aligned to a clear patient-focused work plan characterised by collaborative working, supporting patients, clinicians, vascular networks and commissioners.

During times of transformational change towards a hub-and-spoke networked model of care, the CRG helped with two reports. The first formed the basis of the service specification of the 'non-arterial' centres of vascular networks which outlined the models of patient services and care provided by 'spoke' hospitals based on the successful experience of vascular reconfiguration in Merseyside, Staffordshire and South Cheshire. This service specification was adopted in the Provision of Vascular Services (POVS) 2015 document from the Vascular Society for Great Britain and Ireland.[6] This was followed by the very well received 'Top Tips for reconfiguring vascular services', a multi-disciplinary document outlining the key lessons from well led reconfiguration that has been a singular reference to help difficult vascular reconfigurations and included in POVS 2018.[7]

The Vascular CRG has made contributions to

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the monitoring of transformation and the performance of vascular networks working with the Vascular Society of Great Britain & Ireland (VSGBI) and the Vascular Getting it Right First Time (GIRFT) programme, building on the recommendations in the 2018 GIRFT Vascular report.[8]

This partnership between GIRFT and NHS England & Improvement led to the establishment of the Joint Programme Board (jointly chaired by the two parties) and the Action on Vascular Programme. The aims were to reach a consensus on the implementation of the Vascular GIRFT recommendations. It facilitated visits to networks where the process of reconfiguration was challenging. It worked closely with clinicians, managers and regional teams tackling difficult issues and sometimes uncompromising views in a mediatorial and supportive rather than a mandatory and dictatorial manner.

The Vascular CRG realised the importance of NHS England tariff and reimbursement to vascular providers, and has kept abreast with changes to the digital currency of the NHS with the Healthcare Resource Group (HRG) structure from payment by results (PBR) to block contracts and blended payments and produced an overview of the changes in national tariff and their relevance to vascular networks in 2017.[9]

From little acorns grow big oaks; this was brought home by a major collaborative effort between the CRG, the NVR, the NHS England and NHS Digital teams responsible for Hospital Episode Statistics (HES) coding and High Cost Tariff Excluded devices working group from NHS Supply chain which concluded the NHS England spend on vascular surgery alone was close to half a billion pounds per year when accurate coding and reconciliation of HES with NVR data allowed all arterial procedures to be included along with device costs such as endovascular stent grafts – a far cry from the original rather conservative and erroneous figure of circa £47 million per year. This put Vascular Surgery and Vascular Services firmly in focus when it came to NHS England's national commissioning strategies and future planning, maintaining visibility with a high profile.

During this decade we have also witnessed an endovascular revolution with the explosion of endovascular techniques, interventions and devices for an ever-increasing range of conditions. Some have proven revolutionary for patient care, however not all have fulfilled early promise; some have led to patient harm and have contributed to considerable soul searching. The NICE abdominal aortic aneurysm (AAA) draft guidelines, in particular the role of endovascular aneurysm repair,[10] led to considerable controversy in the vascular community. The measured and statesman-like response from the VSGBI in collaboration with the CRG considerably enhanced our standing as a vascular community nationally and abroad.[11]

There was further evidence of clear, sensible, compassionate and collaborative leadership by the CRG as the world had to deal with the consequences of the COVID-19 pandemic prompting a national lockdown in March 2020. The CRG worked tirelessly and closely with the VSGBI Executive, NHS England Specialised Commissioning, GIRFT and allied societies such as the British Society for Interventional Radiology to issue guidelines regarding elective and emergency vascular surgery to keep patients safe whilst ensuring continued management of the most urgent vascular patients.[12] As the pandemic ebbed and flowed between further waves, weekly meetings ensured ongoing real-time regional and national perspective of the effects of the pandemic on patients, their families, staff and hospital services nationwide with subsequent timely guidance to allow for safe resumption of services, and in time the less urgent vascular services.[13]

Following the resumption of elective activity, the NHS England Specialised Commissioning Action on Vascular Programme advised by the CRG has continued to review vascular networks with diligence to current staffing and rotas, numbers of procedures undertaken as recommended in VSGBI POVS 2021,[14] enquiring on timely delivery of services and reporting of patient outcomes, both on the NVR, in order to keep vascular patients and vascular services firmly in the limelight and on par with other time-critical conditions such as cancer and cardiac surgery as the NHS struggles to deal with the demand on resources and waiting lists.

The VSGBI and its Audit and Quality Improvement Committee has an established track record of quality improvement programmes (QIP) to benefit patients such as the AAA QIP.[15] The VSGBI launched the Peripheral Arterial Disease Quality Improvement Framework (PAD QIF) in 2019, updated in 2022 to improve the timelines to care of patients with critical limb-threatening ischaemia.[16] The Vascular CRG strongly supported the VSGBI's well written clear NHS England incentivised payment Commissioning for Quality and Improvement (CQUIN) scheme for 2022–2023, rewarding excellence and supporting provider units to put measures in place to improve the quality of care for these patients, the subject of a previous editorial in this journal.[17]

The CQUIN which has been renewed for 2022–2023[18] is part of a package of measures put in by the VSGBI and our members, surgeons and interventional radiologists from the British Society for Interventional Radiology, supported by the Vascular CRG and many others that will ensure eventual success of the PAD QIF programme.

Similarly, the Vascular CRG has worked in collaboration with the Cardiac Surgical CRG to produce the Aortic Dissection toolkit, an excellent example of collaborative working between multidisciplinary teams to produce guidance on regional delivery of safe services for patients with potentially lethal aortic dissections.[19]

The Vascular CRG is currently developing advice and guidance on paediatric vascular surgical services, an area of current multidisciplinary interest, and novel drug treatments for arteriovenous malformations. The Vascular CRG has also had a few less successful endeavours. The Specialised Services Quality Dashboards were stymied by the lack of data support from provider units and fell by the wayside during the COVID-19 pandemic. The Vascular CRG engineered a collaborative plan with two national

audits, the NVR and the National Diabetic Foot Audit, aiming for a single commissioning strategy for the delivery of effective diabetic foot services between Clinical Commissioning Group (CCG)-led services in the community and tertiary care provided by vascular services with integration into preventative foot care protection services and postoperative rehabilitation in the community – a dream yet to be realised.

Vascular surgery continues to thrive. There are several reasons for this. We have a successful and effective national screening programme. As a specialty we are clinically led with evidence-based fully audited practices, particularly in the UK. We have demonstrated accountability and governance with the NVR as an exemplar national registry that closes the audit loop. Our patients and services were hard hit during the pandemic and vascular surgery became a protected specialty. We have demonstrated moral, ethical and compassionate leadership and have been open, honest and transparent with our failures. The Vascular CRG has always prioritised patients' interests. The CRG's collaboration with NHS Supply chain and Procurement, the Outcome Registries and Patient Safety programme board, and partnership with the VSGBI and the NVR allows a critical review of data on new procedures and devices to ensure vascular patients come to no harm and vascular services provide value for money. As we move into the era of integrated commissioning, the Vascular CRG will work with Integrated Care Boards to prioritise multidisciplinary diabetic foot care amongst other initiatives supporting integrated care across the spectrum of vascular disease management in order to make a real difference to these patients.

Conflict of Interest: RDS and ADP are members of the National CRG for Vascular Surgery. ADP is chair of the Audit & Quality Improvement Committee VSGBI, Clinical Lead for the NVR, Chair of SSDP and Co-Chair of NCIP Vascular Surgery. RDS is Chair of the CRG, NHS England Specialty Advisor for Vascular Services and VSGBI representative on RCS England Council.

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