Lothian NHS Board

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Your Ref
Our Ref 8343

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Dear

FREEDOM OF INFORMATION – *EXTERNAL REVIEW*

I write in response to your request for information in relation to the Interventional Neuro-radiology service.

Question:

A copy of the report written by Professor George Youngson, Dr Angus Cameron and Mr Iain Reid documenting the full details of the outcome of the external review of interventional neuroradiology services. This review was commissioned jointly by Dr Tracey Gillies, board medical director of NHS Lothian, and Dr Jennifer Armstrong, board medical director of NHS Greater Glasgow and Clyde, in 2018. The outcome report was shared in a paper only format with relevant parties at concurrent meetings in Glasgow and Edinburgh on the 8th of January 2019.

Answer:

I apologise that this response has been provided to you outside the statutory timescale of 20 working days as set out in FOISA. We aim to respond to all requests promptly and within timescales but unfortunately this is not always possible. I am sorry for the delay and any inconvenience this has caused. We were aware that NHS Greater Glasgow and Clyde were taking this forward already and did not wish to duplicate the work being carried out by them for the exact same information.

We are treating your request under our procedures for responding to requests for information under the Freedom of Information (Scotland) Act 2002. Our response to your request is as follows:

Personal information

The Interventional Neuro-radiology service is a highly specialist service, with only a small number of staff. At the time the report was written, there were only four interventional neuroradiology consultants within NHS Scotland; three within NHS Lothian and one in NHS Greater Glasgow and Clyde. Due to the extremely small number of staff, it would be extremely easy for individual staff within the service to be identified. Given that a significant amount of the content within the full external report relates to individual members of staff, it is considered that

this would require a significant level of redaction in order for the information to be sufficiently anonymised.

The report also contains a level of information regarding individual members of staff. This is of a detailed level which, if disclosed, would enable the identification of individuals. The report would not have been prepared in the expectation of publication and therefore disclosure would be in breach of data protection principles.

To provide information which would pose a risk that an individual or individuals could be identified from that information would be contrary to, and would put NHS Lothian and NHSGGC in breach of, Data Protection principles.

We therefore decline to provide this information on the basis that this is personal information. Section 38 of FOISA provides that information is exempt information if it constitutes personal information and that to disclose this information would contravene one or more of the data protection principles. The exemptions within FOISA that we have relied upon to withhold this information are section 38(1)(b) read in conjunction with section 38(2)(a)(i) of FOISA. This is an absolute exemption which means that if information is withheld under this exemption, we are not required to consider whether it is in the public interest to withhold it.

Prejudice to effective conduct of public affairs

We consider that release of the full external report would be likely to prejudice substantially the effective conduct of public affairs and that this should be withheld under section 30(c) of FOISA.

At the time that the report was written, working relationships within the service across NHS Lothian and NHSGGC were in a fragile position, with many challenges being faced in enabling the services in both boards to remain supported and sustainable. Work has been done against the action plan to improve and progress relationships and working arrangements.

However there is a significant concern that release of the full external report would have a detrimental and retrograde effect on the progress that has been made. It should be recognised that, in order to instigate effective and sustainable change, some challenging areas needed to be addressed.

We consider that there is a clear public interest in withholding documents prepared solely for internal communication where they provide detailed advice on sensitive ongoing issues, and due to the high likelihood of individuals being identified, and that this therefore outweighs the arguments in favour of the release of information.

It should also be noted that the external report has had an extremely limited circulation within both NHS Lothian and NHSGGC. It is the summary report that has been used within the service to create the action plan and take forward requirements and recommendations.

If the report were considered for redaction, it is felt that the level of redaction that would be required would render the remaining information almost meaningless.

Consequently, NHS Lothian and NHSGGC are of the view that disclosure of the summary report would offer assistance in connection to this request and this has been supplied as part of this response.

I hope the summary information provided helps with your request.

If you are unhappy with our response to your request, you do have the right to request us to review it. Your request should be made within 40 working days of receipt of this letter, and we will reply within 20 working days of receipt. If our decision is unchanged following a review and you remain dissatisfied with this, you then have the right to make a formal complaint to the Scottish Information Commissioner within 6 months of receipt of our review response. You can do this by using the Scottish Information Commissioner's Office online appeals service at www.itspublicknowledge.info/Appeal. If you remain dissatisfied with the Commissioner's response you then have the option to appeal to the Court of Session on a point of law.

If you require a review of our decision to be carried out, please write to the FOI Reviewer at the email address at the head of this letter. The review will be undertaken by a Reviewer who was not involved in the original decision-making process.

FOI responses (subject to redaction of personal information) may appear on NHS Lothian's Freedom of Information website at: https://org.nhslothian.scot/FOI/Pages/default.aspx

Yours sincerely

ALISON MACDONALD
Executive Director, Nursing, Midwifery and AHPs
Cc: Chief Executive
Enc.

Summary of the External Review of Interventional Neuroradiology Services NHS Greater Glasgow and Clyde and NHS Lothian.

This review was commissioned by the Medical Directors of NHS Greater Glasgow and Clyde and Lothian in April 2018. The purpose was to characterise the nature of the Interventional Neuroradiology Service with a view to ensuring a more sustainable service in the longer term. The information provided was obtained through interviews with staff within both services, carried out by an external review group and also by clinical reference group comprised of individuals in the service across both health boards, in addition expert opinion was also obtained from the relevant Royal Colleges and managed service network.

1. Background

There is recognition of increasing demand for this specialist service within NHS Scotland and this has resulted in a service under pressure with only four interventional neuroradiologist consultants within NHS Scotland, three within NHS Lothian and one in NHS Greater Glasgow and Clyde. While the shortfall in Consultant numbers is recognised nationally, a past record of discord in NHSGGC had, until recently, affected recruitment and retention within the Glasgow site.

A further factor compounding the above difficulties relates to the requirement to develop a mechanical thrombectomy service within NHS Scotland. This potential development would be predicted to increase dramatically the number of patients referred both within normal working hours and especially as emergency situations.

Due to the recognition of increasing pressure on the single handed consultant in Glasgow a partial interim solution was implemented between March and July 2018 whereby patients with acute subarachnoid haemorrhage were transferred to Edinburgh for appropriate emergency management. This arrangement was supplemented by the development of a National MDT meeting held weekly with contribution of consultants from both Edinburgh and Glasgow as well as neurosurgeons from Glasgow. During this period and indeed subsequently Edinburgh colleagues have provided acute cover at weekends alternating between the Edinburgh and Glasgow sites. With this arrangement Glasgow agreed to accept acute neurosurgical patients from Forth Valley and Dumfries and Galloway which would normally be transferred to the centre in Edinburgh.

2. Procedures and Pathways

The clinical care pathways for patients presenting with acute haemorrhagic stroke in both Glasgow and Edinburgh were examined. It was recognised that within Glasgow there is inconsistency in the timing of reimaging investigations required in some patients while the pathway for arranging reimaging investigations within Edinburgh is centralised and fully functional. It is also recognised that there is a lack of input from Glasgow to the outcomes of care audit carried out by national review bodies. This occurs routinely in Edinburgh and it is recognised that national benchmarking should be a prerequisite for the national service going forward.

3. Mechanical Thrombectomy for Ischaemic Stroke

The national planning group has established a review group to examine this treatment modality in NHS Scotland. It is recognised that the earlier that mechanical thrombectomy is performed the better the functional outcome and early patient assessment with appropriate rapid imaging are clearly essential for success. It is estimated that the annual predicted caseload within NHS Scotland

would be 6-800 cases per year. This would have implications for Accident and Emergency Departments as well as Neuroimaging Services and the Scottish Ambulance Service. In addition it is estimated that such a potential increase in workload would required a total of 10 INR consultants within NHS Scotland in addition to the requisite number of support staff, multidisciplinary team workers for example; nurses, radiographers and anaesthetists.

4. Scottish Radiology Workforce

Currently there are three filled full time equivalent consultant INR posts in Edinburgh. In Glasgow there is one filled post, one vacant post and one post occupied by a consultant returning to INR work after a prolonged absence. There are currently two INR trainees in Edinburgh but none within Glasgow. The review has exposed a mismatch in the supply and demand of the medical workforce capable of deploying the skills of interventional neuroradiology; it has demonstrated the need for rapid access to neuroradiology imaging as well as dependency on other key staff such as nurses, radiographers and neuro anaesthetics. At the present time, in common with many parts of the UK, there is not capacity within the current consultant interventional radiology workforce within Scotland to provide a mechanical thrombectomy service. However, there is ongoing engagement with national bodies to determine if other specialty consultants can be trained in this technique thereby increasing availability and progressing the introduction of this service.

5. Equipment and Facilities

The imaging equipment in both Glasgow and Edinburgh is under active consideration for replacement. It is recognised that if a mechanical thrombectomy service is to be made available then additional equipment will be required. Edinburgh is due to relocate from the Western General Hospital to Edinburgh Royal Infirmary in 2019; this will result in the acquisition of a new biplaner Neuro-angiography suite and a second INR suite would be required to accommodate a mechanical thrombectomy program. Within Glasgow a second biplane suite could be accommodated within the ICE (imaging centre of excellence) and active consideration to relocation to that site is underway. Equipment of similar specification in both INR sites would encourage the ongoing development of cross site working and purpose built facilities could also enhance the attractiveness of the service to potential new applicants.

6. Staffing

The four staffing groups required to provide the service are Radiology (Medical), Nursing Staff (INR suites and Critical Care), Radiographers and Neuroanaesthetists. Recruitment to consultant radiology positions in Edinburgh has been successful in the last five years and previous issues with regard to team working in Glasgow are being addressed to allow a culture to be developed to encourage a supportive leadership style and high standards of professional behaviour. There should be zero tolerance of any behaviours which would undermine the above culture. Glasgow would be advised to seek intervention from experts in this area when seeking to develop the local service.

7. Nursing Staff

There are slight differences between Glasgow and Edinburgh in the nursing roles and areas of responsibilities among senior nursing staff. Recruitment and retention in this group has not been particularly difficult and the Managed Service Network Nursing Group has been noted to be a successful venture. The clinical nurse specialist in Edinburgh has been particularly effective and has

resulted in good patient education and feedback, as well as providing continuity in follow up. The Lothian nursing team is recognised to be under resourced in comparison with the position in Glasgow. A new Lead Nurse appointment to the Scottish Network to oversee coordination and follow up of patients is recommended.

8. Radiographer Staff

There are similar challenges in relation to workforce along with the requirement of covering other radiological services while on call. Access to a larger pool in both Glasgow and Edinburgh would be necessary if mechanical thrombectomy is to become successful in future.

9. Anaesthesia

The service in both Glasgow and Edinburgh benefit from well provided neuroanaesthetic services. There are concerns within Edinburgh regarding imminent retirals and a possible reduction in trainee numbers with the move to Edinburgh Royal Infirmary.

10. Management Structures

At the start of the review process INR services in both Glasgow and Lothian were managed through the Directorates responsible for imaging. During the review process a recommendation was made by the review group to transfer interventional neuroradiology in Glasgow from the Diagnostic Directorate into Regional Services. That transition took place on 02/09/2018.

11. Management Style

The review had the sense that the management style was committed and as supportive as possible. The Managed Service Network is suggested as a possible contributor to cross board working by providing advice on roles which could work across both units and support their recruitment. A useful framework for future development would be a single INR network within NHS Scotland delivered from both Glasgow and Edinburgh. Such a network would allow the development of a National Clinical Lead position for INR within NHS Scotland as well as a possible Lead Nurse role; this would encourage the development of protocols and procedures across the network and also allow outcomes to be monitored.

12. Appraisal/Performance Review

Insightful appraisal could allow supportive processes to be introduced for individuals deemed under excessive pressure. In these cases mentoring and coaching could be considered in a proactive manner. While coaching of a number of clinicians is underway in both health boards this could be channelled to this particular service with benefit.

13. Process Review

The local MDT in Lothian is seen as a valuable contribution to patient care, quality assurance and improvement. The National MDT implemented during the emergency measures period in 2018 has been regarded as successful and a positive contribution by all parties involved. The National MDT is planned to continue on a longer term basis. Although the Lothian team continue to participate in regular Morbidity and Mortality Meetings these terminated in Glasgow in 2018. A specific

recommendation around a quarterly Morbidity and Mortality Meeting combining both INR and Neurosurgical practice was made. Quality assurance initiatives and Datix submissions should continue in both sites, and it is suggested that the Neuroanaesthetists in both centres would appear to be well placed to adopt an overseeing duty in such activities. The review recognises that elements of the above practice are already in place in both centres but also that this should be considered an institutional obligation. A leadership role by experienced clinicians at local level could create a positive work environment for all concerned within the extended team.

14. Preferred Option for Service Design

Single Service Network Model – development of a national INR service network along the lines of an MSN service and being provided from two locations would allow formalisation of cross board activity. This model would also allow standardisation of policies and procedures as well as consistent procurement of equipment. It would encourage national data collection as well as the development of national lead roles for example Lead Clinician / Lead Nurse. It would also result in more efficient use of the workforce within a scarce clinical environment, and maximal deployment of a scarce clinical pool.

15. Training, Education and Simulation

An assessment of training numbers formed part of this review from the perspective of workforce planning and service implications. It is recognised that there are fiscal constraints surrounding the funding of INR training posts with all current training posts originating from the South East Deanery. A second training post was established in Edinburgh in August 2018 and INR training is generally highly regarded among the trainee community. There is also the issue of training for thrombectomy and who should provide that service. The Royal College of Radiologists has recently submitted a credentialing proposal on the components of a program designed to equip suitable clinicians with the requisite skills for performing mechanical thrombectomy. The potential workforce for such a program could include neurosurgeons, neuroradiologists as well as vascular and interventional radiologists. A recent census from the British Neurosurgical Association suggested there was an appetite for hybrid training to include both neurosurgery supplemented by INR training to permit reaching competence in both aneurysm coiling and mechanical thrombectomy. Consideration should be given to approaching NES with the proposal that post CCT training positions should be established for a limited period of time in Scotland. It would certainly be important for there to be dialogue between NES and NHS planners in order to contribute the necessary workforce to treat stroke patients in Scotland in the future.

Requirements and Recommendations

The review recommends the following Requirements (which should be addressed urgently) and Recommendations (which are important, but less urgent).

Requirements

The following issues require to be urgently addressed:

a) In the first instance, recruitment to the full establishment should take place to allow the current workload to be addressed. Thereafter after each centre should aim to recruit to

provide four consultants in each service (in anticipation of future expansion required by thrombectomy) and additional numbers thereafter as determined by the extent of clinical need.

b) The Edinburgh service has provided significant support to Glasgow in the last year. This has managed to maintain an effective service for patients. For the future we recommend the development of a mutually supportive network between both centres to maintain consistent standards, enhance the potential for recruitment, to increase the sustainability of services, and to form the basis for a National Thrombectomy Service.
c) The arrangements for weekend on-call should be reviewed to improve recruitment and retention.
d) Decisions as to the site and extent of future provision of facilities requires urgent attention. The Edinburgh service is moving to the Little France site in 2019 and the facilities in Glasgow require to be upgraded.
e) The system for follow-up of aneurysm patients in Glasgow has not functioned fully and this requires to be addressed as a priority.
f) The maintenance of a positive culture within the INS is Glasgow is essential to improve recruitment to vacant posts and enhance recruitment to, and development of, a national thrombectomy service.
g) In order to provide assurance of quality of services, it is essential that data is maintained for audit, and benchmarking against other UK centres. Mortality and morbidity meetings should take place regularly, possibly involving both centres, and any lessons learned should be formally introduced.
h) The process of recruitment and selection should be reviewed to ensure that these include the full range of competences.

Recommendations

1. ***Patients***
    a. A rigorous patient follow-up policy needs enacted in Glasgow and particular emphasis placed on follow up and re-imaging of patients with unprotected aneurysms. There must be compliance (non-discretional) with agreed standard operational policies for post-operative imaging of SAH patients.

2. ***Tasks***
    a. Current workforce numbers are in need of review particularly in relation to nursing and radiography. Moreover, the development of a workforce subgroup of the National Thrombectomy Planning Group comprising anaesthesia, radiology, radiography, and nursing to identify staffing needs will benefit preparation for stroke thrombectomy service in Scotland. The group might also review bed and critical care requirements. This will assist both centres to plan their workforce on the basis of potential future developments.

3. ***Individuals***
    a. Poor collaboration and discord in the past have impacted on recruitment into the INR service in Glasgow and could compromise introduction of a thrombectomy service.

b. Ongoing monitoring of behaviours in the Glasgow service is required and appropriate mentoring/coaching put in place to enable the service to move forward.

c. An analysis is recommended of all individuals and all teams involved in neurovascular services using organisational psychology expertise to provide the requisite support and result in reputational change.

d. The Scottish Training Board in Radiology should be approached for the development of two post-CCT training fellowships in thrombectomy to be enacted over a two-three year period to explore expansion of the thrombectomy workforce (including out of Scotland attachment if required).

4. Team

a) As stated above in requirements, there is a need to ensure restoration of the current consultant establishment in Glasgow but additionally consideration given to the expansion of the INR establishment in each centre coincident with the development of, and sufficient to provide for the needs of, a mechanical thrombectomy service. Four whole time equivalent consultants should be the establishment for each centre in the short to medium term extending to five in the long term to ensure capacity for providing an INR service for stroke patients (and others) in Scotland.

b) There needs to be an expansion in workforce of nursing staff and radiographers.

c) National neurovascular morbidity and mortality meeting should be put in place with participation from INR and neurosurgical services in both centres.

d) Chairmanship of local MDT meeting must be revised.

e) Daily safety meetings/briefings must become normal practice with a quality assurance/patient safety lead being appointed for this purpose in neurovascular teams in each centre.

f) Instruction in team training and human factors training in INR and neurosurgery (through the assistance of the Scottish Simulation Centre) would benefit the dynamics across teams in both centres and is recommended.

g) Complex INR procedures should be identified as benefitting from a “dual operator” approach

5. Environment

a. Expansion of the existing/new facilities to develop a second INR room with appropriate biplanar equipment be in each centre would be beneficial at the present time and would be essential if a thrombectomy service is to be developed.

b. During acquisition of new equipment across the two sites, the same specification should feature so that clinicians covering both sites will benefit from familiarity with that equipment.

c. There is a need for urgent decision-making in relation to re-provision of the INR facilities in the INS.

6. Organisation and management

a. A national, single, INR service network for Scotland should be established with clinical services provided from initially two centres with a view to subsequently extending the network.

b. There would be value in recruiting internationally for a lead clinician for the national INR network who would work across both centres. Such an individual would need to be a highly respected clinician with appropriate clinical skills, but also able to provide the requisite leadership, motivational and communication skills. The lead would also require the ability and authority to manage discord. Recruitment from outwith Scotland would bring the benefit of new ideas and an international perspective. No appointment should be made if the selection team identifies that the motivational and leadership attributes are inadequate. The post could be extremely attractive if the individual was given a prominent role in the setting up of a thrombectomy service across Scotland.

c. The review strongly supports national contributions to audits from the whole of the Scottish service in order to obtain the reassurance of benchmarking performance.

d. The opportunity to locate complex elective INR care in one centre ought to be considered.

e. INR services in Glasgow should relocate into the same managerial infrastructure as neurosurgery (already enacted).