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1. Introduction

These ‘*top tips*’ are aimed at anyone, and everyone, involved in the reconfiguration of local vascular services to produce a united network of partner hospitals. They are based on practical experience of reorganisation and have been compiled with the help of all disciplines within vascular services, together with their Commissioning and Public Health colleagues.

The advice that follows contains practical, experience based, pointers to help vascular services still not fully configured into a network model in which a single arterial centre provides specialist inpatient vascular care. We have assumed that a network will serve a population size of at least 800,000 people, usually more, generating over sixty abdominal aortic aneurysm repairs per year.

Whilst the guidance is aimed predominantly at those working within hospitals and their commissioning colleagues, it is important to remember the roles played by council oversight and scrutiny committees, ambulance services, rehabilitation professionals and patient groups in developing the new network structures; their close involvement from the outset has often been a marker for a successful outcome.

This document is organised into sections that follow logically from a high-level decision to reorganise local vascular services, through the process of reorganisation and concluding with the final operational points that make a new network work well. Each section can stand alone, so that you can dip in and out, to suit your present progress through the reconfiguration process. If things aren’t going well it is worth looking back at the previous section to see if perhaps something important has been missed or not given a sufficient priority.

2. Understand the process

2.1 *Reorganisation of services is not easy*, this goes some way to explaining why the reorganisation into vascular networks remains incomplete in England. It requires commitment from all parties:

- **NHS England/NHS Scotland/NHS Wales/HSC in Northern Ireland/HSE**, as commissioners of specialised services. Reorganisation is the ‘day job’ of commissioners and reconfiguration can flounder without strong commissioning lead for change;
- **Local Clinical Care Groups (CCGs) or Commissioning Groups (LCGs) or Health Boards**, who are already driving change and transformation in local health systems. Their importance is two-fold. First, as commissioners of many of the interdependent services, such as diabetic foot and venous services (in England). Second, because of the impact of Sustainability and Transformation Partnership (STP) programme leads across the whole health economy;

Vascular service reorganisation is only part of wider change in health service delivery that is underway across the NHS. Many of these changes will support rather than impede the setting up of vascular networks and so involvement is essential.

- **Chief Executive** within acute hospital Trusts, along with their executive boards;
- **Clinicians**
 - working within vascular services, including vascular surgeons, interventional radiologists, vascular nurse specialists and clinical vascular scientists;
 - working in inter-dependent services, including emergency departments, diabetologists, stroke physicians, cardiologists and cardiac surgeons, rehabilitation physicians and their teams;
 - wider colleagues;
- **NHS Ambulance Trusts**, who will need to develop acute patient transfer protocols;
- **In England, Local Authority Oversight and Scrutiny Committees (OSCs)**, almost all Health OSCs consider vascular reorganisation a significant change. NHS England provides national guidance on consultation and stakeholder engagement. Consider asking patient support groups and/ or other patients who use other services in which there are ‘hub and spoke’ network arrangements to join the engagement and consultation processes; their experience is informative, and their insight valued by local people who will be affected by the changes. Patient and public voice colleagues are invaluable supports at public meetings;
- **Patients, patient relatives and patient carers**, though a formal process of public and patient engagement, this includes online information and public meetings. Using local NHS guidance on consultation and engagement will mean all the important stakeholders are involved early on;

2.2 *Barriers to forming a successful network exist*, experience is that there are several perceived, and many real, barriers that will need to be overcome. Amongst the most common are:

- The wide geographical distances a network may have to cover to serve the population, resulting in increased travel for patients and their families;
- Significant distances between partner organisations, with the implications for the delivery of remote outreach clinics;
- Commissioning arrangements are often not robust. There can be a perception amongst both clinicians and Trust managers that commissioners lack the appetite to enforce change;
- A feeling of division between the designated arterial centre and the non-arterial vascular centres in the partner hospitals. This is felt by Trusts and staff alike;

- The perception of ‘*winner*s’ and ‘*loser*s’ with a sense of inferiority and loss of services and status felt by non-arterial vascular centre Trusts, and those who work there, as opposed to being part of something bigger, the new Vascular Network;
- A lack of will or desire to change years of practice.

On a practical level too, vascular networks with a single arterial centre create operational difficulties:

- Having employees within different organisations can create barriers to consistent job planning;
- Capacity issues at the arterial centre for inpatient beds, theatre sessions, interventional radiology, vascular imaging (including the number of vascular scientists) and outpatient clinics;
- Maintenance of expertise in the non-arterial centres;
- Repatriation agreements being tested by the pressure on acute admissions to non-arterial centres;
- Incompatible information systems for sharing between partner hospitals;
- Concerns about less than hospitable working conditions, onerous rotas and lack of junior staff;
- Travel and parking;
- Financial constraints.

2.3 *Successful reconfiguration requires a well led steering committee* (or ‘Reconfiguration Board’).

A successful and sustainable new network model will only be achieved by:

- **Strong commissioning**, this needs to be someone’s specific job, not just another ‘pot boiling’ in the commissioning office. Service redesign is the daily bread and butter of healthcare commissioners. In common with other service reconfigurations developing a new vascular network requires a steering committee with representation from across the geography involved. This must include Commissioners, Hospital Executives, local CCGs or Health Boards, the Ambulance Trust and clinical input from a Clinical Advisory Group (see below);
- **Engaged clinicians**, the clinical advisory group is the central plank in getting agreement on clinical protocols etc. for the new network (see below). This group should lead on the development of the network clinical model. Their work must start early, well before the site of the arterial centre has been agreed. Regular meetings of clinicians of all disciplines from across the network, both within the formal structure of the clinical advisory group and informally (i.e. following MDT meetings, evening meals or visits from clinicians working in areas that have already reorganised) are important so that the future can begin to be described in a level of detail that can allay some fears;
- **Establishing the view from the CEOs**, are there other services that require a change in delivery so that it would be sensible to consider them together?
- **A well-managed change project**, the [NHS Change Model](#) is extremely helpful and a comprehensive repository of resources. Ideally an individual experienced in the change process will have a prominent role in the reorganisation project; this is particularly helpful to set out clear timelines for change and provide support when these are not being met.

There is mileage in using a change methodology with which people are familiar; most institutions will have a favourite approach and using this can save time.

2.4 **Change is hard**, one vascular surgeon remarked ‘*disappointingly the only way to do it seems to be properly*’ after going through a service reconfiguration. **There are no shortcuts.**

To be successful the steering committee, which provides Executive and Commissioner leadership, will need to be supported by two key groups to help address the challenges and operational difficulties of developing the new network structures:

Clinical Advisory Group

This group is composed of local vascular surgeons, interventional radiologists, specialist nurses and vascular scientists. It goes without saying that all organisations potentially involved in the reorganisation should have representation on the group that will define the future for them all

- Topic specialists should take the lead in forging the agreements that result in the supporting documents that describe the clinical pathways for the new network;
- This group must look outwards to the interdependent specialities. A reconfiguration that leaves the diabetic foot protection services in partner hospitals in disarray, or disrupts an interventional radiology rota, could not be considered successful;
- Vascular nurse specialists and vascular scientists may need their own sub-groups to ensure all disciplines are able to make progress speedy. They are key to getting agreed pathways and common reporting standards;
- There are lots of documents from clinical advisory groups about and so those yet to reconfigure can easily adapt and adopt rather than writing these from scratch.

Operational Implementation Group

Service managers also need their own group. It again goes without saying, that all involved organisations should have representation on the group that will define the future for them all

- There is so much to consider in reorganising vascular services that it is unrealistic to think that clinicians will update their managerial colleagues following meetings;
- This group must work closely with IT teams in all involved organisations;
- Just as for the clinical documents, many services have successfully reconfigured and the inter-institution agreements (i.e. Service Level Agreements ‘SLAs’) can easily be collated, adapted and adopted rather than starting with a blank page.

3. Change is inevitable

The first national [GIRFT](#) report for vascular surgery in England written by Professor Mike Horrocks has recently been published. The first recommendation states “*Ensure all units are operating within a hub and spoke network model, as defined by the national service specification, emulating the most advanced hub and spoke models that exist currently. This in turn should deliver improved early decision-making capability and access to diagnostics, allowing early treatment, prioritised by degree of urgency.*”

The report makes explicit that full implementation of vascular networks is a key recommendation and that the NHS in England could save more lives by enabling patients to receive urgent vascular surgery sooner.

In response NHS England have, from April 2018, commenced a peer review process for vascular networks based on the vascular service specification and POVS 2015.

It is a matter of when, not if, English vascular services that aren't compliant with the NHS England Specialised Service commissioning guidelines must change.

It is vital that the Steering Committee, the Clinical Advisory Group and the Operational Implementation Group provide a reality check that change is inevitable.

Change is hard to adapt to, but the sky doesn't fall in when reorganisation happens. In the best interests of patients, the tax payer expects health professionals to just get on with it:

- Discussions and agreements at CEO level are vital so that it's clear to everyone that there is going to be change;
- The benefits of service redesign in terms of improved clinical outcomes and cost effectiveness should be restated regularly and should drive the process;
- Early engagement with local patient groups and local health overview and scrutiny committees is a common feature in successful service reconfigurations.

Successful reorganisations are achieved when the needs of patients, expressed in clinical terms by the clinical advisory group in their pathways, and improved through the implementation group and consultation with patient groups and Health Oversight and Scrutiny Committees or Health Boards, are understood.

This process does not function when one or more individuals, often Consultant Surgeons, but also Chief Executives, dominate discussions and drive a different clinical agenda.

- Being part of change is better than having it imposed upon you, which is what will happen if people, or organisations, choose not to participate;

How would you explain to local patients that your system hasn't reorganised when others have and their patients are reaping the benefits?

4. Agree the clinical model

The first stage in the reorganisation process is to get agreement in principle over what you are trying to achieve within your network. This process must be informed by:

- Vascular Society of Great Britain and Ireland's Provision of Vascular Services ([POVS 2015](#))
- Royal College of Radiologists and British Society of Interventional Radiology Provision of Interventional Radiology Services ([POIRS 2014](#))
- NHS England National Vascular Service Specification ([Specialised Vascular Services](#))

These documents set out how services must look both at the network arterial centre and at the non-arterial vascular centres:

- **The specification is the specification**, service specifications and POVS specify what happens in an arterial centre and what can take place in the non-arterial vascular centres, **there is no wriggle room**.
- **Sixty abdominal aortic aneurysm (AAA) repairs per annum** is the minimum for a vascular network. In published studies improvements in outcome are observed to around 100 AAA repairs per annum¹. In a small number of the least densely populated areas, such as Western Ireland, Mid and West Wales, the SW Peninsula and N Cumbria the minimum should be the standard. In densely populated (i.e. urban settings) commissioners should aim to develop networks with higher AAA volumes.

¹ Few UK units perform more than 100 AAA per annum, it's not known if improvement continues thereafter.

Establishing the site of the arterial centre

In some networks this may be an easy decision, for others this decision can derail the entire reconfiguration process. This is particularly the case when two or more arterial centres of similar size and volume are reorganising into a network model.

Remember that the patients come first and so, where everything else is equal, factors such as accessibility, 'fit' with other health system changes or geography may be determining factors.

5. Barriers to change

Due consideration must be given to the following four blocks to successful reconfiguration:

- **Vascular surgeons and interventional radiologists are loyal to their teams.** Consultants will often oscillate back and forth between the arterial centre and the non-arterial vascular centres, the nurses, radiographers, clinical vascular scientists and others with whom they have close long term relationships will be facing significant job changes. Everyone finds this hard;
- **Non-arterial work**, vascular surgeons, interventional radiologists, nurse specialists and vascular scientists may perform other, non-vascular, roles (e.g. clinical, educational or managerial). They will have formed close working relationships with colleagues in other specialities in their Trust, and not just within surgery and radiology;

These bonds can be painful to break, with some clinicians deciding to forego their arterial work.

- **Lack of clarity in what the future might mean**, experience suggests that this uncertainty about the future prevents change. It's the human things like the provision of a desk, somewhere to park and access to a secretary that make the difference;
- **Perceived loss of status amongst the teams who move.** Change can be highly emotive, when one vascular surgeon was asked “*What would make it OK for you to work in another centre?*” the reply was “*If I wasn't made to feel like a loser when I went there*”.

6. Lessons learned

The following four lessons have been learned from talking to both individuals and teams who have been through a partial or complete reorganisation of services into a modern vascular network:

- **Be aware of the importance of ‘status’**, non-arterial centres will perceive themselves as having ‘lost’ their vascular service. Emphasise the detail of the service at these partner hospitals, e.g. being able to confirm that a vascular consultant will be available on weekdays and a vascular nurse specialist every day, together with continued input into the diabetic foot protection service, renal access and day case angioplasty (if this was offered before) can smooth the transition;
- **Acknowledge individual choices**, some people won't want to be part of the new network and that's their professional choice. The reality is that they can choose to be part of the new structure or they can develop non-vascular areas of practice. Sometimes resistance arises from a lack of familiarity with techniques or different ways of working. Consultant to consultant and/or team to team mentoring has been used to address this with good effect;

Continued resistance to the change won't stop it happening. The choices of one or more individuals must not outweigh the benefits to patients of a successful service reconfiguration.

- **Avoid inequality**, or any perception of differences or superiority, regarding vascular surgeons, interventional radiologists, specialist nurses or vascular scientists, who have always been based at the Trust providing the network arterial centre and staff who have been based at partner hospitals;

Over time, inequalities become a significant obstacle to developing an effective and sustainable network team. They should be avoided at all costs.

- **Accept help**, there is almost always a need for some significant organisational development input from an external source to transform disparate clinicians into a network team. One day is never enough but depending on the level of acrimony, the equivalent of one week might be.

7. Once the arterial centre has been identified

This may come early or late in the reconfiguration process. Either way it is an important milestone when the steering committee agrees the arterial site because work on pathways and protocols can then progress to final versions for sign off by the reconfiguration steering group:

- **Standardise referral protocols** into the arterial centre, together with the investigations and the capacity of the non-invasive imaging that is available in the non-arterial network hospitals. Inevitably there will be differences, but as far as possible try to get consistency for the sake of smooth, rapid transfer of patients. For example, we have often found great variation in the way diabetic foot services work in the partner hospitals or the investigations that can be undertaken in a non-arterial vascular site. None of this serves the patients well;

Start this work early because it can involve the partner hospitals in complicated, and occasionally difficult, negotiations with each other and with their CCGs.

This is also what is promised in patient and public consultation so it's important to deliver on it.

- **Agree repatriation 'rules'** this can make or break the capacity of an arterial centre to deliver good, timely care and so again, needs early agreement. Usually this needs to be at executive level because of the implications it has on the wider functioning of all hospitals concerned;
- **Retain vascular nurse specialist posts**, losing any of these vital members of the vascular team will have a detrimental effect on the network. A specialist nurse presence in the non-arterial vascular hospitals is the glue that holds the network together. Amongst other things, they ensure timely review of internal requests for vascular opinions, that relevant investigations are performed and available and the smooth transfer of patients to and from the arterial centre;

It is equally important that nurse specialists spend time in the arterial centre to attend the multi-disciplinary team and management meetings, to maintain their expertise and to gain experience.

- **Vascular clinicians** should all be given the opportunity, and be encouraged, to become part of the new vascular network.

Vascular nurse specialists

In general, vascular nurse specialists will face a change in how they execute their role, but their jobs remain intact. They are still subject to significant change and this has challenges.

In common with other senior clinical staff they face

- A new management structure;
- An increase in time spent travelling to the arterial centre and non-vascular hospitals;
- New ways of working, such as review of inpatient referrals at non-arterial centre hospitals;
- The need to bring often disparate operational practices together across sites;
- The challenge of forming new relationships with a significantly expanded clinical team and across a number of clinical sites.

- **As far as possible, banish the divide between the arterial centre and the non-arterial vascular hospitals**, experience suggests that ideally all vascular surgeons and vascular radiologists who are part of the service and the out of hours' rotas, should have their contracts held at the arterial centre;

When a vascular service is transferred between independent hospital Trusts, vascular clinicians will have their contracts moved by the legally binding TUPE ('Transfer of Undertakings, Protection of Employment, Regulations') process to the new single Trust provider. This may need to be a staged process, but if that's the case, there should be a clear completion date.

- **New appointments should be by the arterial centre**, as this goes a long way to eliminate the divide and avoid perceptions of inequality. It encourages loyalty to a single provider – the named vascular network - rather than competing loyalties between partner Trusts;

Steering committees should consider how this may relate to the vascular nurse specialists and other clinical staff too. Networks in which contracts are retained in the non-arterial vascular hospitals will find it decreases the ability of the service to respond quickly and flexibility to changing service needs.

- **Centralisation encourages and ensures a single point of job planning** for consultants and vascular nurse specialists. It also encourages the organisation to hold the consultants accountable for planned clinical sessions;

There should be near parity in job plans for out-patient sessions, whether at the arterial centre or non-arterial vascular centre. The same is true for arterial centre theatre and angiography sessions and cross cover for study/annual leave or during the emergency week on call.

- **Be cautious about 'transition arrangements'** especially if they are badged as a move to something along the lines of 'one service delivered on two/three/four sites'. This option only pays lip service to the network model. Whilst a period of transition is essential for an orderly transfer of inpatient activity, extended transition proposals are dangerous. They are often argued to give the opportunity for 'common protocols' etc. to be developed prior to a move, but are ultimately a delaying tactic. In our experience, agreeing to a 'transition period' with no endpoint in sight means there are always reasons why the 'shared protocol' hasn't been able to be produced in the time available, e.g. heavy on-call, delays in getting it through the approval boards in all institutions etc. Once these delays happen, if it's been agreed that all these needs to be in place before the move, the move is put back;

Most importantly, whilst transition arrangements are going on, it does not bring any of the benefits of reorganisation to patients.

- **If faced with a 'transition package'** ask yourself what will have changed in 2yrs, 3yrs or 5yrs – whatever the transition period suggested – that will make the shift ok when it isn't now? The suggested timescales are rarely arbitrary. They are usually chosen by those who opposed the change and often correspond to the career change-over time of management/commissioning personnel with the subsequent loss of organisational memory;

The risk is that delay gives those opposing changes the opportunity to go back to square one, claiming things have changed and suddenly, you're back into another review process.

- **Consider 'buddying up' key members** with their counterparts in a network that is up and running. There are few problems that you will encounter that haven't happened before. A lot of time and anguish can be avoided by working with others who've been through the experience. Members of NHS England's Vascular Clinical Reference Group are useful [contacts](#).

8. Assuring success

8.1 *Managing aspirations, disappointments, people and personalities.* A key role for not only the steering committee but for of all concerned in managing the process of reorganisation is to understand the aspirations, disappointments, people and personalities involved:

- **A shared vision really does help**, people in successfully reorganised vascular services have an agreement on what they are trying to achieve. Their commitment is first to patient care within the population they serve, second the hospital, and third the individual's own interest;

Knowing that everyone has accepted change which may not be to their own benefit builds trust.

- **Clinical leads must lead by example**, successful leaders go out of their way to accommodate their patients and their colleagues, whilst still maintaining the shared vision. They prove to be the impartial voice of reason. Their actions demonstrate that shared vision for the service, rather than just paying lip service to it. The on call and clinical commitments of clinical leads are no better nor worse than anyone else – neither is their office!
- **The network MDT process will almost always require change**, with non-confrontational, supportive membership as the norm. All consultants, whether originally from the hospital that is now the arterial vascular centre or from a non-arterial vascular hospital, need equal opportunity to attend and present their cases. There needs to be less of what in the past was characterised as 'alpha male' behaviour and more explicit demonstrations of support, particularly from the senior members of the team. Many of the junior/less experienced consultants use the MDT as a mechanism for helping with their decision making or even formulating their thoughts. This requires patience and support from the others with greater clarity or brevity of thought and word or to whom decision making comes more easily, usually because of time and experience;
- **There will always be the odd naysayer** or the outlier who feels themselves marginalised when all the other members of the network buy into the shared vision. Such individuals need to be offered encouragement and opportunity to get back in the fold or support to consider and take up other options. Experience tells us they often come around, even if partially and that makes a big difference. Or some leave which, for both the individual and the network, should be viewed an opportunity rather than a loss.

8.2 *Organising the network.* A new network will only work well if sufficient planning has gone into ensuring its function and organisation:

- **Networking arrangements are new** to vascular services and change is disruptive. Due consideration should be given to staff who must change to working in unfamiliar hospitals and working environments with new colleagues;

Another time, another place and it could apply to anyone.

- **Working across different hospital sites** poses challenges for staff. However, the obvious benefits in patient care, improved outcomes and work-life balance with sustainable on call rotas should overshadow the changes to established or historical practice, along with being part of a wider more supported organisation – the Vascular Network;
- **Cross cover arrangements** improve operating theatre and interventional radiology utilisation for the provider organisation. This ensures patients are treated in a timely manner on a vascular list. It also provides equity in theatre/angio. suite access for elective vascular lists for all interventional radiologists and vascular surgeons, whilst being recognised by the job planning processes;

- **Fair and equitable distribution of vascular sessions** at the arterial centre is important to all consultants in the network. Having fixed sessions at the arterial centre (e.g. theatre lists) with corresponding fixed sessions at the non-arterial vascular centre (e.g. outpatient clinics) is often best for job planning and ensures predictability;

Cross cover for consultant of the week / study / annual leave should be shared and offered equitably to all consultants in the network.

- **Outpatient facilities** need to be available daily at the arterial centre and at least twice weekly at non-arterial vascular centres to ensure access for the population served by the entire network;
- **Surgeons/Interventional Radiologists with non-arterial site commitments** during the day of the MDT may need the opportunity to discuss their patients first. Although everyone should have the MDT timetabled into their job plan, things can over run and it's only polite to extend this courtesy to those who must travel afterwards;
- **On-call rotas** should consider a later start to the after-hours on call (6.30 – 7pm) to allow consultants to complete daytime commitments to the non-arterial vascular centres with time for handover from the on-call consultant of the week at the arterial centre;
- **Job plans** should also account for travel times between sites. Wherever possible, sensible job planning should avoid repeated daytime travel back and forth between sites at peak hours;
- **On-site support**, simple things such as suitable office space, access to IT systems and a computer together with a secretary both at arterial centre and non-arterial vascular centres should be mandatory. These arrangements are important for providing equality and should be a priority for the operational implementation group;
- **Parking arrangements** at both sites for consultants travelling back and forth are essential. Any priority parking permits should be available to all for the duration of on call;
- **Shaping networking alliances, rotas and working arrangements**, in many networks the vascular surgeons have taken a lead role in this aspect of designing the network. Often vascular interventional radiology has suffered in comparison. Vascular network structures must consider the needs of interventional radiology provision both at the arterial centre and at the non-arterial network hospitals.

There may already be a short-fall of interventional radiology support within some Trusts. Vascular reorganisation must not destabilise these services further. It is helpful if the vascular surgical networking arrangements support similar interventional radiology networking based on local policies.

9. Take home messages

Reconfiguration of services is never easy but those about to embark on a vascular reorganisation may find they have opportunities that were not available before. In England, the advent of the Sustainability and Transformation Plans (STPs) are heralding health service change on a scale not seen for some time. This fluidity may serve to remove what is perhaps the single most important barrier to reconfiguration, namely a misplaced institutional ‘pride’.

An atmosphere in which the designated arterial centre is viewed as the ‘winner’ and the partner hospitals as the ‘losers’ can hold a vascular network back for years.

Conversely, a health economy in which there is simultaneous change in all providers across a range of services has a much better chance of creating an environment of evolution rather than revolution,

Reconfiguration is neither quick nor easy but the benefits to patients are now so apparent, that an unwillingness to tackle the difficulties can no longer be considered a justifiable stance for those involved in the delivery of health care.

10. Helpful contacts

The following have offered to help networks seeking assistance with reconfiguration:

<i>Organisation</i>	<i>Contact details</i>	
Vascular Society of Great Britain and Ireland (VSGBI)	<i>Secretary</i>	Sophie Renton Email: secretary@vascularsociety.org.uk
	<i>Wales Northern Ireland Republic of Ireland</i>	Louis Fligelstone Denis Harkin Ciaran McDonnell
British Society of Interventional Radiology (BSIR)	<i>Council</i>	BSIR Council Email: council@bsir.org
Society of Vascular Nurses (SVN)	<i>President</i>	Nikki Fenwick Email: nikki.fenwick@sth.nhs.uk
The Society for Vascular Technology of Great Britain and Ireland (SVT)	<i>President</i>	Helen Dixon Email: h.dixon@nhs.net
NHS England Vascular Clinical Reference Group (Vascular CRG) Professor Rob Sayers (Chair) Email: Rs152@leicester.ac.uk Steven Duckworth (Commissioner) Email: steven.duckworth@nhs.net Tel: 0113 825 3050 Mobile: 07730 376516 Claire O'Donnell (Public Health) Email: claireo'donnell@nhs.net Tel: 0113 825 2754 Mobile: 07825 282041	<i>North</i>	Michael Wyatt Trevor Cleveland Email: mike.wyatt@nuth.nhs.uk Email: trevor.cleveland@sth.nhs.uk
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