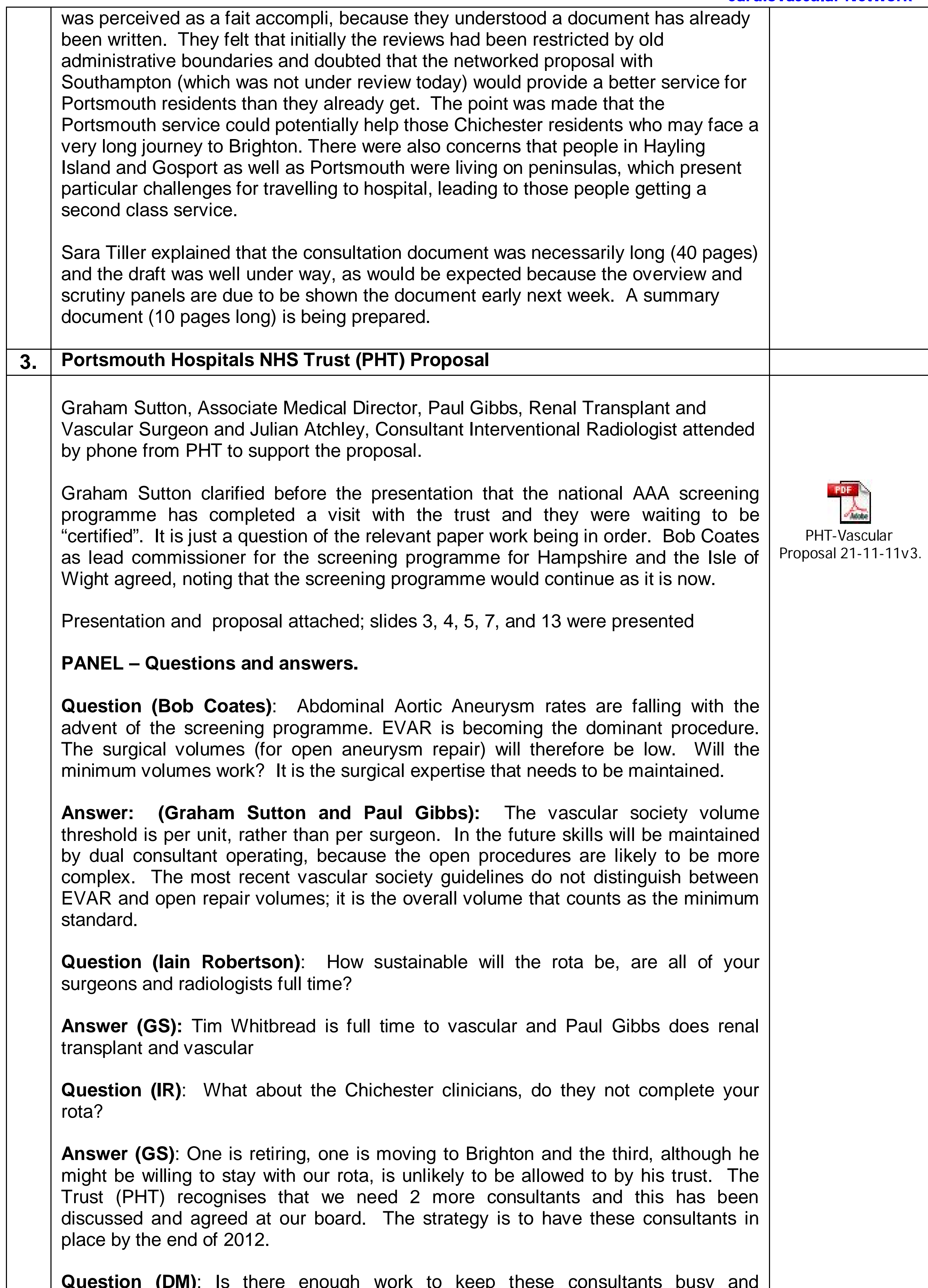
South Central Clinical Networks
Cardiovascular Network

# South Central Vascular Network Assessing Panel

Thursday, January 5th, 2012, 4 to 5.30pm, Oakley Road Southampton

# Minutes

| | ITEM | Attachments |
|---|---|---|
| 1. | **Present** | |
| | By Phone:<br>**Charles Waddicor**, Berkshire PCT Cluster Chief executive, Chair of the South Central Cardiovascular Network (Chair)<br><br>**David Mitchell** - Vascular Surgery Specialty Director / Consultant Vascular and Renal Transplant Surgeon, North Bristol NHS Trust and Chair of the VSGBI Audit and Quality Improvement Committee.<br>**Iain Robertson** - Consultant Interventional Radiologist North Glasgow University Hospitals NHS Trust and President of the BSIR.<br><br>**Deborah Tomalin**- Director of Sussex Managed Clinical Networks, representing NHS Sussex<br><br>In the Room:<br>**Syd Rapson-** PHT Governor<br>**Jock McLees** – Portsmouth LINk<br>**Andy MacDowell** – Portsmouth LINk<br>**Harry Dymond-** Chair Southampton Local Involvement network (LINK)<br>**Sarah Elliott**- SHIP Cluster Director of Nursing and lead for the Vascular Review<br>**Dr Barbara Rushton-** Liphook GP and Lead for South East Commissioning Consortium CCG (Portsmouth and South East Hampshire)<br>**Andy Douglas** – Petersfield GP and Primary care lead for the South Central Cardiovascular Network<br>**Dr Steve Townsend-** GP in Southampton, lead for Southampton CCG<br>**Bob Coates**- SHIP Cluster Consultant in Public Health, Chair of the SHIP AAA Screening Programme Board<br>**Sara Tiller**- Communications Director- SHIP cluster<br>**Emma Mc Kinney**- SHIP Project Manager Safe and Sustainable Review<br>**Beverley Meeson**- South Central Cardiovascular Network Manager (notes) | |
| 2. | **Apologies** | |
| | **Jonothan Earnshaw** – Consultant Vascular Surgeon, Gloucestershire Royal Hospital NHS FT, Secretary of the Vascular Society of Great Britain and Ireland (VSGBI) and Clinical Director for the NHS Abdominal Aortic Screening Programme<br>**David Kessel** – Consultant Vascular Radiologist, Leeds Teaching Hospitals NHS Trust and Past President British Society of Interventional Radiology (BSIR).<br><br>These experts were dealing with emergency patients so could not join. They have sent in their views separately, see attached.<br><br>**James Mapstone** – Clinical Director of Programme - Acute Care, SHA<br><br>CW welcomed and thanked the panel for participating in the process. CW asked the assessing panel if any had pecuniary interest in the outcome of the meeting. All members agreed that they would did not have pecuniary interest in the outcome of panel decision.<br><br>Portsmouth LINk members and governor expressed their concern that the process | |



| | | |
|---|---|---|
| | was perceived as a fait accompli, because they understood a document has already been written. They felt that initially the reviews had been restricted by old administrative boundaries and doubted that the networked proposal with Southampton (which was not under review today) would provide a better service for Portsmouth residents than they already get. The point was made that the Portsmouth service could potentially help those Chichester residents who may face a very long journey to Brighton. There were also concerns that people in Hayling Island and Gosport as well as Portsmouth were living on peninsulas, which present particular challenges for travelling to hospital, leading to those people getting a second class service.<br><br>Sara Tiller explained that the consultation document was necessarily long (40 pages) and the draft was well under way, as would be expected because the overview and scrutiny panels are due to be shown the document early next week. A summary document (10 pages long) is being prepared. | |
| **3.** | **Portsmouth Hospitals NHS Trust (PHT) Proposal** | |
| | Graham Sutton, Associate Medical Director, Paul Gibbs, Renal Transplant and Vascular Surgeon and Julian Atchley, Consultant Interventional Radiologist attended by phone from PHT to support the proposal.<br><br>Graham Sutton clarified before the presentation that the national AAA screening programme has completed a visit with the trust and they were waiting to be "certified". It is just a question of the relevant paper work being in order. Bob Coates as lead commissioner for the screening programme for Hampshire and the Isle of Wight agreed, noting that the screening programme would continue as it is now.<br><br>Presentation and proposal attached; slides 3, 4, 5, 7, and 13 were presented<br><br>**PANEL – Questions and answers.**<br><br>**Question (Bob Coates)**: Abdominal Aortic Aneurysm rates are falling with the advent of the screening programme. EVAR is becoming the dominant procedure. The surgical volumes (for open aneurysm repair) will therefore be low. Will the minimum volumes work? It is the surgical expertise that needs to be maintained.<br><br>**Answer: (Graham Sutton and Paul Gibbs):** The vascular society volume threshold is per unit, rather than per surgeon. In the future skills will be maintained by dual consultant operating, because the open procedures are likely to be more complex. The most recent vascular society guidelines do not distinguish between EVAR and open repair volumes; it is the overall volume that counts as the minimum standard.<br><br>**Question (Iain Robertson)**: How sustainable will the rota be, are all of your surgeons and radiologists full time?<br><br>**Answer (GS):** Tim Whitbread is full time to vascular and Paul Gibbs does renal transplant and vascular<br><br>**Question (IR)**: What about the Chichester clinicians, do they not complete your rota?<br><br>**Answer (GS)**: One is retiring, one is moving to Brighton and the third, although he might be willing to stay with our rota, is unlikely to be allowed to by his trust. The Trust (PHT) recognises that we need 2 more consultants and this has been discussed and agreed at our board. The strategy is to have these consultants in place by the end of 2012.<br><br>**Question (DM)**: Is there enough work to keep these consultants busy and | PHT-Vascular Proposal 21-11-11v3. |

productive? Won't patients be routed through the Chichester system to Brighton?

**Answer (GS):** Our proposal looks at the numbers involved for the volume of work. PHT is closer than Brighton for Chichester residents, but we recognise that they won't all be referred into the QA. We will have to find things for the appointees to do.

**Question (DM)**: Are you looking for your new surgeons specifically to support the renal service?

**Answer (PG)**: It would depend on the skills of the people that applied for the posts.

**Question (DM)**: You need a strategy and to attract the best people you need to be clear about what they are going to do. Has this been thought through yet?

**Answer (PG and GS)**: We have looked at another surgeon for the renal service as a possibility. UHS will have the same problems. They are proposing a 1:10 rota, what will all those people be doing? Several strategies are available; until we know who applies, it is difficult to plan.

**Question (DM):** What else could your surgeons be doing: renal transplantation, other general surgery? Where is the vision?

**Answer (GS)**: We are keeping all our options open. I have discussed this with the surgeons involved and there will be a problem if we fix the brief now and then can't find people with those skills.

**Question (Andy MacDowell to David Mitchell):** You have stated that patients will be "routed through the system"; surely local residents have choice about where they are treated?

**(GS):** We plan to carry on our present clinics in Emsworth and Petersfield and to start new clinics in Chichester and Bognor.

**Question (Steve Townsend)**: What would be the effect on the service in (University Hospitals Southampton (UHS) if this proposal is accepted?

**Answer (GS):** The UHS service is viable without the Portsmouth work.

**Question (Syd Rapson)**: Are the outcomes at PHT below international standards?

**Answer GS and DM):** No they are not

**Question (BC):** What proportion of contacts are major procedures that would require dislocation (moving) to Southampton?

**Answer (PG):** 1-2 per week of each of the major procedures. In addition there are 5 outpatient clinics a week with about 20 patients in each, so about 100 patient contacts a week. (These would be staying at PHT). We operate on about 10% of the patients we see. It may be, we see a patient for a long time before surgery. Other contacts include nurse led clinics, vascular lab work. Operating is only a small part of the work. It is the ongoing relationship with the patient that is important.

**Question (Syd Rapson)**: Would a network with Southampton lead to deskilling of the surgeons at Portsmouth?

**Answer (PG):** This is a serious concern, not so much for the surgeons because they would be operating at Southampton, but the lab staff and allied heath professionals. I feel that outcomes may actually deteriorate in that situation. We do transplants for an area covering 2 million people, how will we maintain standards?

| | | |
|---|---|---|
| | **(DM):** You have a 4 transplant surgeon renal unit, yet you are appointing more general vascular surgeons and I don't understand why. Evidence shows that overall vascular workload improves outcomes, so for example if you do a lot of surgery on ischaemic legs, you will also be good at aneurysms. However the issue of accessibility and locality of services are valid considerations<br><br>**Question (BC):** My reading of the evidence is that we need networks with centralised complex vascular surgery to improve outcomes for patients for the future. What is happening around the country?<br><br>**(DM):** Networks are coming together around populations of 800,000 to one million, although in a couple of areas this has been fudged.<br><br>**Question Andy Douglas):** Could a network with Southampton as the hub include some complex surgery at PHT?<br><br>**DM:** At the present time we are in a state of flux. In the recent carotid endarterectomy audit s we have seen the number of units drop from 140 to 121 in a matter of months. Aneurysm surgery requires complex experience and this is not feasible in every hospital<br><br>**AD:** Is that a yes?<br><br>**IR:** It is a yes for interventional radiology undoubtedly The British Society of Interventional Radiology has issued recent guidance stating that provided there is appropriate governance some vascular radiology procedures can be performed outside the main vascular centre.<br><br>**AD:** This is good because local people are anxious about losing everything and not getting it back if standards change in the future | |
| **4** | **Expert Panel Scoring and Clinical Comments for Commissioners** | |
| | **Portsmouth Proposal to act as a stand alone unit: Does this meet the specification and is it viable?**<br><br>The views expressed here are not a collective decision and recommendation, as only two members of the panel were present. An overall statement from each clinician is therefore provided. The panel have had the Portsmouth business case for perusal since 16.12.11. **The independent expert panel scores are appended to the minutes.**<br><br>Received at the meeting<br><br>1. David Mitchell: "This is quite a large unit with an activity volume that will make it viable as a standalone unit, but this is borderline. It is a concern that the unit is not networked and there is a query about sustainability in the long term"<br><br>2. Iain Robertson: "There is no doubting the commitment of the Portsmouth clinicians and management. However I have concerns about sustainability and the use of extra consultant resource in the long term<br><br>Received after the meeting by email: | |

3. Jonothan Earnshaw: "From NAAASP perspective, the proposed solution is workable. The existing local programme would simply refer detected AAA either to Southampton or Portsmouth, as geographically appropriate. The Portsmouth hospital was initially subject to pre-implementation quality assurance from NAAASP, but this has not yet been validated, and it would need to be completed before screen detected AAA could be referred. The bid relies on capturing future work and I am uncomfortable about that. I imagine that conditions will get tighter for vascular commissioning, and I doubt the unit is sustainable in the medium term, however, on pure scoring terms, and if the promised personnel are delivered, it fulfils existing criteria"

4. David Kessel: The service meets the specification but the following points related to the desirability and sustainability of such a service seem pertinent. Drivers for the service to remain in Portsmouth , several factors are cited in the bid
   - Financial (see below)
   - Utilisation of capital resource – the BSIR position is that endovascular interventions can occur outside "vascular centres" – thus it seems logical that the Portsmouth angiographic facility would still be used for the benefit of inpatients and appropriately selected outpatients.
   - Support for local services – any arrangement for a joint service with Southampton would surely have as a condition the support for existing services such as the renal transplant and dialysis services.

   Finances
   - The financial plan relies on services from Chichester being commissioned from Portsmouth, this is not guaranteed.
   - There also appears to be a suggestion of a complete loss of income for vascular services with a combined service with the centre at Southampton. There needs to be clarification that this is the case as PHT staff would be involved in the service provision and some of the work – clinics, imaging and image guided intervention will almost certainly stay in Portsmouth. Would all this income be lost?
   - The costs for on call interventional radiology are likely to be an underestimate. In Leeds the remuneration is 1.5 PA based on repeated diary exercises showing an average of nearly 4 hours per day.

   Viability
   - The workload appears small for the planned numbers of consultant staff. This raises issues of acquisition and maintenance of competence and also questions regarding what the consultant job plans will actually entail.
   - Training is likely to be an issue certainly on the vascular surgical side given the likely numbers of trainees in the region

## 6 Next Steps

Sarah Elliott explained that this part of the process was to establish an independent clinical view of the proposals for consultation. The PCT cluster was aligning its deliberations on this issue with the Sussex Review. The output from this meeting will inform the SHIP consultation document and the engagement documents for Sussex (their HOSC has not required a formal consultation). It is important that we obtain the scores from the other clinicians. The PCT is working in the financial aspects of the proposal with the Portsmouth Hospitals NHS Trust.

The PCT will be working to launch the consultation document on the 16th of this month. The document will be shared with the OSCs early next week.

GPs commissioners who currently refer into PHT will be meeting with UHS and PHT clinicians on the 11th January to provide a clinical challenge to both the stand alone and the network proposal and test issues of clinical safety.

| 7 | **Full Panel Views on the Process and the Recommendation** | |
|---|---|---|
| | CW asked all panel members to express the views on how the panel was run and to indicate their level of content or unease with the clinical recommendations.<br><br>• Most present felt that the recommendations were fair and that the panel process had been fair.<br>• Portsmouth lay panel members, although pleased that the meeting had been courteous and that they had been allowed to ask questions, were still sceptical that the outcome had not already been decided.<br>• Concerns were expressed again by Portsmouth lay members about the issues of living on a peninsula and the possibility of a receiving a second class service and about the effect on co-dependent services<br>• Mr Rapson also asked why the people of Portsmouth should have a worse service than they have at present and that the move to Southampton would reduce the level of care for them.<br>• Mr MacDowell and Mr Rapson felt that the process was being rushed, however Mr Dymond who had been attending the meetings for the last 15 months, suggested that the process had been more than fair, with several modifications to proposals having happened since late 2010.<br><br>Deborah Tomalin representing NHS Sussex assured the panel that the views of the people of Sussex would be properly sought and taken into account. | |
| | Charles Waddicor and Beverley Meeson warmly thanked everyone for participating | |

**South Central Vascular Network Review Panel Responses: 5th January 2012 Telephone Conference**
**Portsmouth Proposal Panel Overall Comments: Does this meet the specification and is it viable?**

1. David Mitchell: "This is quite a large unit with an activity volume that will make it viable as a standalone unit, but this is borderline. It is a concern that the unit is not networked and there is query about sustainability in the long term

2. Jonothan Earnshaw: "From NAAASP perspective, the proposed solution is workable. The existing local programme would simply refer detected AAA either to Southampton or Portsmouth, as geographically appropriate. The Portsmouth hospital was initially subject to pre-implementation quality assurance from NAAASP, but this has not yet been validated, and it would need to be completed before screen detected AAA could be referred. The bid relies on capturing future work and I am uncomfortable about that. I imagine that conditions will get tighter for vascular commissioning, and I doubt the unit is sustainable in the medium term, however, on pure scoring terms, and if the promised personnel are delivered, it fulfils existing criteria.

3. David Kessel: The service meets the specification but the following points related to the desirability and sustainability of such a service seem pertinent. Drivers for the service to remain in Portsmouth , several factors are cited in the bid
   - Financial (see below)
   - Utilisation of capital resource – the BSIR position is that endovascular interventions can occur outside "vascular centres" – thus it seems logical that the Portsmouth angiographic facility would still be used for the benefit of inpatients and appropriately selected outpatients.
   - Support for local services – any arrangement for a joint service with Southampton would surely have as a condition the support for existing services such as the renal transplant and dialysis services.

   <u>Finances</u>
   - The financial plan relies on services from Chichester being commissioned from Portsmouth, this is not guaranteed.
   - There also appears to be a suggestion of a complete loss of income for vascular services with a combined service with the centre at Southampton. There needs to be clarification that this is the case as PHT staff would be involved in the service provision and some of the work – clinics, imaging and image guided intervention will almost certainly stay in Portsmouth. Would all this income be lost?
   - The costs for on call interventional radiology are likely to be an underestimate. In Leeds the remuneration is 1.5 PA based on repeated diary exercises showing an average of nearly 4 hours per day.

   Viability
   - The workload appears small for the planned numbers of consultant staff. This raises issues of acquisition and maintenance of competence and also questions regarding what the consultant job plans will actually entail.
   - Training is likely to be an issue certainly on the vascular surgical side given the likely numbers of trainees in the region

4. Iain Robertson: "There is no doubting the commitment of the Portsmouth clinicians and management. However I have concerns about sustainability and the use of extra consultant resource in the long term.

Individual scores and comments are overleaf:

**Panel Scores**

| **Portsmouth Proposal** | Jonothan Earnshaw | David Kessel | David Mitchell | Iain Robertson |
|---|---|---|---|---|
| Does the proposal fulfil the national AAA screening programme requirements? | Subject to NAASP QA validation | | | |
| Are you satisfied that there is a robust plan to deliver the increase in capacity to the levels set out in the service specification? (Yes or No) | I doubt the unit is sustainable in the medium term | Yes but it is not clear that this is sustainable | There is the volume to stand alone and a plan but the plan is not robust | Technically can fulfil the criteria by appointing but is this sustainable? |
| Scores on scale 1-4 for: | | | | |
| Staff | 3 | It is not clear from the bid exactly what the surgeons and radiologists job plans are Surgeons 2.5, Radiologists 3, Nurses 3 Anaesthetists 4 | Surgeons, IR and nursing 3 anaesthetist 4 | 2 Surgeons, IR and nursing 3 anaesthetist 4 |
| Facilities | 3 | 3 | 3 | 3 |
| Operation delivery | 3 | 3 | 4 | 4 |
| Cover | 3 | 3 | 3 | 3 |
| Data collection | 3 | 3 | 4 | 4 |
| Outcomes and track record | 3 | 4 | 4 | 4 |
| Uptake of new technology | 3 | 3 | 4 | 3 EVAR adoption rate is slower than one would anticipate |
| Geography | 4 | 4 | 4 | 3 |
| Education and training | 3 | 2 this is likely to be problematic especially given the likely numbers of vascular surgical trainees in the region | 2 I have concerns about how this unit will work for training & attracting trainees | 2 |
| Financial factors | Not known | Not known | Not known | Not known |

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Unsatisfactory | Minimum Requirement | Satisfactory | Good |