Dudley Metropolitan Borough Council

Agenda Item No. 11

Select Committee on Health and Adult Social Care - 6th April 2011

Report of the Director of Partnerships and Service Development

Specialist Vascular Surgery Services for Dudley, Wolverhampton and Walsall

1.0 Purpose of Report

1.1 To advise members about early work that is underway to consider the reconfiguration of vascular surgery services across Dudley, Wolverhampton and Walsall and the reasons for this. The report indicates that the proposals, when they emerge, may constitute a substantial variation of service in which case a formal consultation with the Committee would be required under s244 NHS Act 2006. Furthermore the need for a joint OSC with Wolverhampton and Walsall should be anticipated if required.

2.0 Background

2.1 Vascular surgery includes the following types of operations:

- Abdominal Aortic Aneurysm surgery or repair *(*or 'AAA'). This refers to a swelling of the main artery (aorta) in the abdomen. Aneurysms occur most commonly in individuals between 65 and 75 years old and are more common among men and smokers. They tend to cause no symptoms, although occasionally they cause pain in the abdomen, back, or legs (due to disturbed blood flow). If untreated they can rupture and many patients die before reaching hospital. Even if patients reach hospital, chances of survival are very low. If detected before they rupture (usually through screening or routine examination), they can be treated through elective surgery, which carries a much lower risk. There are two approaches to surgery – open surgery ('open') or using a form of 'key-hole' surgery ('EVAR').
- Carotid Endarterectomy. This is a surgical procedure used to prevent stroke by correcting a narrowing (*stenosis*) in the common carotid artery which supplies the head and neck with oxygenated blood. 'Endarterectomy' is the removal of material on the inside ('end-') of an artery.
- Amputations.

2.2 Evidence based practice, reflected in the West Midlands Quality Review Service (WM QRS) standards, demonstrates that vascular surgical outcomes (both for elective and emergency surgery) are improved when the surgical episode occurs in a single centre of excellence covering a base population of at least 800,000 people. Latest evidence confirms that patients treated at specialist centres have a significantly reduced chance of dying or having a complication as a result of their operation. Black Country residents do not currently have a local specialist centre available.

2.3 This base population of 800,000 is also required to run an AAA Screening Programme. It represents the number of patients needed to maintain competence among vascular specialists and nursing staff and the most efficient use of specialist equipment, staff and facilities. An AAA Screening Programme Office can be located at a different site to the inpatient surgery site as most of the screening will be undertaken in community settings, like other screening tests eg breast screening and cervical cytology screening.

2.4 An AAA Screening Programme is being introduced in the Black Country. One of the outcomes will be the identification of more patients requiring preventative, elective inpatient surgery. It is imperative therefore to ensure that surgery services are optimally configured to provide the best treatment outcomes for patients. This is the key driver behind plans to reconfigure inpatient services. Patients receiving elective treatment for an asymptomatic condition must be offered the best possible outcomes and these can only be achieved at a specialist centre.

2.5 In the Black Country, there are currently four locations for vascular surgery:

- Dudley Group NHS Foundation Trust
- Walsall Hospitals NHS Trust
- The Royal Wolverhampton Hospitals NHS Trust
- Sandwell and West Birmingham Hospitals NHS Trust

Sandwell and West Birmingham Hospitals NHS Trust are included with a similar configuration involving Birmingham hospital sites, and so the discussion in this report focuses on just three locations - Dudley, Walsall and Wolverhampton. Applying nationally based estimates to our population levels, across these three areas, suggests that around one hundred AAA procedures per annum will be required.

2.6 No single unit in the Black Country can currently fulfil the quality standard with the current configuration of provision, or meet the required population size to deliver best possible outcomes. In parallel with changes in service configuration there is a corresponding change in the nature of specialised surgery with vascular surgery becoming a ‘sub-speciality’ in its own right. This means that in future, vascular surgeons will only undertake vascular procedures and will not have dual qualifications which would enable them to undertake non-vascular interventions.

2.7 The challenges surrounding the current configuration of services are not unique to the Black Country. The process of reconfiguring specialist vascular surgery services to deliver best quality care is being repeated across the West Midlands, and has already been undertaken in other parts of England and Wales.

2.8 The main driver for change in the proposed service reconfiguration is the reduced mortality from AAA to be achieved through the introduction of AAA screening. As a result, over time, the majority of operations for AAA repair will be planned – thereby reducing the proportion of emergency procedures required. The access to out-patient, day case and rehabilitation services should be unaffected and the quality of these services should be improved.

2.9 In order to look at the overall model of vascular services within the geography of the three PCT areas, health representatives from commissioner and provider

organisations met in Autumn 2010 to consider the way forward. From this meeting it was agreed to establish a project with a number of work-streams which would contribute to the production of a commissioning plan for Specialist Vascular Surgery Services. These work-streams include:

- Agreement about the clinically-led criteria for judging where the inpatient site should be.
- Specification of the clinical model (including how services would operate across the sub-region and the dependencies between them).
- Healthcare Needs Assessment to understand trends, and evaluate how different sites may affect inequalities, or disproportionately affect certain populations.
- Capacity assessment – looking at current activity and predicted growth as well as workforce and skills availability.
- Public and patient involvement and communication planning (including work with OSCs and local LINks).
- Health Inequality Impact Assessment
- Final decision-making process – looking at how this is set out, ensuring it is transparent, inclusive and acceptable to all stakeholders.

2.10 This work is at an early stage but will need to progress speedily. A clear outcome is that emergency vascular surgery and some complex in-patient elective procedures will be located at one of the three hospital sites. The work-streams above will all contribute towards a determination of where this should be and with a clear rationale why.

2.11 Because of the nature of the changes, we anticipate that the Overview and Scrutiny Committees in Dudley, Walsall and Wolverhampton will consider this reconfiguration a substantial variation, and so this report (and subsequent reports) will form part of a formal consultation with the Committee arising from s244 of the NHS Act 2006 and the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002.

2.12 At an appropriate time it is proposed that a joint OSC is held (s245 NHS Act 2006) for Dudley, Wolverhampton and Walsall to consider the progress of the work-streams described above.

2.13 Project milestones and outputs are attached at Appendix 1 and the project lines of accountability are set out in Appendix 2.

3.0 Finance

3.1 No financial issues arising from this report

4.0 Law

4.1 The Duty to Involve patients and the public under s242 of the NHS Act 2006; to formally consult Overview and Scrutiny Committees under s244; and the convening of a joint OSC (s245), as advised by the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002, will guide this work, as well as mandatory national guidance and quality standards produced by the Department of Health and its agencies. The Equality Act 2010 and regulations advising the general and specific equality duties will also be complied with.

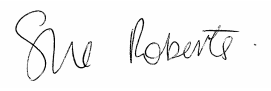
5.0 Equality Impact

5.1 An equality impact assessment will form part of the work-stream for assessing health inequalities and the differential impact on diverse communities.

6.0 Recommendation

6.1 Members are asked to

i. Note the report
ii. Advise on how they wish to be kept informed of progress as this work develops
iii. Give consideration to a joint OSC with Wolverhampton and Walsall local authorities.



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Appendix 1

Project Milestones and Outputs

(Extract from Vascular Services Reconfiguration Project Brief v5 8th Feb 2011)

Phase	Objective	Outputs	Level of decision making	Deadline
1	Establish project structure, lines of accountability, and decision-making	Project brief	Black Country Cluster Board	Feb 2011
1	Develop and maintain clear structures and processes to ensure information, engagement and consultation with key stakeholders.	Communications and engagement plan	Black Country Clinical Leaders Senate – Project Board	March 2011
1	Undertake Healthcare needs assessment of Black Country Vascular Services	Healthcare needs assessment	Black Country Clinical Leaders Senate – Project Board	April 2011
1	Redesign the elective and emergency vascular service care pathways (Including Ambulance protocols) and propose clinical services model which meets agreed clinical standards	Proposed model of clinical services in Black Country	Black Country Clinical Leaders Senate – Project Board	May 2011
	Implement AAA screening in Black Country in parallel with Vascular Services Reconfiguration	Commissioning plan for AAA screening across Black Country	Black Country Local Collaborative Commissioning Board	June 2011
1	Agree commissioning specification meeting agreed models of care that are in line with the financial principles agreed by commissioners.	Service specifications for hub and spoke services	Black Country Local Collaborative Commissioning Board	June 2011
2	New service specifications circulated to providers	Providers reply to new service specifications	Black Country Local Collaborative Commissioning Board	July 2011
2	Receive proposals from providers and review against agreed commissioning specification	Decision on location of hub and spoke services	Black Country Local Collaborative Commissioning Board	Sep 2011
3	Commission services according to service specification	Necessary notification and contracting arrangements	PCT/ GP commissioning consortia	Sep 2011 -March 2012
3	Providers develop and deliver implementation for the reconfiguration of service delivery according to new specification (new project brief and PID required)	Project Brief, PID and Implementation Plan	The Black Country Cluster Board and providers agree to the implementation plan.	Sep 2011

Appendix 2

Project lines of accountability, communication and reporting