

# Review of Services for People with Vascular Disease

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Visit Dates: May to November 2010

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# SERVICES FOR PEOPLE WITH VASCULAR DISEASE

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## INTRODUCTION

West Midlands Quality Review Service (WMQRS) was set up as a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews - often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on the WMQRS website: <http://www.wmqi.westmidlands.nhs.uk/wmQRS/>.

Reviews of urgent care, critical care, stroke (acute phase) & transient ischaemic attack (TIA), and vascular services in the West Midlands were undertaken between May and November 2010. Full reports of each visit are available on the WMQRS website, including details of compliance with Quality Standards and membership of the visiting teams. This report contains the vascular services section from each of the 2010 visit reports. These should be read in the context of the full visit reports, including details of compliance with WMQRS Quality Standards for Services for People with Vascular Disease, Version 1, April 2010

These visits were organised by WMQRS on behalf of the West Midlands Vascular Services Care Pathway Group. The dates for each visit are given in Appendix 1.

The reports reflect the situation at the time of the peer review visits. Services may have changed and developed since these visits.

## ACKNOWLEDGMENTS

The West Midlands Vascular Services Care Pathway Group and West Midlands Quality Review Service would like to thank the staff and patients of the West Midlands vascular services for their hard work in preparing for the reviews and for their kindness and helpfulness during the course of the visits. Thanks are also due to the visiting teams and their employing organisations for the time and expertise they contributed to these reviews.

## **NORTH WARWICKSHIRE HEALTH ECONOMY**

### **GEORGE ELIOT HOSPITAL NHS TRUST**

#### **General Comments**

There was a clear plan for the development of vascular services, supported by both NHS Warwickshire and the George Eliot Hospital NHS Trust. The vascular service was commissioned from University Hospitals Coventry and Warwickshire with in-patient services at University Hospital Coventry and out-patient and day case services at George Eliot Hospital (as well as other locations in Warwickshire). The commissioning plan had not yet been fully implemented and George Eliot Hospital NHS Trust should work closely with NHS Warwickshire and University Hospitals Coventry and Warwickshire NHS Trust to ensure full implementation and address any issues which arise. A review visit to the Coventry and Warwickshire vascular service will take place in September 2010.

#### **Commissioning:**

NHS Warwickshire had a clear commissioning plan for vascular services. The vascular service was commissioned from University Hospitals Coventry and Warwickshire with in-patient services at University Hospital Coventry and out-patient and day case services at George Eliot Hospital (as well as other locations in Warwickshire). It will be important for NHS Warwickshire actively to monitor implementation of this plan and to work closely with George Eliot Hospital NHS Trust to address any issues identified.

## WORCESTERSHIRE HEALTH ECONOMY

### WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

#### General comments and achievements

A generally good vascular service was provided serving Worcestershire and Herefordshire with a single in-patient site at Worcester. This service had the expected catchment population. The service was not yet meeting several of the expected Quality Standards. For some standards, this was because specific requirements in respect of imaging and anaesthetic services, guidelines and protocols were not in place. For others, Quality Standards may have been met in practice but no evidence of this was provided, and so no assurance was available to the service itself, its commissioners or the visiting team. There was good teamwork between consultants and nursing staff. Based on the National Vascular Database information presented to reviewers, outcomes were good. The service had been accepted by the National AAA Screening Programme as one of the early providers of screening.

#### Immediate Risk:

- 1 Level 2 critical care was being delivered to an unknown but significant number of patients in areas where there was no assurance that medical and nursing staff had competences in critical care and where there was no critical care consultant ward round or regular input to the care of patients from staff with critical care competences. Reviewers were told that level 2 patients were 'often' cared for in the vascular and 'sometimes' in the surgical high dependency units, including the use of vasopressors and inotropes and the delivery of non-invasive ventilation. Whilst these interventions assist in the management of critically ill patients, they can cause harm and should only be instigated and managed by appropriately trained staff. Reviewers were told that intensive care staff are contacted when patients get into difficulties but there was no regular contact between the departments over the care of these patients. The outreach service did provide support if required but was not available at all times (which would partially mitigate the risks to patients).

#### Concerns

- 1 Patient flow: Vascular beds, including day case beds, were often occupied by medical and trauma patients who resulting delays for patients needing vascular surgery. (Further detail is given in the health economy section of the main report.)
- 2 Guidelines and protocols were not documented. Guidelines and protocols were therefore not available, especially for junior staff, and it was not possible for them to be audited.
- 3 Data on individual vascular specialist activity levels were not available. It was therefore not possible to confirm that vascular specialists were undertaking sufficient activity to maintain competence. It was also not possible to confirm that all vascular interventional procedures were undertaken by vascular specialists or staff under their supervision.
- 4 An anaesthetist with up to date experience dealing with vascular emergencies and an interventional radiologist were not yet available at all times.
- 5 Nursing staff on the vascular ward did not yet have the competences expected by the Quality Standards.

#### Further considerations

- 1 Reviewers were told that orthotic services were not always able to respond in a timely way. This aspect of the service may benefit from review.
- 2 There was no community-based exercise programme for people with claudication. It may be helpful to review the need for this service and the potential to direct patients to existing exercise programmes.

- 3 Multi-disciplinary clinics for the assessment of patients with diabetes and complex foot problems were not available.
- 4 Development of the clinical nurse specialist role would enable support to be given to patients around areas such as health education and surveillance.
- 5 Data on interventional procedures were not yet being submitted to the British Society of Interventional Radiology Registries.

**Good practice**

- 1 A good one-stop clinic was available providing immediate duplex scanning at the first clinic visit for patients presenting with arterial and venous disease. This service was available at all sites in the catchment area.

**Commissioning:**

No specific commissioning issues were identified.

# **SOUTH STAFFORDSHIRE (WEST LOCALITY) HEALTH ECONOMY**

## **MID STAFFORDSHIRE NHS FOUNDATION TRUST**

### **General Comments and Achievements**

This vascular service was provided by a small close-knit, well-established team. There were good links between the surgical, ward, theatre and rehabilitation teams. A good vascular laboratory was available. There were good displays for patients on the ward.

**Immediate Risk:** None

### **Concerns**

- 1 Data on the number of procedures undertaken by individual surgeons were not available. The number of major procedures undertaken at Stafford Hospital has reduced recently and it was not clear that surgeons were undertaking sufficient procedures to maintain competence.
- 2 The service did not have the 800,000 population expected for a vascular service. The on-call rota was already shared with University Hospital of North Staffordshire NHS Trust and plans for the transfer of in-patient services to Stoke were being discussed. There was no agreed date for this transfer or understanding of the impact on the working arrangements for individual surgeons. The Stafford service had two consultant surgeons running a 1:2 rota in normal working hours. This arrangement would not be sustainable within the new service.
- 3 There was a lack of written policies and guidelines. It will be important to develop these as part of the creation of the combined vascular service with University Hospital of North Staffordshire NHS Trust.

### **Further Consideration**

- 1 Reviewers were told that data were being submitted to the National Vascular Database and British Society of Interventional Radiologists Registries but no evidence of this was available. The Trust should ensure that these data are being submitted so that outcomes can be compared.
- 2 Several Quality Standards expected for in-patient vascular services, including nursing competences and availability of interventional radiology, were not met. This would have been 'concerns' except for the plans to transfer in-patient services to Stoke.

### **Good Practice**

- 1 A 'one-stop' out-patient clinic was run with vascular imaging available at the same time as consultant and nurse assessment.
- 2 There was a well-established exercise programme in a community location which also provided good patient support and health promotion.
- 3 A community ulcer clinic ran alongside the vascular clinic which saved patients attending twice.

### **Commissioning:**

Commissioners need to be actively involved in agreeing the date and arrangements for the transfer of in-patient services to University Hospital of North Staffordshire NHS Trust and the extent of services that should continue to be provided at Stafford or Cannock Hospitals.

# NORTH STAFFORDSHIRE HEALTH ECONOMY

## UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST

### General Comments and Achievements

A good service was provided by committed staff. The service did not yet have the expected catchment population of 800,000 but there are plans to develop a single service with Mid Staffordshire. The on call rota was already shared and there were plans to centralise in-patient vascular services at University Hospitals of North Staffordshire. A very good vascular laboratory service was available 10 sessions per week. A tissue viability nurse worked across both acute and community services. High dependency care was also available.

**Immediate Risk:** None

### Concerns

- 1 Data were not being submitted to the National Vascular Database or the British Society of Interventional Radiology Registeries. Clinical outcomes therefore could not be compared with other services.
- 2 At the time of the visit, the vascular service did not serve a population of 800,000 with a single in-patient site. There were plans for this to be developed but timescales and implications on bed capacity were not yet clearly defined.

### Further Considerations

- 1 The model of care was 'traditional' with no one-stop clinics, nurse-led clinics and multi-disciplinary clinics with other disciplines. There may be the potential to stream-line patient pathways and make better use of available expertise by developing these approaches.
- 2 Provision of 24/7 interventional radiology support should be considered as part of the development of the service.

### Good Practice

- 1 Arrangements for liaison with renal services were very good. As a result, patients usually had a functioning fistula in place before the start of dialysis and there was a low rate of dialysis on lines.
- 2 A very good intervention room was available suitable for combined endovascular and open procedures.

### Commissioning:

The vascular service did not yet have the expected catchment population of 800,000. Plans for a service with this population were being discussed but there were not clear timescales for implementation.

## **SOUTH STAFFORDSHIRE (EAST LOCALITY) HEALTH ECONOMY**

### **BURTON HOSPITALS NHS TRUST**

#### **General Comments**

Vascular services were not reviewed in detail. Reviewers were told that patients needing vascular services are referred to Leicester. Pathways within the Trust appeared robust. (See commissioning section.)

#### **Commissioning:**

##### **Concern**

Commissioners did not have a clear plan for commissioning vascular services, or awareness of the standards that these services should be meeting. There was not clarity over the extent of assessment, surgery and follow up to be undertaken locally.

## COVENTRY & RUGBY HEALTH ECONOMY

### UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

#### General Comments and Achievements

A good vascular service was provided with good leadership. Facilities were also good. Aneurism mortality and post-surgery stroke rates were low. There was a good handover meeting from the surgeon on-call, including involvement of imaging services. It may be helpful to involve nursing staff in this meeting as well.

**Immediate Risk:** None

#### Concerns

- 1 An interventional radiology service was not yet available at all times. The Trust was aware of this and was developing plans for the provision of this service.
- 2 In-patient vascular services were provided on two sites (University Hospital, Coventry and George Eliot Hospital, Nuneaton). There was agreement in principle for these services to be sited only at University Hospital, Coventry but no date for implementation of this change had been agreed.

#### Further Considerations

- 1 The number of procedures per surgeon appeared low for some surgeons in the data provided to the reviewing team. These, and the number of interventional radiology procedures, should be kept under review to ensure that all vascular specialists are undertaking sufficient procedures to maintain competence.
- 2 New arrangements for the care of carotid endarterectomy patients immediately post-surgery were about to be introduced. These arrangements should be reviewed after implementation to ensure standards of care available have been maintained or improved.
- 3 Emergency theatres are shared with neuro-surgery, gynaecology and other specialties which can result in delays in access to theatre for vascular patients. The Trust was aware of this problem and was planning to increase the availability of emergency theatres.
- 4 Renal access services were run separately from the vascular service. Reviewers suggested that there may be significant benefits from integrating this service with vascular service.
- 5 'One stop' clinics were not yet available, including scanning. Reviewers thought this could be achieved relatively easily because of the vascular laboratory facilities available.
- 6 Data collection support to the service would benefit from review to ensure full collection of National Vascular Database and BSIR datasets by all vascular specialists without impact on clinical time.
- 7 The review of stroke services at Warwick Hospital identified that staff providing these services did not regularly receive communication from the vascular service. It may be helpful to review arrangements for communication and liaison with referring teams, including communication on discharge.

#### Good Practice

- 1 A very good vascular laboratory was available with five technicians. This enabled a very rapid response from the service. Pre-, post- and intra-operative TCD monitoring and vein graft surveillance were easily available.
- 2 A vascular counsellor provided counselling, massage and psychological support for patients with vascular disease.
- 3 A good diabetic foot clinic was available with input from chiropodists, diabetologists and vascular surgeons. It could be improved further by including an orthopaedic surgeon with a foot interest

**Commissioning:**

Commissioners need to ensure agreement of timescales for the move to a single in-patient service. Commissioners also need to clarify the services which should be provided on other sites within the vascular service and monitor implementation of this agreement.

## WOLVERHAMPTON HEALTH ECONOMY

### ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST

#### General Comments and Achievements

Vascular services were provided from very good facilities. The vascular ward had several side rooms with en suite facilities. A 'high care' unit was available on the ward and there was easy access to theatres. The team had a good vision for a 'vascular centre' with plans for eight additional beds and a vascular 'hybrid' theatre. The service was developing fenestrated EVAR and thoracic aneurism stenting services. There were good links with community rehabilitation services and a good CNS-led exercise programme.

Progress had been made in establishing an 'out of hours' vascular surgery rota with Dudley and Walsall. An interventional radiologist and vascular anaesthetist were also available when the Wolverhampton vascular surgeon was on call. The West Midlands Ambulance Service was not yet fully aware of these arrangements and patients were still being taken to the nearest hospital. A meeting to resolve this issue was taking place on the day of the visit.

**Immediate Risk:** None

#### Concerns

- 1 The visiting team was concerned about inconsistency in vascular imaging practise, reported difficulties in accessing vascular imaging, and issues reported to the visiting team about quality assurance of non-invasive imaging.
- 2 The 'high care' unit was providing level 2 critical care, including giving inotropes and invasive monitoring. This unit was not declared as providing critical care and did not have regular critical care consultant input. Nursing staff had competences for caring for patients with vascular disease but not critical care competences. There were, however, good links with the outreach team and patients needing ventilator support were transferred quickly to the intensive care unit.
- 3 Data had not been entered into the National Vascular Database since September 2009 other than for carotid patients. The service was not, therefore, in a position to compare outcomes with other units.
- 4 Most of the clinical guidelines and protocols expected by the Quality Standards were not in place. As a result, audit of compliance with guidelines and protocols was not possible.
- 5 The vascular service did not have the 800,000 population expected for an in-patient vascular service. The catchment population was approximately 350,000.
- 6 There were no elective lists for vascular access for patients needing renal dialysis. Patients were 'slotted into' other lists and reviewers were told of delays in getting patients onto these lists. Multi-disciplinary meetings to review the care of patients with renal disease were not taking place.

#### Further Consideration

- 1 The number of procedures undertaken by each surgeon and each interventional radiologist should be kept under review. The number of surgeons on the out of hours vascular rota (1:11) appeared high for the population served and it may not be possible for all to maintain competence. (This issue will be considered more seriously at future reviews if it has not been monitored and appropriate action taken.)
- 2 The tissue viability service in the community had recently undergone significant change of staff. As a result, patients were being brought back to out-patient clinics more frequently. The service should work with commissioners to ensure this issue is addressed as outcomes could deteriorate if out-patient clinics become overloaded and delays result.

- 3 Some surgeons were doing one-stop clinics. Other surgeons were not yet running these because they were awaiting the arrival of an additional portable Duplex machine. Vascular ultrasound was not routinely available at weekends. When the Wolverhampton surgeon was on call, consultant radiologists would provide vascular ultrasound if required.
- 4 Much of the patient information was awaiting ratification. It will be important to make sure this is finalised and that all patients are offered the information that is then available.
- 5 Robust arrangements for multi-disciplinary discussion with stroke and TIA services were not in place although ad hoc discussions took place as considered necessary.

**Commissioning:**

- 1 The vascular service did not have the expected catchment population. Commissioners were aware of this and discussions were taking place about integration of services with neighbouring areas.
- 2 Tissue viability service arrangements should be reviewed to ensure patients are being reviewed in appropriate settings.

## SHROPSHIRE HEALTH ECONOMY

### SHREWSBURY & TELFORD HOSPITAL NHS TRUST

#### General Comments and Achievements

A good, well-organised service was provided at both Princess Royal Hospital and Royal Shrewsbury Hospital. Very good patient information was available, including a 'personal health care record' which is also used by other specialties involved in the patient's care. Information leaflets were also available on the Trust intranet. Good bereavement information was available. A shared consultant on-call rota covering the services at Princess Royal Hospital and Royal Shrewsbury Hospital had been established.

**Immediate Risk:** None

#### Concerns

- 1 The service had only one vascular nurse specialist covering both sites. This nurse specialist mainly worked with patients with venous disease and so little nurse specialist support was available to other patients.
- 2 The vascular high dependency unit was not declared as an area which may provide level 2 care. Reviewers were concerned that this area was providing some level 2 care, including CPAP, but did not have the appropriately trained nursing staff and input from critical care consultants. Regular support from the outreach nurse was provided but this service was not available at all times.
- 3 The service was running from two in-patient sites and there was no agreed plan for moving to a single in-patient site. Neither site had an interventional radiologist and vascular anaesthetist available at all times.
- 4 The service as a whole did not have multi-disciplinary discussion. The teams at Telford and Shrewsbury met separately but never together.

#### Further Consideration

- 1 Data were being input into the National Vascular Database by consultants, usually in their own time, because administrative support for this work was not available.
- 2 The catchment population for the service was approximately 500,000. In view of the rural nature of the population, this was being considered by the National Abdominal Aortic Aneurysm Screening Programme as a centre for vascular screening. If this is not approved, the health economy will need to consider whether in-patient services should continue to be provided locally. If the service is approved as a centre for vascular screening, the health economy should monitor carefully the number of vascular procedures undertaken by each vascular specialist to ensure competence is maintained.
- 3 VNUS and foam treatments were not offered for patients with varicose veins. These treatments could be given on an out-patient basis and avoid the need for a day case or in-patient stay.

#### Good Practice

- 1 A database with 15 years' data about vascular surgery was kept at the Royal Shrewsbury Hospital.
- 2 An excellent follow-up service was provided for patients with amputations. This included support nurses and physiotherapists and had good links with limb-fitting services. Initially, patients came every two weeks. The frequency of attendance was then reduced but patients could contact the service at any time if they had concerns about their amputation.

#### Commissioning:

If Shropshire is approved for Abdominal Aortic Aneurysm Screening then a clear plan for moving to a single in-patient site will be needed.

## DUDLEY HEALTH ECONOMY:

### DUDLEY GROUP OF HOSPITALS NHS FOUNDATION TRUST

#### General Comments and Achievements

This was a well-organised service with good multi-disciplinary working, including with podiatry, diabetes and orthotics services. The vascular laboratory provided a very good service from 9am to 5pm on weekdays. The ward had actively engaged with the productive ward programme and there were plans to create a twelve bedded vascular area as part of bed reconfiguration in autumn 2010. Surgeons had recently joined with those in Wolverhampton and Walsall to create a vascular on-call rota for nights and weekends. The West Midlands Ambulance Service was not yet fully aware of these arrangements and patients were still being taken to the nearest hospital. A meeting to resolve this issue was planned.

**Immediate Risk:** None

#### Concerns

- 1 The vascular service did not have a catchment population of 800,000.
- 2 The service did not have an interventional radiologist and anaesthetist with up to date experience in the care of vascular patients available at all times.

#### Further Consideration

- 1 It will be important to monitor the number of procedures undertaken by surgeons and interventional radiologists to ensure that activity is sufficient for competence to be maintained.
- 2 Data from the National Vascular Database should be used to compare outcomes with other services.
- 3 Several guidelines expected by the Quality Standards were not documented, were out of date, or did not appear to be in a Trust-wide format. The governance arrangements covering policies and procedures may benefit from review.

#### Good Practice

- 1 The ward environment was very well organised, including good access to high dependency care.

#### Commissioning

A clear plan is needed for commissioning a vascular service with the expected catchment population and meeting the appropriate Quality Standards

# HEART OF BIRMINGHAM AND SANDWELL HEALTH ECONOMIES

## SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

### General Comments and Achievements

This service, based at City Hospital, was well-organised and provided a comprehensive approach to the care of patients with vascular disease. The service was well-supported with four clinical nurse specialists and a surgical practitioner. Three interventional radiologists were regularly involved with the care of vascular patients. Specific clinics were run for patients with claudication, leg ulcers and abdominal aortic aneurysms. The service was offering EVAR and carotid stenting. Endovenous varicose vein treatment was also available. The service had joined with University Hospitals Birmingham NHS Foundation Trust to form a 1:6 vascular surgery rota.

Patient information and clinical guidelines were very good and clear. The evidence of compliance with the Quality Standards was very well presented. Minuted departmental meetings were held monthly and showed a very well-organised approach to the running and development of the service.

### Immediate Risk: None

### Concerns

- 1 The service did not have a catchment population of 800,000. The current catchment population was approximately 600,000. There was no plan, agreed with commissioners, for establishing a service with the appropriate catchment population.
- 2 An Interventional radiologist and an anaesthetist with vascular experience were not available at all times.

### Further Consideration

- 1 A one-stop clinic for patients with arterial disease may be a helpful addition to the clinics already offered. This would require increase availability of Duplex scanning.
- 2 The C-arm in theatre was relatively old and may need replacement soon. The service may also wish to consider acquiring a cell saver.
- 3 The service had little administrative support for data collection, including for inputting data to the National Vascular Database.
- 4 Further consideration may need to be given to middle grade medical staffing and ensuring that sufficient support for daytime theatre assistance continues to be available.

### Good Practice

- 1 Team-working within the service was excellent. Consultant ward rounds covered all vascular patients. An electronic theatre diary allowed patients to be slotted into the next available theatre slot for any consultant. Consultants operated together on complex cases.
- 2 Letters were written to patients with a copy to their general practitioner. This meant that patients had access to all relevant information in appropriate language.

### Commissioning:

A clear plan for moving to a catchment population of 800,000 with a single in-patient site was not yet in place. This will be needed in order to meet the expected Quality Standards and for approval for Abdominal Aortic Aneurysm Screening Programme.

## WALSALL HEALTH ECONOMY

### WALSALL HOSPITALS NHS TRUST

#### General Comments and Achievements

Vascular services were provided by a team of committed staff who were trying hard to achieve the expected standards. The environment on the vascular ward was good. Progress had been made with the establishment of a Black Country rota for emergency vascular surgery. Reviewers were impressed that carotid endarterectomy was offered within days of referral for patients who needed this procedure.

**Immediate Risk:** None

#### Concerns

- 1 The vascular services at Walsall Hospitals NHS Trust were of serious concern for a combination of reasons:
  - a. Audit of the number of interventional procedures and outcomes for each vascular specialist (surgeon and interventional radiologist) was not available. Only one surgeon was submitting data to the National Vascular Database. There was some evidence that the number of procedures undertaken by some vascular specialists was low. In particular, interventional radiologists were reported as undertaking a maximum of one vascular procedure per week and one vascular surgeon undertook mainly bariatric surgery and had other duties which restricted his time for vascular work. The issue should be investigated without delay to ensure that all vascular specialists (surgeons and interventional radiologists) are undertaking sufficient procedures to maintain competence. This audit should include comparison of complication rates with other services.
  - b. The vascular service had a catchment population of less than 300,000. (The expected catchment population is at least 800,000.)
  - c. Interventional radiology and an anaesthetist with experience with vascular emergencies were not available at all times.
  - d. Nursing staff on the vascular ward did not yet have the expected competences. Staff were aware of this and plans were in place.
  - e. Limited arterial duplex was available.

#### Further Consideration

- 1 Following the audit of number of procedures undertaken by each vascular specialist (see concern 1), consideration should be given to whether joint procedures between Walsall vascular specialists, or in collaboration with another service, may be a helpful part of maintaining competence.
- 2 Renal patients were referred to Wolverhampton vascular surgeons for permanent access surgery. Further discussion with the renal service may be helpful as it was not clear to reviewers why these patients could not have their surgery locally.
- 3 'One-stop' clinics were not yet available and should be considered as part of the future development of the service.

#### Commissioning:

The vascular service did not have the expected catchment population. Commissioners were aware of this and discussions were taking place about integration of services with neighbouring areas.

# BIRMINGHAM EAST & NORTH AND SOLIHULL HEALTH ECONOMIES

## HEART OF ENGLAND NHS FOUNDATION TRUST

### General Comments and Achievements

A very good vascular service was provided by a strong multi-disciplinary team. A good range of treatments was provided, including complex EVAR. Foam / radiofrequency ablation therapy was available on all hospital sites. The service had started running the abdominal aortic aneurysm screening programme. The vascular ward had been integrated with the thoracic surgery ward for some time. The service had a catchment population of over a million and ran from a single in-patient site at Birmingham Heartlands Hospital.

**Immediate Risk:** None

### Concerns

- 1 Full data on patients with aortic disease were being entered onto the National Vascular Database but data on other conditions were not being entered routinely and so activity levels for each vascular specialist and outcomes could not be compared.
- 2 Ward nurses did not have all the expected competences. This situation had arisen partly because four nurses with vascular experience had recently moved wards. Evidence of assessment of competence was also limited.
- 3 Interventional radiology was not yet available 24/7 but there were plans for this to be introduced early in 2011.

### Further Consideration

- 1 Diabetic foot clinics were not yet available on all sites. A clinic took place at Good Hope Hospital but not at Birmingham Heartlands Hospital or Solihull Hospital. There were plans to start clinics when a new consultant is appointed.
- 2 The vascular clinical nurse specialists' roles were mainly out-patient based. It may be helpful to look at the potential for greater involvement with in-patients and with providing support, advice and training to ward nursing staff.
- 3 At the time of the visit, the consultant vascular surgery rota included a Clinical Fellow. This may not be a sustainable approach but there were plans to appoint an additional consultant.
- 4 Middle grade staffing comprised one relatively junior middle grade doctor. The extent of middle grade cover which is needed should be kept under review to ensure it is sufficient for the needs of the service.
- 5 The vascular ward did not have a gym area and it may be helpful to consider if this could be developed.

### Good Practice

- 1 Individual patient information leaflets.
- 2 Team-work was very good, including dual consultant operating for more complex surgery.
- 3 The vascular service had a dedicated ward-based physiotherapist who attended ward rounds and MDT meetings, was heavily involved in discharge planning and provided local rehabilitation for some patients with amputations. This avoided the need for some patients to travel to Selly Oak for rehabilitation.

### Commissioning:

No commissioning issues were identified.

## APPENDIX 1 VISIT DATES

Health Economy	Acute Trust	Visit dates 2010
South Warwickshire	South Warwickshire NHS Foundation Trust	11 & 12 May
North Warwickshire	George Elliott Hospital NHS Trust	20 May
Herefordshire	Hereford Hospitals NHS Trust	16 & 17 June
Worcestershire	Worcester Acute Hospitals NHS Trust	22 & 23 June
South Staffordshire (West) Locality	Mid Staffordshire NHS Foundation Trust	30 June
North Staffordshire	University Hospital of North Staffordshire NHS Trust	7 & 8 July
South Staffordshire (East) Locality	Burton Hospitals NHS Trust	14 July
Coventry and Rugby	University Hospitals Coventry & Warwickshire NHS Trust	7 & 8 September
Wolverhampton	Royal Wolverhampton Hospitals NHS Trust	22 & 23 September
Shropshire	Shrewsbury & Telford NHS Trust	28 & 29 September
Dudley	Dudley Group of Hospitals NHS Trust	6 October
Heart of Birmingham and Sandwell	Sandwell & West Birmingham Hospitals NHS Trust	13 & 14 October
Walsall	Walsall Hospitals NHS Trust	19 October
Birmingham East & North and Solihull	Heart of England Foundation Trust	16 & 17 November