SE Wales Vascular Network Business case Peer Review –Thursday 5th August 2021

In attendance:

External Peer Reviewers:
Marcus Brookes - Consultant Vascular Surgeon & Clinical Lead for the Bristol Bath Weston Vascular Network
Louise Hichens – Vascular Physio team lead, Bristol Major Arterial Centre
Alison Guy – Lead OT General Surgery, Bristol Major Arterial Centre
Susan Ward – VNS Brighton, Lead nurse for Sussex Vascular Network

External Reviewers who will provide feedback but could not make the session:

Graham Bowen, Head of Podiatry Solent NHS Trust
Sabine Sonnenburg, Consultant surgeon and Clinical lead for Wessex Vascular Network
Dr Nick Ambler, Consultant Clinical Psychologist, Service lead at North Bristol NHS Trust

In attendance:
Peter Carr, Director of Therapies, ABUHB
Victoria Le Grys, Programme Director
David McLain, Clinical lead ABUHB
Marie-Claire Griffiths, Chair Rehab Group, Planning lead CTM
Mike Rocker, Chair Network Clinical Advisory Group, Surgeon CTM
Glenys Mansfield, General Manager Scheduled Care ABUHB
Catherine Twamley, Lead Nurse General Surgery CAV
Carly Podger, Finance lead CAV
James Dalton, Finance lead ABUHB
Mike Bond, Network Op Group Chair and Director of Operations Surgery Clinical Board CAV
Kate Rowlands VNS CAV
Claire Constantinou, Dietetics lead CAV
Carole Jones Physio Lead Cardiovascular CAV
Debbie Davies, Therapies lead CTM
Matthew Temby, Director of Operations CD&T Clinical Board CAV
Clare Wade, Director of Nursing, Surgery Clinical Board CAV
Claire Fudge, Lead for OT CAV
Andrew Wood, Consultant Radiologist, CAV
Andrew Gordon, Lead Radiologist CAV

Core sections of the case (outside of Hub and Spokes specifically) General suggestions and agreements during session

Activity data presentation to be reviewed - Bristol used HES data and NVR data used to inform implementation of network, broken down into the procedures, noted that historical data for SEW not as reliable. Suggest putting some of the info from demand and capacity work into the case to support the clarification of activity changes. **Mike Bond**

Strengthen Case for change section - Value Based Health statement to be added to support the case in section 4.3/4.4. Engage CEDAR to get any benchmarked information. **Vicky Le Grys & Kevin Conway**

Network Model of care section - Network therapies workforce standards to be added and justification against standards chosen within the rehab section of the case under Network model. **Matt Temby & lead therapists from network group**

Network model of care section - Spoke models of care section suggest amalgamation as repetition. **Vicky Le Grys & Planning leads**

Workforce section - overview to be added **Terrie Waites**

Rehabilitation

Hub section of the case

Physiotherapy

CAV confirmed used all Wales staffing tool for staffing model. 2.3 qualified and 1 rehab assistant to share with OT. Happy with this due to fluctuations in workload. Currently on 0.7 Physio covering a number of specialties, this would allow time to be ring fenced for Vascular.

Confirmed similar to model provided at Southmead, case mix can be very varied and it is not predictable. Having a local spoke for Cardiff is good as local patients in Bristol stay often for a length of time waiting for a bed in the Hub.

5 day service at the moment in Bristol – hoping shortly to move towards 7 day a week.

Question put to reviewers - Any work on impact of any additional therapy service in terms of efficiencies (LOS improvement) improved patient outcomes through PROMS/PREMS? No and no link to LOS evidence or PROMS/PREMS delivered in Bristol at present.

Rehabilitation medicine session in Hub and comments re COTE

Bristol fund 1 consultant rehab session in addition to enablement centre. Team approach, amputation councillor is very important. Found rehab consultants hard to recruit to.

We asked the reviewers whether they would welcome more sessions and whether this would add value. Bristol noted they felt this was not just about rehab needs of the group it's how we address them, what Bristol have is a geriatric liaison service, a lot of what they do overlaps. Interplay between the two. They noted how valuable this was.

Bristol has 6 funded COTE consultant sessions. Confirmed that one of the London MAC's also has ward round with COTE physician, they found this valuable.

Recommendation to Programme – consideration of COTE sessions to support Hub to work as a part of the team inc rehab consultant. **CAV team – Mike Bond to pick up locally with rehab consultants and COTE team**

Dietetics

Dietetic associated safe caseload standards – looked at current caseload for malnutrition and issues with diabetes, renal and wound healing. Have 0.3 band 5 covers current ward plus addition is for

expansion of beds and increased complexity of patients (all arterial) therefore increase in banding. That's why step-up costs.

Action - Section to be reviewed for wording to be strengthened **Claire Constantinou**

OT
Low level of staffing currently within CAV. 0.7 WTE spent on Vascular currently. BSRM standards are applied. 1 to 15 ratio applied.

Action – band 5 line within case workforce table to be removed as confirmed start with 5 day week for go live rather than 7. **Claire Fudge**

Action - Band 7 post is a lead for whole CAV pathway and therefore will need to be split between CAV hub and spoke case. **Claire Fudge**

Bristol thought service proposed at CAV may well be a little stretched. Bristol don't do PREMS/PROMS - this is key that this is rolled out. Bristol have 1 x band 6 1 x band 5, 1 x band 7 for all surgery and this is not currently enough.

CAV confirmed Therapies are going from a model working across multiple specialties to servicing a vascular hub and new model requires a description which is a shift. – **Action** to be added to the therapies section of Hub case – **Matt Temby**

Rehabilitation CTM UHB – Spoke case

Slight update to case currently being undertaken**. Action Marie-Claire** to update master business case.

Learning from the Major Trauma moving to a network model. Challenging to identify who delivers what, no consistent number of vascular patients seen. Post Op primarily, impacts in the spoke inclusive of those patients who transfer out and a lot that go directly home and don't come back into hospital beds, clinical lead 8a post to support the coordination of all CTM patients for rehab and reablement.

Expectation set improved care within a hub setting and therefore need to ensure communication with patients is clear. Know we are missing some, going home and GP's, community staff are not used to dealing with these patients and need additional information support locally from teams. Enhancing exercise programme for prehab and to offer preventative, conservative management option rather than surgery.

Bristol noted Support for this concept, for patients seen by generalists by specialist therapy team no matter where patients go.

Rehabilitation AB UHB– Spoke

Already have a hub and spoke model since moving to the Grange, well established repatriation and rehabilitation processes and pathways and good links with teams. So for ABUHB patients model will be the same but the location of the hub will change, so have already out these processes and workforce in place. Therefore, no requirement for uplift in relation to this at this point

MCG noted a description of this would be helpful to support CAV and CTM case. **Action – Arvind Kumar** will look at this for AB to see if there is unmet need. Vicky to link Arvind with AB lead therapists on Rehab group

Rehabilitation CAV UHB– Spoke

Spoke patients currently cared for in UHW on B2, new model will see patients transfer to Lakeside Wing initially before longer term model at University Hospital Llandough. 8 beds.

Currently minimal therapy service for patients, most covering all surgical specialties. Cannot take provision from those UHW beds, they will kept to support the hub. So will need to be provided.

No provision currently to support intermittent claudication class for CAV, may be able to do POAC. This needs to be reviewed as isn't equitable with CTM & AB provision.

Confirmed nurse led claudication classes but no physio support, cannot develop without it.

CTM offered support to come together to consider on a regional basis as some areas CTM/CAV similar. **Action – Debbie Davies & Carole Jones** to discuss possibility of joint class.

General comments re rehab in spokes
CTM lead therapist, felt having a role responsible for Vascular patients for each of the Health Boards would be very helpful, particularly for those patients who go directly home from the hub (which have increased since move to CAVUHB.) **Action** – for consideration at local spoke groups **spoke group leads**

Action - Noted that lead therapy role for the network needs considering. Bristol noted this would be a very good role to have. Don't have this in Bristol network but would be of real value . Local teams important and central coordination role is key to ensure focus is not only on the hub, please to see this has been considered from the start. **Vicky Le Grys** to update network section

Network roles

Bristol encouraged us to look at additional lead roles – noted new version of POVS will have recommendations to have leads for the network – to include IR, Anaes and Specialist nurse as part of their role. Data coordinator/manager role will be key to good data completeness.

Agreement role of lead nurse should be considered if strengthens, structure. Brighton – leadership role within network. VNS managed day to day by their matron but joint clinical governance and meet regularly to ensure consistency. So leadership role to bring others together rather than line management.

Action – Sue Ward, Brighton to share JD for leadership role, will also correct structure in business case.

Admin - Bristol noted MDT coordinator role is busy, admin staff crucial when you run clinical across and hard to sustain in spokes so need to ensure its resourced. Having the band 8a manager will really help to ensure admin support across the network.

Bristol currently not ODN, not as robust as these proposals but in support of them.

Action - Vicky Le Grys to update network section

Transport - no queries

Informatics
Query whether MDT is remotely available. Confirmed yes.

Bristol noted IT constraints within spokes – Bristol when started used notes from local hospital, now pull notes from Hub hospital. Access to all op notes, patient info. Data is on an app. Have to develop a model where every clinic is run from your hub hospital, use laptops to directly access Hub systems.

CAVUHB confirmed that paper notes but if you can use portal the op note isn't quite solved as not yet connected to get it downloaded on portal. CTM confirmed at the moment its manageable because local consultants still undertake their own clinics closer to home.

Bristol agreed to keep links with us. **Mike Ogonovsky** to link with Bristol network manager in developing plan for SEWVN

Hub section (excl rehabilitation)

Interventional Radiology
No queries

Hub beds
Bristol confirmed that with a Population at 1.5m, 35 beds at MAC is consistent with a number of networks including Bristol. Detail – number of patients who are medically fit still on ward dichotomy of vascular, elective workload goes in and out quickly but amputees and frail patients have much longer LOS so variable. Work on rehab as set out is important, pleased to see work on this.

Key patients can come into Hub quickly and take priority as they will already be in the bed.

Finance confirmed aware assumptions in case but no issues.

PACU & ICU
Impact of COVD has been challenging in terms of type of beds available for infection purposes, particularly PACU. CAVUHB confirmed this is being looked at in detail, implementation of a flexible model of care to support patients who need a higher level of care.

In Bristol patients either go through post of recovery unit, carotid 4-6 hours then to vascular ward. Occasionally booked for HDU bed. ITU major open cases. Brighton, Carotid and EVARS back to ward, Open AAA or complex EVARS go to ITU or based on anaesthetic review. Number of elective booked HDU

Brighton nursing on ward is usually 1:4/1:5, now running 1:8/1:9 due to COVID impact of staffing levels.

Hub theatres
Bristol – area that caused most concern due to: A -need for hybrid theatre. B- need for adequate theatre time for time critical cases. AB noted remains biggest concern but as a way to move forward agreed to 6 plus access to urgent lists and review at 3 months critical.

Bristol have now taken over majority of diabetic foot service every afternoon, bring impact on need for theatre space.

Bristol noted should look at complex aortic service – be clear about other tertiary services that needs planned vascular lists which eats into emergency workload.

Don't underestimate the need for more. Look at how you provide IR capacity, may require more through week for EVARs rather than 1 days a week.

Concerns around availability of staff to provide level of theatre staff.

Brighton confirmed that from Brighton perspective looks fine.

Surgical model & Junior model
ABUHB noted currently not clear on proposals for increasing medical staffing. Proposal for this year no increase, what's the view on this.

Additional middle grade to be reflected in this next years allocation for UHW.to be added to the case – **Action Kevin Conway**

Bristol confirmed 0 - When Vascular became a separate specialty juniors didn't come with it.

Bristol had exactly the same as what is reflected in this case now when they started. However, if we have fewer that 3 trainees on a ward for a week worse feedback, with high turnover of some patients and longer stay, complex patients makes more challenging. 3 foundation programme docs, with a 4th but depends on whether they are on G. Surgical on call. Core trainees on ward less. Had to back up with more consultant time on ward. Didn't have a middle grade rota on ward when started. Have run Ward based F1's this model but have used Fellows and have managed to recruit teaching fellow, relatively helpful to have more. Funded within business case – now fund 2 senior fellow, would encourage us to do the same.

Bristol feedback, noted that spoke models ref to reliance on gen surgery juniors, this can be challenging in reality.

Action – need to confirm current junior doctor support baseline. **Glenys Mansfield, Kevin Rocker & Mike Bond**

Vascular Nurse Specialist
Action - Current numbers to be tweaked to ensure correct. No comments on hub section, Brighton- VNS have huge coordination role, needs to be monitored to see how progresses.

Reviewers were asked if anything missing from Hub case:

Complex geriatric assessment very important and impact it can have on LOS. As move more and more to tie critical pathways and less time to prehab patients. Decision about who to operate on is very important. Bristol run POPS model. Input from Reg or consultant.

Vascular Scientists and Technologists
Not much detail around –scientists are key and the provision within hub but also network sites important in running assessment prior to transfer (tie pressure, duplex), noted there is additional resource, but this section may need to be bolstered. **Action - Mike Bond** to take back to teams at UHW to check

Spoke sections (excl rehabilitation)

No major issues raised outside of earlier rehab discussions. Brighton – just noted need to ensure that you have enough VNS to support spokes, noted VNS would stay at local hospitals.

Having separate spoke models of care in business case more confusing to read. Having one section on models of care would really help in having something coherent. **Action Vicky Le Grys** to review with clinical and planning leads

Attachment 1

Comments received post review meeting.

Dr. Sabine Sonnenberg, Clinical lead of Wessex network

"The business case is extensive and sound and seems to benchmark well with equivalent vascular units in terms of staffing and bed capacity. I would like to make the following comments:

1)I could not see a mention of a dedicated multidisciplinary diabetic foot clinic provision. We found that providing such a clinic in the hub as well as large volume spokes improves care.

2) we have managed to reduce LOS by establishing a hospital at home service in which patients with negative pressure therapy can be cared for in their own home by a dedicated team of nurses. This links in with the diabetic foot clinic. I don't know if such a service already exists in your region and you may want to consider incorporating this in the business plan.

3) I note that the original plan of 8 all day theatre sessions has been reduced to 5+1 IR days. I appreciate that this reduction is based on detailed modelling. This has shown that the increased efficiency in the hub will mean less theatre sessions are required. My experience is that centralisation does not increase efficiency. This is mostly related to the complexity of patient and information transfer. In addition, the complexity of procedures has increase and will continue to increase. Procedural changes in theatre have also reduced efficiency in the past years. I suspect that the reality will not uphold the increased efficiency the modelling predicts.

Lasty a minor point: In the bench marking table Southampton is noted to have 35 beds. In fact we only have 22. However this is not enough to cohort our patients on one ward. The bed numbers proposed for the South East Wales vascular network are much more appropriate.

I hope this is helpful. Good Luck!"

Attachment 2

Comments received post review meeting.

Mr. Graham Bowen, Clinical Services Manager, Solent NHS Trust

My only comments are from my experience:

1. *Introduce Toe pressures to run along side the ABPI as we know ABPIs can unreliable in Diabetes patients*
2. *Great to see WIFI in the documents / pathway*
3. *Pathway – time frame for referral / lint to outcome*
4. *The out of hours cover / weekend cover – experience shows that patients present Fridays that places pressure over weekend for admissions / interventions*
5. *In Southampton's s MDT, we have every experience OPD who has been upskilled to undertake all digital / forefoot amputation / surgical debridement - one option to increase the workforce is to do the same for the Podiatry team ?*
6. *In the service spec is possible to look at more integration with podiatry and use their skills to work along side / support in the plan / in running clinics / being champion of the foot and lower limb / involvement in the "hot" clinic*

Hope that helps from the foot and lower limb side