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Dear Colleague

As a few months have now passed since my last letter to you on vascular services, I thought it might be an opportune time to write to you with an update.

The SHIP PCT Cluster and CCGs have made it clear throughout that we wish to commission a network model of service as this will provide the most sustainable service for patients going forward. In order to facilitate further discussions about how local Trusts could work together to deliver this model we held a seminar for Trust executives and clinicians and some of our stakeholders in June. At the seminar it was agreed that the Cluster would work with the two Trusts and their clinicians to continue their dialogue about how a network model could be delivered. The Cluster and the CCGs also gave a commitment to monitor the quality of existing services at each of the local Trusts and pay particular attention to their compliance with the Vascular Society of Great Britain and Ireland (VSGBI) standards.

As part of this quality monitoring, all the standards in the VSGBI specification have been included in this year's contract with both Trusts and we have developed a clinical governance framework to allow us to monitor the Trusts against these standards. In practice, this has involved the Cluster scrutinising information about patient outcomes, with cases reviewed on a patient-by-patient basis by our Medical Director, Director of Nursing and GP lead for Cardio Vascular services. I am pleased to report that, as a result of this work, we are confident that patient outcomes and the quality of service at our local Trusts is not a current area of concern.

Nevertheless, as you will recall, Portsmouth Hospitals NHS Trust (PHT) has not been fully compliant with the VSGBI standards because it needed to recruit two additional vascular surgeons, in order to be able to offer the required one-in-six rota. The Cluster had agreed to allow the Trust some time to go through a recruitment process and we are pleased to report that one additional surgeon has now been recruited. As a consequence, the Trust is currently operating a one-in-five rota.

However, we remained concerned that the Trust has not yet recruited the required sixth surgeon and we have formalised our concerns by escalating matters through our contract with the Trust.

Meanwhile, we have continued to work with the Trusts to facilitate discussion between clinicians and a meeting chaired by Jonothan Earnshaw (an expert vascular surgeon from the South West) took place in October. The meeting was attended by Simon Holmes, Medical Director at PHT, Professor Cliff Shearman, Gareth Morris and Mike Phillips, vascular surgeons at UHSFT, Graham Sutton, Associate Medical Director (surgery) at PHT, Mark Pemberton and Perbinder Grewal, vascular surgeons at PHT, Paul Gibbs, renal and vascular surgeon, PHT, and Niall Ferguson, Hampshire clinical commissioner.

At the meeting, clinicians from both Trusts recognised that the impending era of specialist commissioning is likely to result in some complex surgery (for example, thoracic aortic endovascular aneurysm treatment) being restricted to designated (high volume) centres. The clinicians agreed that the possibility of some patients requiring such treatment being sent to centres outside of Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) for their surgery would be reduced by centralising this work in the SHIP area. They also acknowledged that the expected reduction in national training posts is likely to result in increased consultant involvement 24/7.

It was agreed that pooling of consultant resource between Queen Alexandra Hospital and Southampton General Hospital would ensure availability of all the team required to provide this service at all times in the SHIP area.

We have been informed that there was an honest exchange during the meeting regarding the concerns held by teams from both Trusts. For PHT, this centred on the need to retain on-site vascular services to protect other specialties and some concerns that full centralisation would not necessarily improve quality of care for some types of vascular patient. For UHSFT, there were concerns about the increased intensity of out of hours work in Southampton that would result from amalgamation of on-call services on one site.

Having considered these issues together, the consultants came to a number of important agreements which included the following:

1. The principle of centralising weekend cover for acute arterial intervention to UHSFT was discussed and was an area of potential agreement
2. The principle of centralising aortic aneurysm treatment on one site received general agreement
3. They would work together on the development of a bid for a joint training programme across both Trusts

The clinicians involved are now working carefully though the details of how these proposals might work in practice. As a result of this meeting, PHT has now confirmed to us that they do not intend to recruit a sixth surgeon. In order to meet the VSGBI standards, it is therefore imperative that the agreed shared rota with UHSFT is developed and progressed without further delay.

This is very encouraging news indeed, and we have asked both Trusts to write to us confirming their support for the principles agreed by their clinicians.

We are still awaiting publication of the new national specification for vascular services, but I hope you will agree that the recent dialogue between clinicians is a very positive step forwards. We believe that an agreement between the two Trusts will put us in a much better position to work together to meet the new specification. This will ensure that we can develop an innovative 'advanced network' across our two large local centres that will ensure high quality services for all local people as the vascular surgery develops into the future.

As always, I will keep you updated and thank you for your support in taking this forwards.

With best wishes

Yours sincerely

D M Fleming (Mrs)
Chief Executive
SHIP PCT Cluster