

Cardiovascular project engagement

A report detailing the responses received on the cardiovascular project during the period of engagement

December 2010



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Executive summary

The cardiovascular project undertook a three month engagement period with the public, patients, local authorities and clinicians, including GP commissioners. A key component of this engagement period was the facility for people to comment on the proposals via a questionnaire. The majority of questionnaires were completed online, however paper questionnaires were also made available for people where this was more convenient for them.

In total 201 questionnaire responses were collected. Respondents were asked to complete 16 questions in total. The questions were broken down in a way that mirrored the structure of the full project model of care document, meaning that were an individual disagreed only with one specific proposal they were able to make it clear that that was the case.

The largest single group of respondents were “other healthcare professionals”, making up 54.1% of all respondents. All areas of the model of care received solid support. This ranged from 68.7% of people supporting the recommendations around mitral valve surgery to 93.9% supporting the proposals around the establishment of electrophysiology networks. Overall 83.2% of respondents either “strongly agreed” or “agreed” with the project recommendations as a whole.

The project also received some objections and criticism. These were specifically around the vascular surgery model of care, mitral valve surgery and the service for patients with high risk acute coronary syndromes. In all three cases the comments have been assessed by the relevant workstream clinical lead and the decision was taken not to re-convene the clinical expert panels to discuss the points.

All of the feedback that the project received via the free text sections of the questionnaire as well as those submissions that were written into the project not in the format of the questionnaire are available in the appendix section.



1. Introduction

Following the publication of the updated NHS Operating framework for 2010/11, the cardiovascular project undertook an extensive three month period of engagement. One of the key components of this engagement period was the establishment of an online questionnaire, allowing people to provide feedback directly into the project. In addition, the project team met with pan-London clinical groups, local authority overview and scrutiny committees, LINK groups and other interested groups and parties. A paper version of the questionnaire was made available at these meetings so that the thoughts and views of these groups could be captured in the same format as those completing the online questionnaire. The combined results of both the electronic and paper questionnaires have now been analysed and are presented in this report.

The project also received written feedback on the proposals, not in the format of the questionnaire. These responses are also presented and considered in this report.

2. Developing the questionnaire

2.1 Cardiovascular project summary document

The full version of the project proposals ran into hundreds of pages of text. In order to make the project proposals more accessible a summary document was produced. Those responding to the questionnaire, were advised to read the summary document first to give them the information they needed in order to answer the questions.

2.2 Creating the questionnaire

The online questionnaire was made up 16 questions in all, 12 of which asked for the respondents views on specific aspects of the project. The other four questions asked for demographic data relating to the respondent and one question sought the respondent's views on how the project should be implemented.

Of the 12 questions on the project proposals themselves, ten questions asked the respondent if they agreed with the proposal, with the respondent answering either "yes", "no" or "don't know" in response. If the respondent wanted to add a comment in addition to responding in the way as mentioned, they were also able to do so. The other two questions allowed for free text response, so that the respondent could write in as much or as little as they liked on the proposal.

It was important to the project to have responses that aligned closely with the project proposals, so that if there were specific areas of the proposals that were more or less contentious than others they would be easy to identify. The questions therefore were broken down to reflect each case for change and model of care recommendation.

2.3 Advertising the questionnaire

The publication of the proposals and availability of the questionnaire was advertised widely. Letters were posted to each GP practice in the capital



(around 1,600 letters) containing an introduction to the proposals and details of how to feed back. In addition, emails were sent to over 1,100 individuals. This distribution list included each Local Involvement Network, Local Medical Committees and Chairs of Professional Executive Committees, Council Leaders and Chief Executives, charities, national medical bodies, Chief Executives and Medical Directors of both PCTs and acute trusts, Members of Parliament and the London Assembly. As with the letters to GP practices, these emails contained the web address for the documentation and questionnaire, as well as the registration details for the stakeholder events.

2.4 Paper version of the questionnaire

Following feedback from some LINK groups and members of the project patient panel the project developed a paper questionnaire. This gave two principle benefits. Firstly, it allowed feedback to be captured as and when the project was discussing the proposals with individuals and groups when there was no computer present. Secondly, it meant that people who were unfamiliar or unable to use a computer to complete the questionnaire could also contribute to the project. Having an electronic and paper version of the questionnaire served to increase the number of contributions during the engagement period.

3. Responses to the questionnaire

3.1 Overall response rate

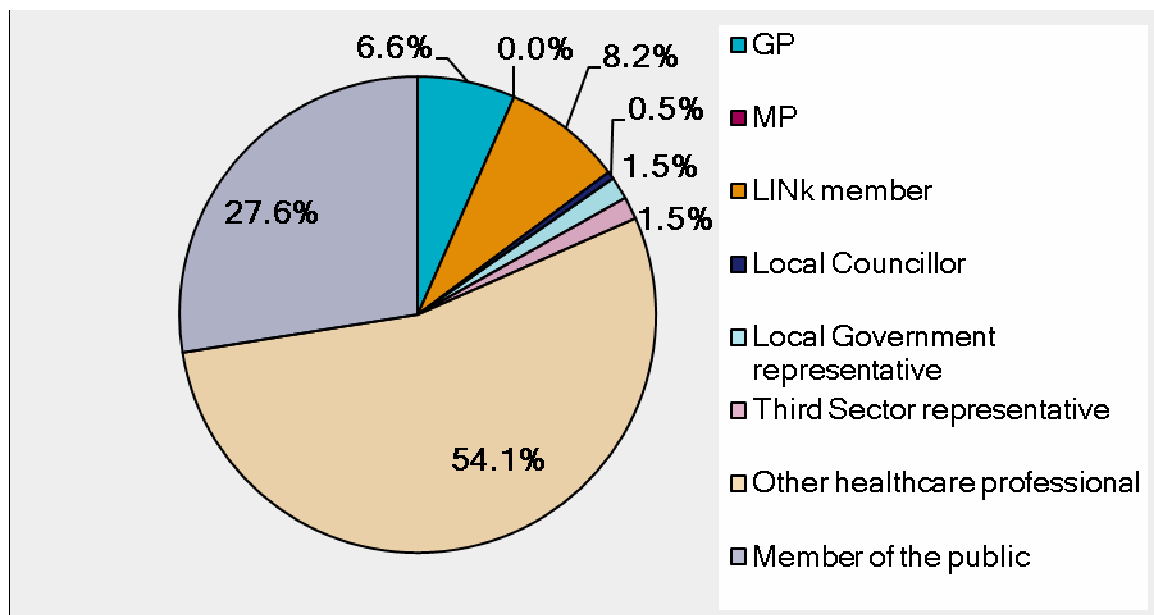
Overall the project received 201 questionnaires. 171 of the responses were received via the online questionnaire and 30 paper questionnaires were also received. Not every question on every questionnaire was completed. This means that although 201 questionnaires in total were received, there were not 201 individual answers to every question.

3.2 Demographic details

Responses were received from individuals from over 100 different organisations – the majority of which were NHS organisations based in London. As can be seen in figure 1 below, the majority of respondents were a healthcare professional.



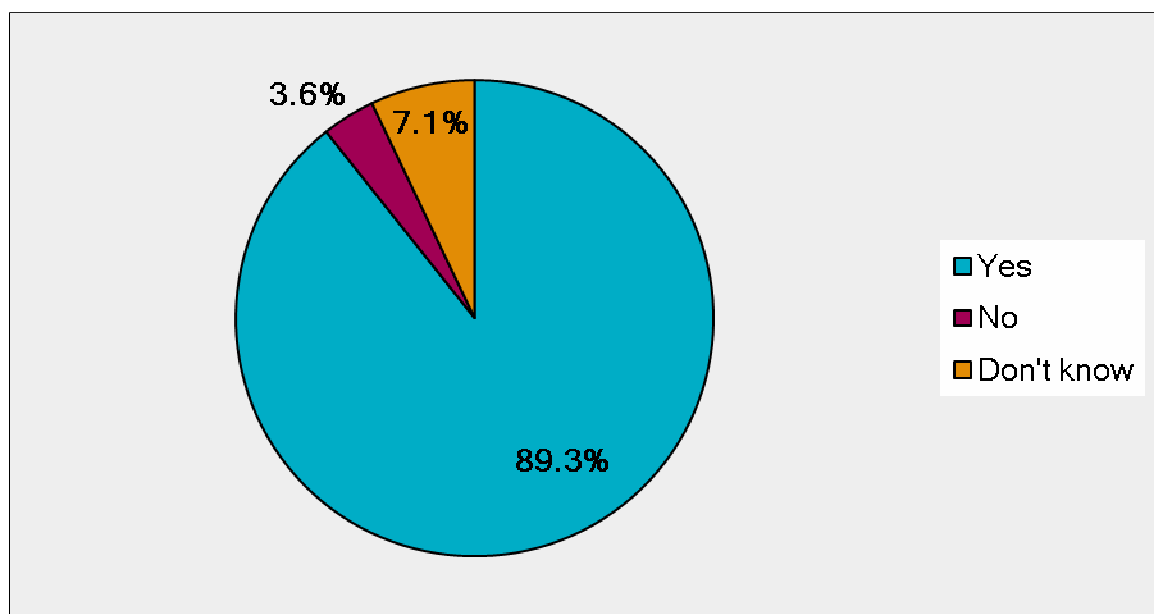
Figure 1. Background/role of respondent



3.3 Responses to questions on vascular surgery

Respondents were asked three questions in relation to vascular surgery. Firstly, they were asked about the case for change in vascular surgery. Responses are displayed in figure 2 below:

Figure 2. Do you agree that the clinical evidence provides a compelling case for change for vascular surgery?

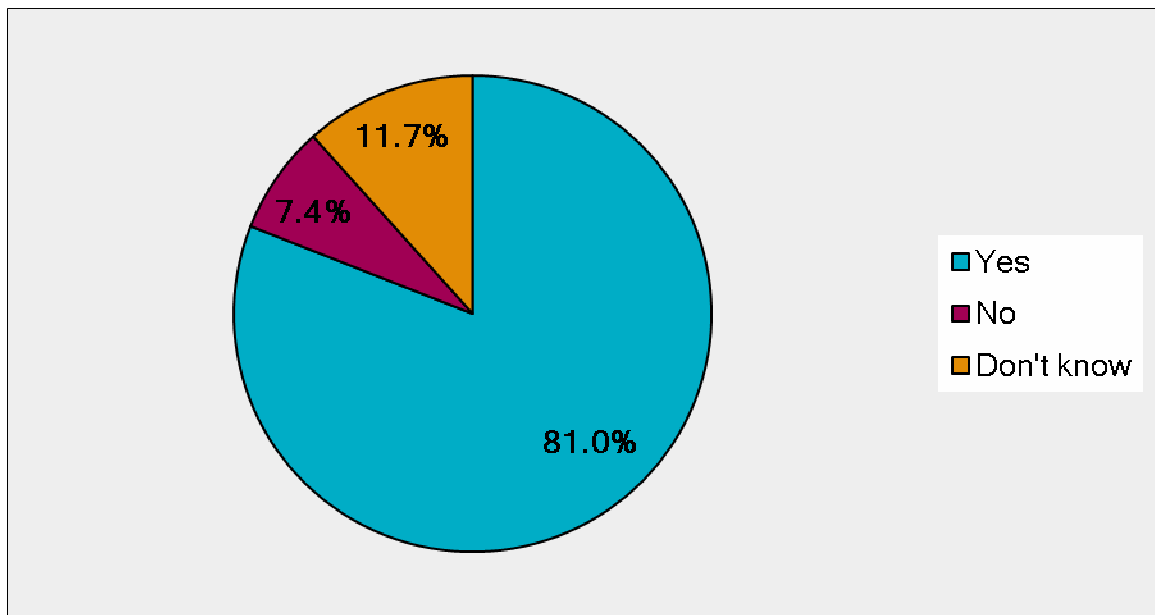


Secondly, respondents were asked about the vascular surgery model of care, and were specifically asked about the number of arterial vascular sites that there should be



across London. Responses are displayed in figure 3 below:

Figure 3. Do you agree that arterial vascular surgery should be centralised onto five sites across London?



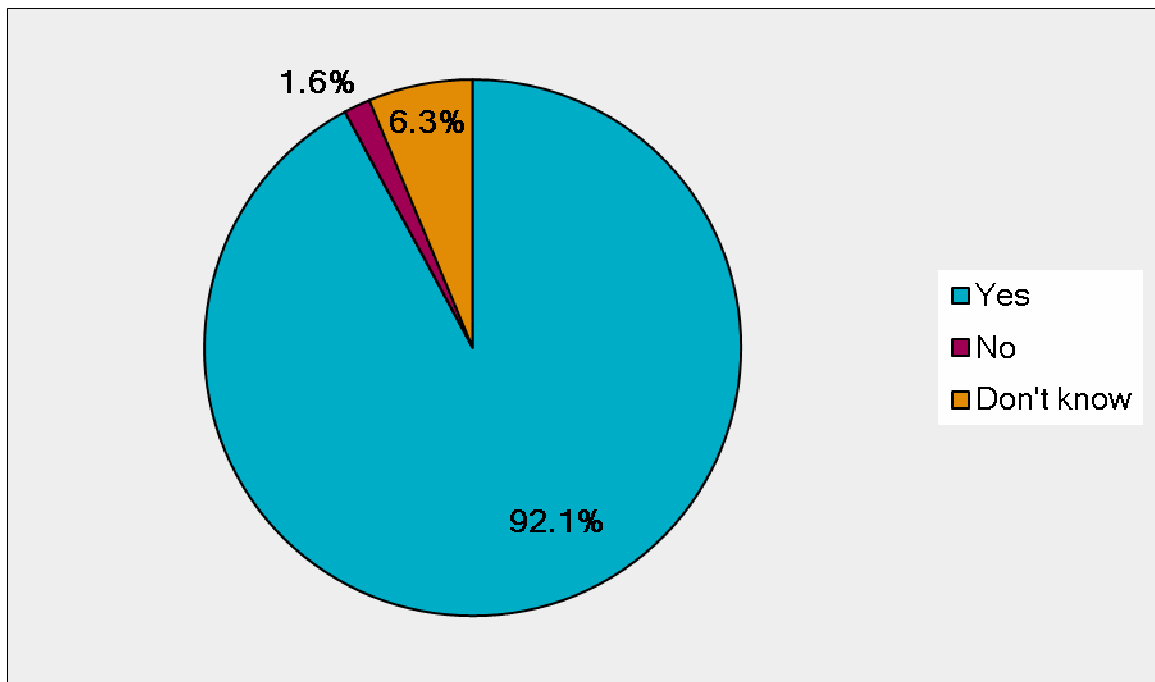
Finally, respondents were given a free text box to write about which services should be provided locally. The vast majority of these responses mimicked what was proposed in the model of care, but all the responses to this question can be found in appendix 1.

3.4 Responses to questions on cardiac surgery

Respondents were asked four questions on the cardiac surgery proposals. The first two questions focussed on the proposed changes to the pathway for patients requiring urgent cardiac surgery. Respondents were first of all asked if they agreed that the service for patients needed urgent cardiac surgery could be improved. The responses are below in figure 4.

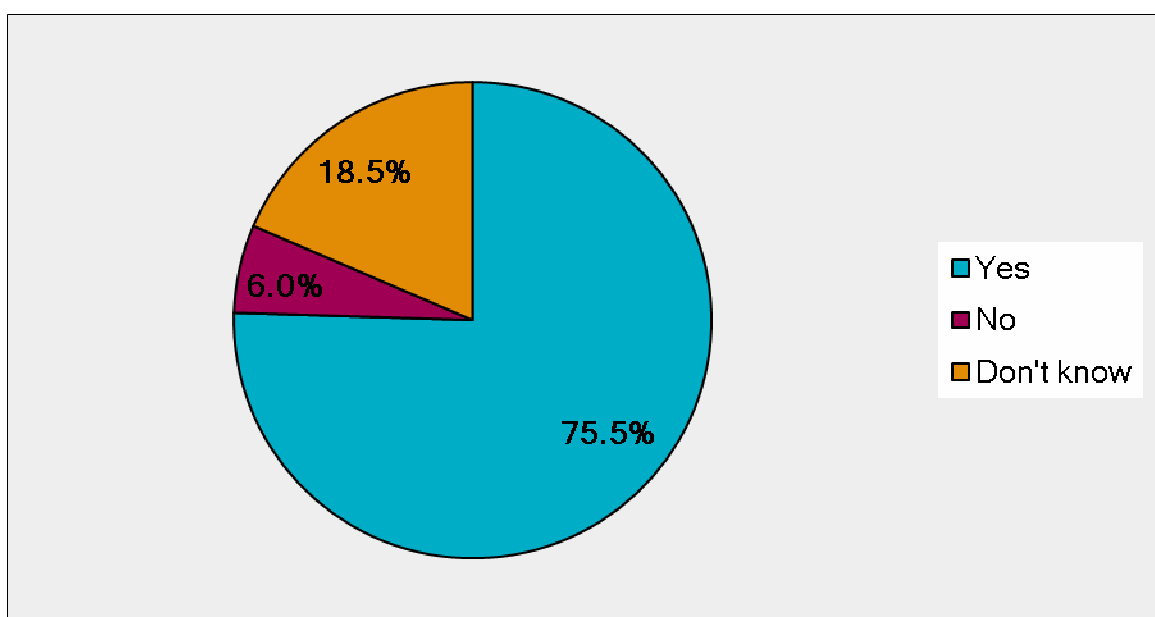


Figure 4. Do you agree that services to patients requiring non-elective cardiac surgery should be improved?



Respondents were then asked if they agreed with the use of an electronic referral system and case managers as the best way to achieve these improvements. Results are shown below:

Figure 5. Do you think that the use of an electronic referral system, coupled with case managers in the receiving centers is the best method to reduce delays for non-elective cardiac surgery?



There was then one question asked about the proposed changes to mitral valve surgery and a pan-London aortic dissection service. Responses in these areas are shown on figures 6 and 7 respectively.

Figure 6. Do you agree that mitral valve surgery should be sub-specialised?

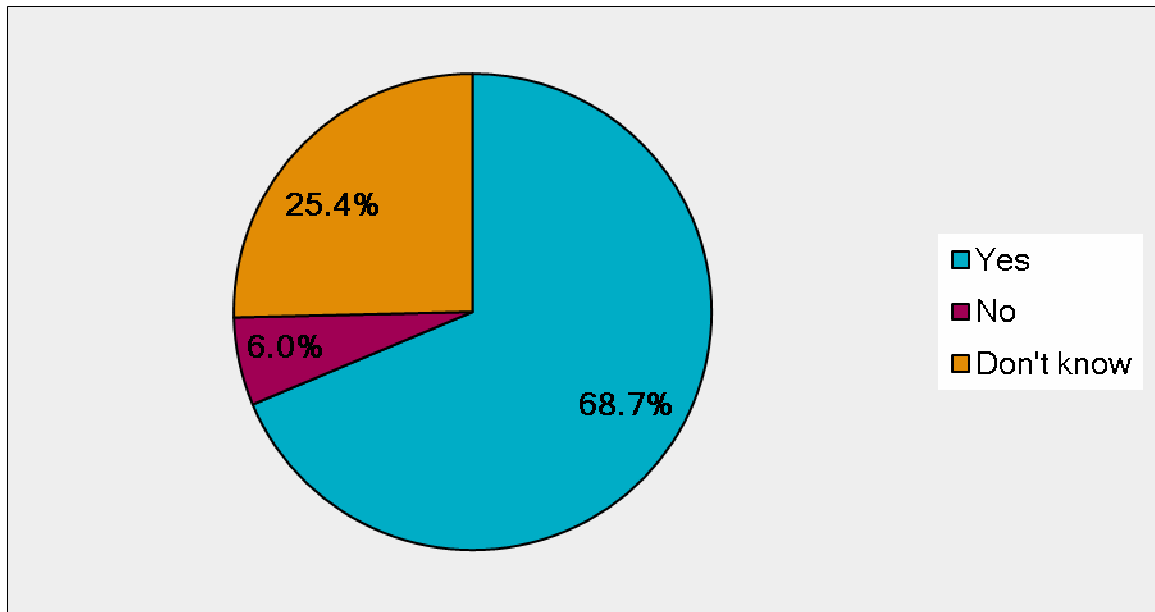
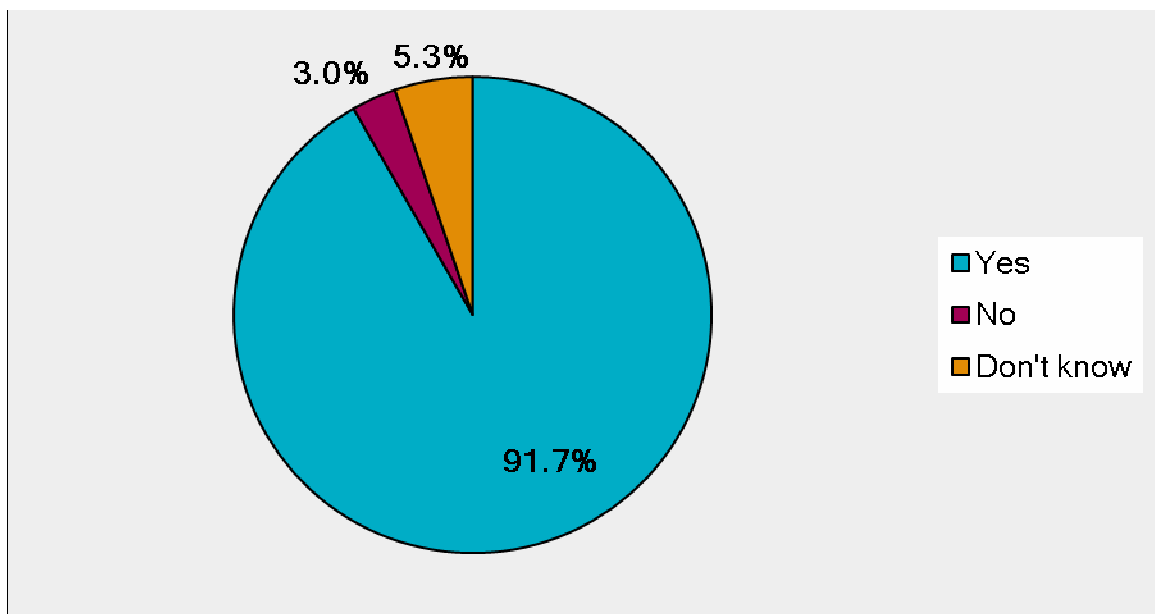


Figure 7. Do you agree that patients requiring surgery for aortic dissection should only be treated at specialist centers by specialist surgeons?



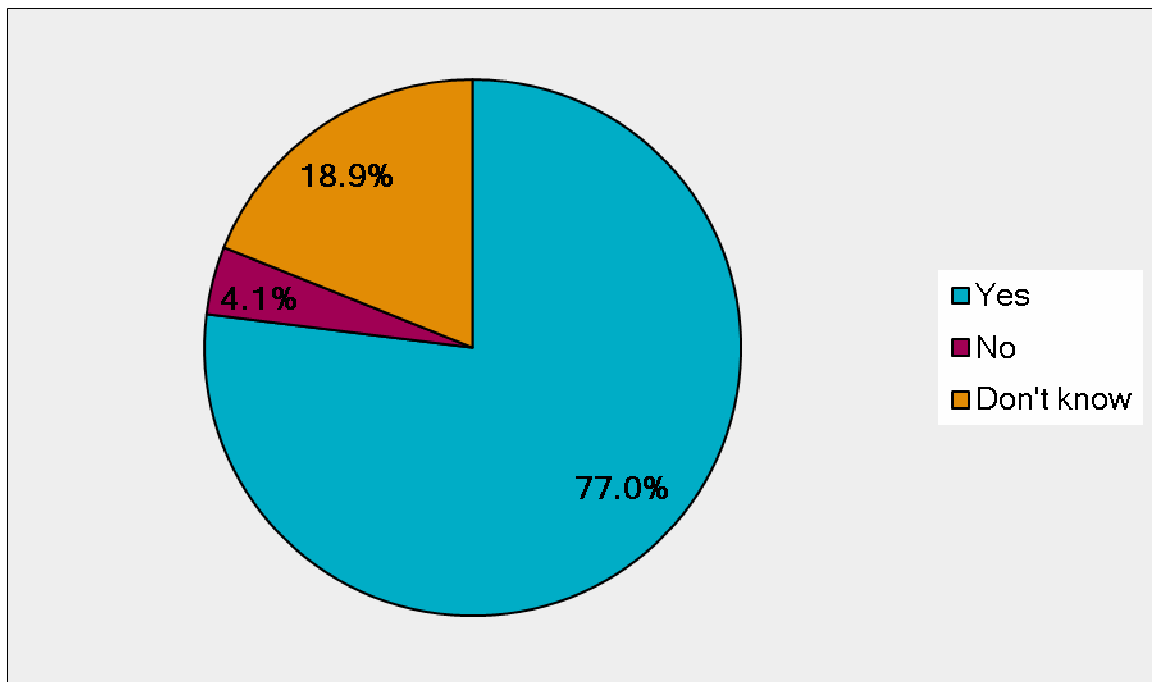
3.5 Responses to questions on cardiology

The questionnaire contained three questions relating to the cardiology section of the model of care; two related to the treatment of patients with high risk acute coronary syndromes, and one related to the formation of electrophysiology networks. The figure below displays the responses to the question which asked for people's opinions on the



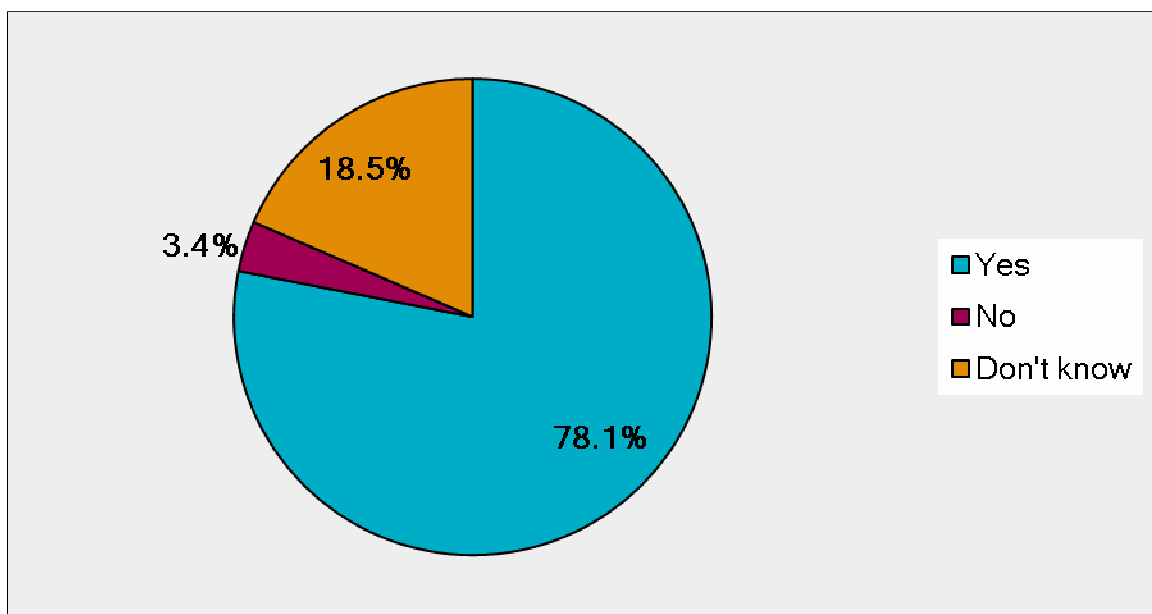
case for change for high risk acute coronary syndromes patients.

Figure 8. Do you believe that services should change for “high risk” NSTEMACS patients?



The next question asked if people agreed with the proposed model of care for this cohort of patients. The responses are shown in figure 9 below.

Figure 9. Do you believe the model of care proposed for high risk NSTEMACS patients is the right one?

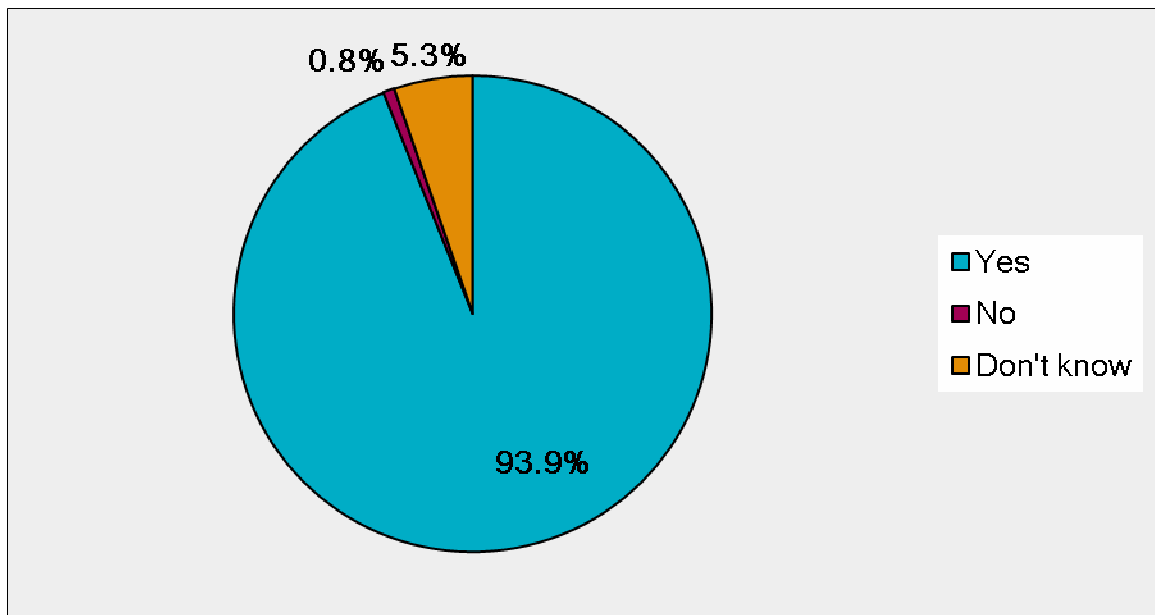


Finally in the cardiology section, views were sought on the proposed model of care for patients with heart rhythm disorders and the proposal to form electrophysiology



networks.

Figure 10. Do you think that hospitals should come together as networks to treat patients with heart rhythm defects?

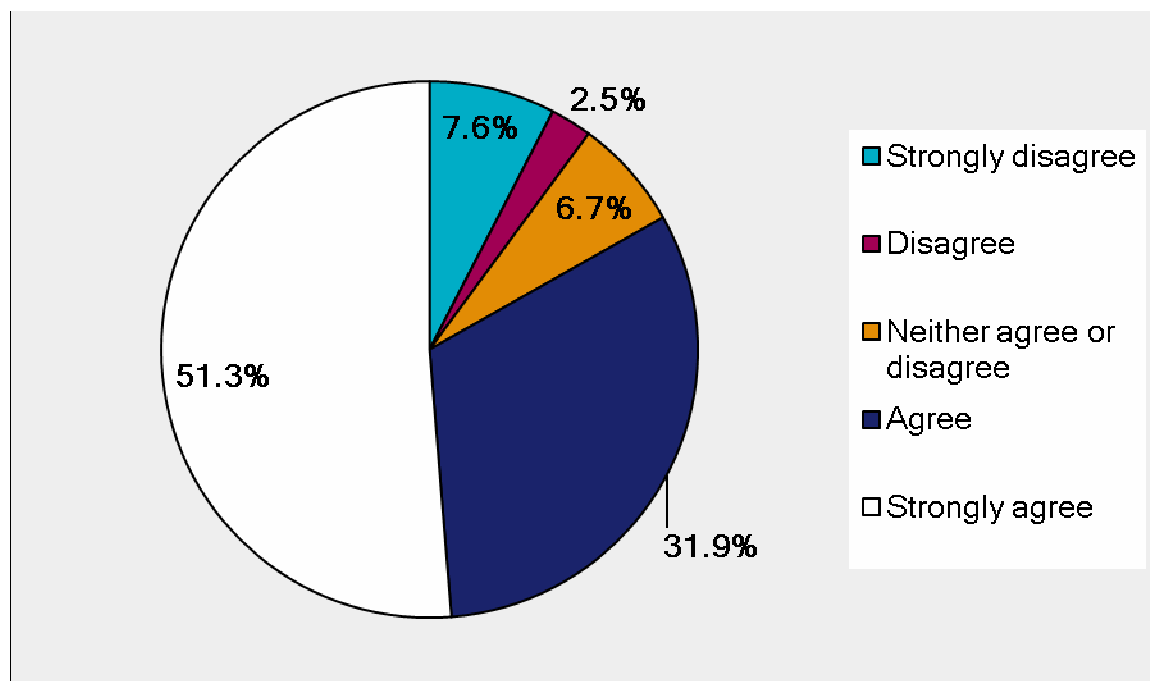


3.6 Responses to the general questions

The questionnaire concluded with three final questions. One question asked respondents to state how strongly they agreed with the project proposals overall. Overall, 83.2% of respondents either agreed or strongly agreed with the project proposals over all. 10.1% of respondents either disagreed or disagreed strongly with the proposals.



Figure 11. To what extent do you agree with the recommendations of the London cardiovascular service proposals?



The final two questions were free text questions. One asked if the respondent had any more general comments on the project as a whole and the other asked how the person thought that the project should be implemented. The free text responses in these areas were broadly supportive and are published in their entirety in the appendix section.

4. Other formal responses

The project team also received several responses to the project proposals not in the format of the questionnaire. Some of these responses took the form of a letter following up an official meeting where support for the proposals had been agreed verbally and then a subsequent letter was sent to confirm a group's support for the proposals.

Other responses were either posted, or emailed into the project team without any other sort of contact taking place with the project team. The table below shows all the organisations from which a response was received and who did not complete a questionnaire. All of these responses are available to read, in full, in the appendix section.

Table 1. Organisations or groups that submitted a formal response on the project proposals not on a questionnaire.

Organisation or group	Location of full response
Barnet & Chase Farm NHS Trust	Appendix 4



Croydon Health Services NHS Trust	Appendix 5
London Borough of Bexley	Appendix 6
London Borough of Croydon	Appendix 7
London Borough of Havering	Appendix 8
London Borough of Merton	Appendix 9
Londonwide Local Medical Council	Appendix 10

The project also received and responded to a letter from North West London Hospitals NHS Trust in April 2010, when the case for change was first available. This letter, and the response can be found in appendices 11 and 12.

5. Objections and criticism of the cardiovascular proposals

Overwhelmingly, the comments received by the project team were positive and supportive in nature. However there were three areas where the project received some criticism. These were in relation to:

- The vascular surgery model of care
- The sub-specialisation of mitral valve surgery
- The patients with high risk acute coronary syndromes

In each of these three areas, the clinical leads were asked to study the feedback and make a decision as to how to take any comments forward either with the individuals who provided the feedback or to seek comments from the project clinical expert panels.

5.1 Vascular surgery model of care

A letter was received from Barnet and Chase Farm NHS Trust commenting specifically on the proposals to centralise arterial vascular surgery. In essence, the feedback stated that the proposals did not take account of the need for a local service, and that as had been proved over the years at Barnet Hospital and Chase Farm Hospital, it was possible to run a safe local arterial vascular service. The full response from Barnet and Chase Farm can be seen in appendix 4.

The comments from Barnet were sent to the clinical lead for vascular surgery. The decision was taken not to re-convene the vascular clinical expert panel as no new evidence was raised in the Barnet submission and the comments made by the Trust were not from specialist vascular surgeons, but the allied specialties. The project did not receive any comments directly from the vascular surgical team at the Trust. The clinical evidence around the provision of arterial vascular surgery is clear that specialist, high volume institutions result in better outcomes for patients. For that reason it was decided not to amend the vascular surgery model of care.

5.2 Sub-specialisation of mitral valve surgery

In the comments section of the online questionnaire, UCLH NHS Foundation Trust stated that they did not support the sub-specialisation of mitral valve surgery. They stated that the designation of individual surgeons and



teams to perform surgery on the mitral valve was not the best way to improve outcomes in this area. The full comments in this area can be seen in appendix 13.

No new clinical evidence was raised by UCLH and so again, it seems unnecessary to re-group the clinical expert panels. However, the clinical lead for cardiac surgery did agree that strengthening the monitoring of performance of those undertaking mitral valve surgery is something that should be re-enforced with commissioners implementing this work.

5.3 Patients with high risk acute coronary syndromes

The project received a detailed submission from Dr Kevin Beatt (a cardiologist) at Croydon Health Services NHS Trust (formerly Mayday NHS Trust). The submission discussed several aspects of the proposed model of care, had several queries and several criticisms of the proposals. The full submission can be read in appendix 5.

The clinical lead for cardiology has contacted Dr Beatt personally to discuss his comments, and in addition Dr Beatt has been offered a meeting with the project team. It is not felt that the model of care should be revised in light of these comments.

6. Conclusion

Overall, the project received broad support during the three month engagement period, with all but one of the model of care recommendations receiving at least 75% support and most of the recommendations receiving support above 80%. Where the project received criticism the project believes that either comments have been incorporated into the proposals or that they do not mean that the clinical expert panels need to be re-convened to discuss these comments as they are unlikely to change the proposed model of care. Commissioners should proceed with implementation.



Appendices

Appendix 1 - Which components of vascular surgery do you think should be delivered locally?

After care and prevention
Aftercare
All
all should be via centres of excellence
angiogram and PCI
Angiograms & similar
Any follow-up or post-operative care.
Any where the decision to do so would be based on clinically sound, economically viable, 'patient centred' reasons - i.e. not based on local, regional or nationally led political motivations.
Anything done under a local?
As much as clinically safe.
as proposed model
As recommended in report
Below knee amputation by necessity
Care that can be provided safely in primary care
Day case, diagnostic and out patient
Diagnostic tests. Angiography and angioplasty. Venous surgery. Diabetic foot care and management of the complications of diabetic feet. Amputations.
Diagnostics Day case surgery for varicose veins etc. Outpatient services
diagnostics, rehabilitation and clinic visits
Don't know
First consultation, some ongoing care / follow-up in conjunction with specialist centre
Follow-up care
high volume low complexity work
high volume procedures which are not complex
Initial diagnosis when patient presents but then rapid transfer to specialist unit
Local sites should provide quality local vascular service. This would include outpatients, diagnostics & day surgery for venous procedures.
low complexity, high volume surgery
Low level, high volume day surgery cases that do not require admission to a specialised unit. Non complex and non emergency care.
lower complexity procedures where endovascular techniques can be used
Lower limb varicose vein
Lower risk and less complex cases - hence initial investigation including data on case mix and outcome is important before making sweeping statements and changes.
Minimal risk surgery
need to look at what skills are available in the local area - so not sure
Non-complex once the procedures of limited clinical value have been reconciled. Follow up and rehab should stay local as should AAA screening and outpatients



none
Non-specialist elements
Not competent to answer that depends on volume and expertise on one hand and post op care etc the success or failure does not sole depend on the skills of the surgeon, the MDT has to be in place to maximise outcome
Not familiar enough with the pathway to comment - however it should be whatever is best for the patient, and not what is best for 'the system'
NOT SURE
Not sure.
Only in Ceners of excellence
OPD, venous element of surgery, some diagnostics, ?amputations could be done locally with support from specialists as they can have a long stay and need local services near for good discharge
Out patient clinics, varicose vein treatments (for patients with appropriate indications), some vascular access work (eg day case wrist fistulas under LA), some vascular interventional radiology (agreed at MDT, generally day case), amputation rehabilitation, in patient leg ulcer care (in conjunction with another specialty eg dermatology)
Out patient services Venous services
Outpatient & day surgery for venous procedures
Outpatient clinics Capability for urgent review of inpatients
Outpatient clinics Rehabilitation Some varicose vein surgery
outpatient clinics wound and ulcer care diabetic foot clinics risk factor management varicose vein treatment simple amputations routine angioplasty
outpatient clinics, varicose vein surgery, day case surgery
outpatient tests
outpatients and diagnostics daysurgery procedures
Outpatients and diagnostics etc
outpatients etc
Outpatients, imaging, elective venous surgery, treatment for hyperhidrosis, elective bypass and carotid work if good interventional vascular radiology available on site.
Outpatients, varicose veins, diabetic foot health, wound dressings, rehabilitation
PCA
Possibly angioplasties, carotid, peripheral vascular
Pre-op investigations, post op suture removal, follow-up for complications
Screening, counselling, rehabilitation
Simple non complex that are able to be delivered without significant infrastructure and with a high enough critical mass for operators to be proficient and to make sure that outcomes are of appropriate standard.
Simpler vascular work such as vein stripping etc but large, specialist surgery should be delivered from a specialist centre with highly specialised staff available.
The most useful parts.



Those procedures that do not require specialist knowledge, surgical techniques or technology. Procedures as specified by your documentation that make up around three-quarters of all vascular surgery could be provided at the local hospital but those that are performed rarely require specialists who are trained in the latest techniques, and have access to the latest tools. It is common sense - you would never ask a mechanic to fix an aeroplane - yes they are both vehicles but one you need specialist knowledge that mechanics just don't get exposure to everyday.

Those which are done enough to provide appropriate outcomes

Varicose vein surgery duplex scanning out patients rehabilitation & amputee rehab
varicose veins

Varicose veins

Varicose veins, vascular outpatients, vascular diagnostics, potentially below knee intervention

vein surgery

Veins.

With regard to the delivery of services, the committee would want to take advice from specialists.



Appendix 2 - Are there any further comments that you would like to make on the proposals as a whole?

a time frame for implementation is needed
a very good piece of work
Another top down approach rearranging the deck chairs. The variation in outcome measures is deplorable but it is a matter for the RCS and PDP of CV surgeons not an excuse for re-organisation
As more and more specialised services accumulate in the same hospitals there will be severe stretch on ITU capacity. There is also likely to be a paucity of skills and services at DGH level. There may also be an additional impact on A&E
As said before electronic systems are only efficient when properly used and from experience this is always breaking down due to bad referral
Best of Luck!
Cardiac networks are the best way to ensure consistency and excellence
I hope the change of government does not derails this important clinically and patient led initiative which is long overdue
I hope this is progressed very quickly and applied to all areas, but especially those with current poor performance
I think that the new model for cardiovascular surgery will improve the way surgery is carried out for those patients who require it, in terms of shorter waiting times, shorter bed stay and having it done by a surgeon experienced enough to do so, hence improving and prolonging patients' lives. It makes a lot of sense.
I would like to have seen cardiac prevention and rehabilitation included in the care of patients post cardiac event. This is an evidence based part of their treatment and care which improves quality of care and life.
It can be difficult if certain on site co-dependencies are made absolute as this is an easy way to block change. It is perhaps preferable to preface interspecialty working with a statement that certain on site codependencies are strongly recommended but in their absence there should be adequate arrangements for rapid opinion/investigation/transfer etc. An example is Stroke services which may have multiple localities feeding into one vascular unit providing carotid intervention.
It's all been said.
Make sure that all the paperwork for the patient is available prior to any surgery
My comments are in relation to Vascular Surgery only. The proposals are entirely in line with; evidence, national guidance, efficient delivery of services and common sense. The key is to ensure that robust protocols are in place to; maintain support for 'spoke' providers and ensure patients are dealt with equally regardless of location.
no
No
no
No
No thanks
NO. Great work done. It is normally helpful to include the codes of data extracted. A very useful set of reports.



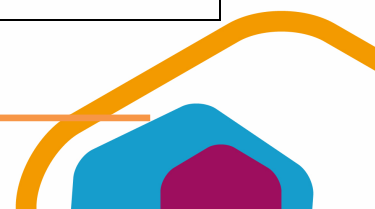
<p>please include the relevant therapists on the pathway including dietitians and physios</p>
<p>Specialisation of services is proven to produce better outcomes - this has been the case with heart attack patients, stroke and major trauma.</p>
<p>The Adult and community PDS Committee supported the proposals presented at the meeting on 21 September 2010 and were impressed with the case for change that was presented.</p>
<p>The idea that hospital units should work together is both logical and well overdue. Avoid centralised referral centres, allow local specialists to refer within their network, this way you integrate the service.</p>
<p>The LINK supports the general principles proposed but cannot fully comments without detaled proposals. [The devil is always in the detail!]</p>
<p>The network is committed to the roll out of the programme.</p>
<p>The proposals look very good, however if they are to be implemented, I feel that excellent pathways and systems of communication will be essential to the success of any changes. Communication between the Drs on the teams at the local and central hospitals, but also the allied health teams will be important, specialist nurses, rehab teams... Recovery following vascular surgery and heart problems is not soley dependent on the quality of the care received from the Doctors, Surgeons and inpatient staff, but also on the quality of communication between the supporting teams at the local sites as well as in the specialist sites. Otherwise teams supporting the recovery of these patients will be inadequately supported, and therefore quality of care will be lost.</p>
<p>The review should have looked at some of the models already in existance.</p>
<p>There is no infrastructure for the vital work of cardiovascular research, clinical trials, registries, audit and data tracking which should also be partly centralised. There is little scope for cardiac rehab and prevention which is equally as important to the entire cardiovascular proposal for London. I'd be happy to present more details of these key shortcomings which have major clinical outcome and financial implications. A more encompassing proposal would attack what matters as equally to patients - pre-care: prevention, aftercare: cardiac rehab and high standards: research and audits!</p>
<p>These proposals have obviously been thoroughly researched and tested against best practice and amongst clinicians and patients. You are to be commended for such a sensible and easy to understand proposal that puts quality outcomes above the common irrational and outdated mindset that the local hospital should deliver all care.</p>
<p>This all sounds vey good. I hope it will not result in the reduction of ou excellent NHS staff but that we will see an improvement for all concerned</p>
<p>This is a good thing. How are gaps in general surgery rotas going to be filled when general surgeons with an interest leave general surgery. How are we going to ensure hospitals co-operate when PCTs & SHAs are stopped</p>
<p>We need to move forward with these proposals in a timely manner as we have already upgraded the services for stroke and trauma.</p>
<p>We should be doing everything we can to care for people with illness.</p>
<p>What are you waiting for? For the patients' sake don't wait for the politicians.</p>
<p>Whilst trying to achieve excellence it is very important to try and achieve continuity of care. The patient always appreciate seeing "someone" who knows them. The conveyor belt system does not help their psychological need though it may have the best clinical outcome.</p>
<p>Would be worth reiterating why this is special for London - its density and relatively small are (compared to regions) make this a viable option</p>





Appendix 3 - How would you like to see the recommendations of the cardiovascular proposals implemented?

A combination of network/CSL and commissioner input could easily take this forward.
All these proposals must be undertaken in the wider context of reconfiguration across multiple services so that system change can occur as smoothly as possible. The populations served by these services will expand beyond consortia so cardiac networks will have to take a strategic overview assisting consortia to generate consensus and create pathways for the entire local population not just their patients.
As much information as possible being made available to patients through local PCT's.
As quickly as possible
As quickly as possible before we all lose our jobs!
as quickly as possible via a workable system not PCT who seem to have tiers of management doing nothing but attending one meeting after another to no avail for years.
As soon as possible
As soon as possible and with steady gradual conversion over a fixed time frame with clear milestones and performance targets for clinical outcomes
as soon as possible with full ppi involvement
as soon as possible. London is the lead centre for reconfiguring change in vascular surgery services in the UK. We cannot carry on delivering haphazard models of care in the modern era. To me, the volume outcome relationship is compelling.
ASAP with with clear instructions to those unit who are not committed
ASAP. Trusts and commissioners need to get together to start the process of developing the networks.
Bit of an odd question - not being a specialist in this area I don't think I'm qualified to comment but I don't believe that GPs, who don't have the knowledge of these services and who have a vested financial interest in how services are commissioned, should be responsible for their implementation.
By joined up commissioning and collaboration between providers as networks
By urgent action across London and especially urgently in poor performance areas
Consult all stakeholders. Determine current state. Propose future state. Agree the transition plan and implement
Driven by informed commissioners and patient groups
each inner London hospital/hospitals should be assigned a team with the expertise to conduct one or more procedures, and should maybe commence with two one or two hospitals at first to pilot and then roll out to other hospitals.
gradually with sufficient resources and support to facilitate a smooth change and to enable effective and sufficient communication.
I believe that cardiac networks are in the prime position to undertake the implementation; in London cardiac networks expanded to become cardiac and stroke Networks and have proved successful with the implementation of the stroke agenda, they are firmly established and well positioned to understand the implications of the changes and work with clinicians and managers to ensure quality services are established and maintained.
I would not



In a coordinated way to promote equality of access and improved quality i.e. local implementation via Networks.
In a timely and cost efficient manner. They should be implemented as soon as possible so as to not lose momentum and risk nothing being implemented at all.
In full!
In planned stages
its difficult to see how gps can individually have a pan london perspective. therefore, either a group of gps that are mandated to act on others behalf or another pan london group.
On BBC News, standardised memo across the NHS Network, GP's and Department of Health,
Presentation to a day long meeting of as many London clinicians as available to discuss strategy and short-comings
Quickly
Quickly and effectively!
Quickly and safely, with the full involvement of relevant stakeholders.
Quickly with cooperation between NHS London / GP commissioners and trusts.
Rapidly with effective clinical governance and regular review of designated centres
Rapidly, with as little bloodshed as possible
sector based coordination between patients, commissioners and providers
The most important factor will be good communication and agreement across the organisational boundaries on the individual patient pathways (i.e person centred)
These comments are regarding Vascular services only: I believe they should be implemented fully and with no hesitation. The changes should serve as a catalyst to promote similar changes, where appropriate, across the UK. Understandably there is much resistance to change on the subject of vascular surgery and UK patients outside London deserve equally good services. The London configuration should be used as a benchmark for other areas.
These need to be project managed with appropriate project management infrastructure. Cardiac Networks can play a role here with involved centres to make sure that all key stakeholders are involved and know what is going on. This process needs to make sure there is not duplication and commissioning groups need to link with networks to make sure financial flows are planned correctly.
They should be implemented ASAP. The various (Cardiac, Stroke, Vascular) local and pan London networks are probably the key to role out. If a Network has experience of any of the models of care, this should be shared with the other Networks.
Through the Cardiac & Stroke Networks who are ideally placed to do so.
Unfortunately unable to access documentaton so could only answer by what patients have told me.
Unsure
will require education acceptance of clinicians and patients leave alone politicians. the case has to be made at every DGH and among commissioning groups. Need to link with better care closer to home so that this doesnt come across as a centralisation agenda. networks need to establish their independance from institutions and individuals - the providers. who will believe that this is about improving out come and not cutting back services in certain hospitals good luck with the implementation.
with care not to quickly
With consideration to all involved staff and patients, to the best possible outcome



With immediate effect and without interim steps - these are likely to become sticking points
With immediate effect.
With much public and patient involvement and education information on reasons for change.
Yes, with changes



Appendix 4 – Response from Barnet & Chase Farm NHS Trust

Barnet & Chase Farm NHS Trust Response to London Cardiovascular Services Model of Care

The Barnet & Chase Farm NHS Trust has read this document with interest and concern. Whilst we are obviously in complete agreement with the requirement to see improvement in the quality of care offered in this field across London we, as a trust, do not believe that this will be achieved to the maximum degree possible using the model presented in this document. In the view of the trust quality of care is made up by a number of criteria including equality and speed of access, the skills and technologies available, case numbers and certain interdependencies as recognised within the document which latter however largely apply only to a relatively small number of super-specialised cases. However a truly excellent service must also take into account the requirement for local access. The majority of our patients requiring intervention are elderly and although it is often claimed that all patients will be “prepared to travel for an improved quality of care” it is surely the hallmark of a service of true excellence that patients should wherever possible be able to access such care locally. The proposals presented appear to serve better the requirements of central institutions and clinicians than those of the majority our patients. In the view of the trust it is regrettable and indeed notable that the clinicians selected to undertake this review are all representatives of central institutions and it is perhaps the case that has lead to a failure to appreciate the value which our patients place upon an excellent local service.

Within the Barnet and Chase Farm NHS Trust all vascular surgery has been undertaken for many years by a team of four specialised vascular surgeons together with a team of five specialised interventional radiologists. We have been early to embrace technological change and have an extensive angioplasty and EVAR programme with excellent outcomes documented. In particular it should be noted that there have been no deaths or serious morbidity within our EVAR series clearly demonstrating the safety of advanced technologies introduced into a large district hospital vascular unit with appropriate governance. The Trust also performs a significant number of angioplasties each year with good outcomes for patients. It is unfortunate that the report chose to use data from the year of introduction of the NHS integrated PAS system into the trust. As has been widely found the “teething problems” associated with the introduction of this system lead to considerable difficulty with the production of accurate activity data and that presented within the document significantly under presents the activity of our vascular surgeons. An up to date set of figures for the unit is appended (appendix 1).

The trust is committed to ongoing development in its vascular surgical services and has for example successfully taken on the challenge of a rapid access carotid endarterectomy service for its stroke patients. Whilst the trust has to date operated an in patient acute vascular surgical service on both sites it is presently in the process of moving acute in patient services onto the Barnet site so that it is completely co-located with the newly equipped interventional radiology suite. The trust has for a number of years provided a 24/7 emergency vascular service from within its own resources, but recognises the need to collaborate with other partner trusts to



achieve a satisfactory service across North London and is collaborating with the North London Vascular Service.

The trust also feels that this review has completely failed to appreciate the very significant contribution which its vascular surgeons make to the other specialities within the hospital which seek their advice and support on a daily basis including for example diabetic management and orthopaedic surgery, as well as the support provided to colleagues undertaking other forms of major surgery within the organisation. In this regard the contribution of the B&CFH as the major provider of surgical cancer care within the North London sector must be appreciated.

As stated at the beginning of this response the trust appreciates the need for a small number of patients with particularly complex vascular problems to be treated in a centre with cardiovascular co-dependency. In the experience of our vascular clinicians it is the case that these cases can be identified at an early stage in their investigation and transferred to a appropriate provider with no evidence of any detriment to the patient. The trust would as such wish to work as part of an extended network , but is forced to point out the difficulties attendant on the transfer of patients to the central London centres owing largely to capacity issues and sees no immediate or indeed medium prospect of a change in this circumstance particularly if this centralisation agenda is pushed ahead. Delays caused by these problems with patient transfer, which are apparent to the trust in fields aside from vascular, give us as an organisation little confidence in the ability of a centralised project to produce a responsive service, whilst the possible transfer of post procedural patients back to a deskilled periphery is we feel a recipe for deteriorating outcomes. The experience of the trust in “hub and spoke working” does not bring us to the conclusion that this model maintains highly skilled personnel in the periphery, indeed rather the opposite, as understandably senior clinicians are attracted to the major centre. It is the view of the trust that if this agenda is taken forward it will be increasingly difficult to maintain essential skills to deal with patients inevitably referred back from the centre and to undertake the myriad other tasks undertaken by our vascular colleagues within this large surgical centre. In addition it is likely that it will be increasingly difficult to attract good candidates to posts at all levels within the service.

Appendix One: Total number of procedures carried out at B&CF in 2009/10

- 39 AAA repairs – 30 EVAR and 9 open repair procedures
- 60 carotid artery surgery procedures - 57 Endarterectomy procedures, 0 Carotid Angioplasty and Stenting and 3 Carotid Artery Surgery
- 82 angioplasties



London Review - cardiovascular services:

Appendix 5 –
Response from
Croydon Health
Services NHS Trust

Proposed model of care

The Stated goals of the model of care are:

- Saving more patients' lives
- Increasing the speed and equity of services
- Improving patient access
- Reducing the length of time spent in hospital
- Meeting unmet needs
- Improving the use of new technology and research
- Making the best use of NHS resources and saving public money.

For patients with Coronary artery disease the following are recommended:

1. Patients with STEMI should be treated with angioplasty at Heart Attack Centres.
2. Patients with NSTEMI should have access to coronary angiography and for patients deemed to be at, "high risk" this should be done within 24 to 72 hours.
3. The proposed model of care recommends improvements to streamline the current patient pathway. The new pathway will:
4. Diagnose and risk stratify patients early
5. Manage patients according to their risk level through the use of an agreed evidence- based risk stratification tool
6. Ensure that "high risk" patients are offered angiography within 24 hours of admission.
7. If the patient is triaged in a hospital that cannot provide angiography within 24 hours, then the patient should be transferred to a unit that can. Units wishing to provide this service should ensure that they are able to offer angiography on a seven day basis and provide commissioners with evidence of weekend working as required.

1. Treatment of STEMI patients

The model for the treatment of STEMI patients was set up in London in 2001 and this



has been adopted as a national standard. The London ambulance service in delivering patients to a heart attack centre is exemplary, particularly when one considers the size of population.

The service provided by tertiary centres is variable with some units incurring unacceptable, “time to treatment” delays, and there is an additional problem with tertiary units declining to accept questionable patients who do not fit the strict criteria for STEMI transfer, but who benefit from the early interventional strategy.

The service is also compromised by physicians at many DGHs who fail to make the appropriate diagnosis or do not do so within the acceptable time frame. In both cases the root of the problem can be traced back to a lack of expertise at the patient interface.

2. The treatment of patients with non NSTEMACS

2.1. High Risk NSTEMACS

The treatment of high risk NSTEMACS has become confused because there is no clear definition of a, “high risk” patient. In the review the criteria incorporates a broad range of patients including many patients who are not at “high risk”.

It should be clear that only a very small number of patients with NSTEMACS (< 1% of patients with acute chest pain) are truly at high risk, to the risk level of a STEMI patient who needs early intervention within the stipulated time frame. In the presence of an insufficient data this group can best be defined as patients with:

- Persistent or recurrent angina with ST- changes (2mm) or deep negative T waves **resistant to anti-anginal treatment.**
- Clinical symptoms of heart failure or progressing haemodynamic instability.
- Persistent life-threatening arrhythmias (VFI VT) unresponsive to treatment.

The diagnosis of high risk NSTEMACS as defined by the above criteria cannot usually be established at first presentation because the criteria defines patients who have failed initial treatment. In this situation, when the risk is difficult to define it is not possible for any useful risk stratification to be performed in the ambulance.

Should patients subsequently develop clinical features that would demand an early intervention there should be systems in place which will allow them to be treated in the same way as a STEMI patients with a critical care transfer to a centre that provides a 24 hour interventional service. This would mean broadening the indications for immediate interventional treatment.

In the context of medical admissions any NSTEMACS could be considered “high risk”, but in the context of NSTEMACS patients only those who fit the above criteria should be classified as high risk.

The review makes a case for considering moderate or low risk patients for the same treatment

as higher risk patients. However, there is currently no data to suggest that NSTEMACS patients benefit from earlier treatment and there is some data to suggest that it may be harmful. Almost all of the clinical trials in this



area compare interventional treatment within the first 48 to 72 hours with later in-hospital treatment or treatment post discharge, without specifically scrutinising patients who present within the first 24 hours. The recent ABOARD study which compared patients treated early to those treated the following day showed a doubling of the myocardial infarction rate in the group treated early ($p=0.09$). There was no advantage in any clinical outcome for those treated early, but there was a reduction in inpatient stay.

Currently there no indication for the immediate transfer of patients to a centre with a 24 hour interventional service when first assessed by the ambulance service or first assessed in the casualty department.

The review should have clearer risk stratification documentation of the NSTEMI patients.

Review statement:

Diagnosis and risk stratification may be possible by ambulance paramedics in future.

At present, ambulance services are unable to carry out the required assessments to

diagnose high risk NSTEMI patients due to lack of equipment and appropriate clinical training.

Proposal

High risk NSTEMI patients should be treated in the same way as STEMI patients with critical care transfers to designated Heart Attack Centres.

Response

There is no data to support this proposal nor does the London review provide any.

Review statement:

Assumptions

The financial modelling for NSTEMI patients makes a series of assumptions. Where this is the case every effort has been made to be conservative in the estimate and give a worst case scenario.

The implied assumption throughout the paper is that the number of patients who currently end their pathway with a non-elective PCI will be the same number of patients who in future will be triaged as high risk. This assumption had to be made to allow for a comparison between what is happening currently and how the proposed new pathway will affect this. The implied assumption throughout the paper is that the number of patients who currently end their pathway with a non-elective PCI will be the same number of patients who in future will be triaged as high risk.

Response:

I do not believe there is a basis for this statement for the reasons given above. Many non-elective PCIs are performed because the



patient is in-hospital and having an invasive investigation; indicated because the diagnosis is uncertain. In this situation there is the option to proceed on to a coronary intervention. This practice is common and cost effective for the provider because it avoids a separate procedure. It is also convenient for the patient who is able to receive definitive treatment at the earliest opportunity. It allows an earlier return to an active lifestyle and an early return to work. However these patients are not at high risk and many of them will have a risk profile similar to those who have chronic coronary artery disease.

A revaluation of the financial modelling should be performed with a more appropriate definition of higher risk patients.

2.2. Non “High Risk” NSTEMI Patients

Review Statement

Case study: North east London pilot

The proposed model was piloted in North East London between November 2007 and January 2008 to assess the feasibility of early transfer of high risk NSTEMI patients from an emergency department to a receiving PCI centre. The pilot was undertaken at Newham University Hospital NHS Trust and Barts and The London NHS Trust (Royal London Hospital). Once risk stratified, patients diagnosed at these hospitals with high risk NSTEMI (based on locally pre-determined criteria) were transferred to the London Chest Hospital. Over 800 patients with suspected acute myocardial cardiac ischaemia were assessed in the two emergency departments. Of these, 11% fulfilled all the criteria and were confirmed as high risk NSTEMI. These patients were treated on the pathway, which involved immediate medical therapy followed by ambulance transfer to the London Chest Hospital for possible PCI.

The north east London pilot data demonstrated that for those patients assessed as high risk NSTEMI, the mean time from entering the emergency department to transfer was 3.5 hours. This comprised 37 minutes to be seen at the emergency department, 88 minutes ‘process’ time, and 78 minutes waiting for the ambulance transfer. Coronary angiogram was performed an average of 12 hours after presentation, with a revascularisation rate of 65% in transferred patients. This compares favourably with the rates of revascularisation in randomised controlled trials of early revascularisation in NSTEMI. This pilot study demonstrates that earlier transfer of patients is feasible and that shorter treatment times can be achieved. Further work would need to be undertaken.

Response:

Although the above data is not published or peer reviewed it does provide an interesting insight into the problem of differentiating patients with diagnosis of NSTEMI from those who do not have acute cardiac ischaemia.

Of the 800 patients assessed in casualty 11% met the criteria for NSTEMI with a high enough risk to be considered for early transfer to a heart attack centre. Of these only 60% needed revascularisation. Data from clinical trials would suggest that only a handful of these patients would have needed early intervention, within the first 24 hours, with the vast majority safely undergoing intervention within the first 48 to 72 hours. It is presumed that in 40% of patients the diagnosis was incorrect reflecting the well recognised problem of inexperienced doctors in casualty departments failing to



make the correct diagnosis in patients with acute cardiac ischemia.

This is a problem that is well recognised by those who treat acute cardiac ischemia, particularly in the context of treating STEMI patients and represents a lack of clinical expertise by junior doctors who are usually the first contact for patients admitted acutely. From the original 800 patients presenting only 53 (7%) needed early intervention, but not necessarily intermediate intervention. Furthermore, filling tertiary centres with patients who don't need to go there will only further delay the transfer of patients who are already waiting for tertiary centre treatment, particularly cardiac surgery.

Working on the assumption that a good proportion of patients who do not need intervention will need an invasive investigation in order to confirm that there is **not** an acute coronary problem and this number might be as high as 10 to 15 per cent of the patients presenting with chest pain, there is still another 640 patients (80%) who will have to be properly assessed, the correct diagnosis made and optimal treatment given. The review does not give sufficient consideration to the management of these patients or to the cost of treating them.

It should be clear that any development based on the North East London model must be flawed.

Review Statement

Additionally, it is envisaged that a proportion of patients currently admitted to a hospital with undifferentiated chest pain and then discharged home without intervention would be triaged in A&E and discharged to their GP without being admitted. This will result in reduced hospital admissions and costs.

Response

The Review recognizes that that problem exists but there is no indication of just how important a problem this is, nor is there an indication of how difficult it is to deal with these patients efficiently. Although early discharge is advocated there is no indication of just how this should be achieved in those patients who have no evidence of acute cardiac ischemia.

The first point to appreciate is that the diagnosis of non-cardiac chest pain is not always easy to make and perhaps more importantly it is often a diagnosis that the patient finds difficult to accept. Inexperienced doctors who are not confident to make a diagnosis are more likely to admit patients unnecessarily and should they discharge patients, anxious that they may have a serious cardiac condition there is a high incidence of readmission.

The problem is compounded by the lack of insight into the prevalence of false positive troponins in a variety of conditions, including chest infections, other inflammatory chest conditions, heart failure, pulmonary embolus and compromised renal function. Patient pathways which over emphasise the importance of positive troponins only compound the problem.

The cost to the health service of dealing with non-cardiac chest pain is unknown but it is clearly substantial. It is also unsatisfactory for



the patient because there is often a delay in obtaining a timely and proper opinion and the burden of experiencing symptoms that are not adequately explained can be a considerable for many. In many cases the most expedient course is to performed early angiography, particularly for those who have known coronary disease but are not thought to have an acute problem.

The issue is relevant to both tertiary centres and referring hospitals and is particularly relevant to be busy casualty departments

The difficulty in dealing with this group of patients has been well recognised for many years and was one of the principal considerations when setting up the Mayday model. (see below).

Cardiologists may not be fully aware of the problem because they did not come across the patients who are usually assessed in casualty and then admitted under the admitting Physician rather than a cardiologist.

3 Delays in transferred to tertiary centres.

Over the past 20 years there has been a failure to appreciate the cost to the Health Service of patients waiting for transfer to specialised centres. There has been little incentive for these well financed centres to provide a more efficient service as there is no financial advantage in them doing so. On the other hand, the referring hospitals with the least resources have had to cover the cost of patients waiting for transfer, a wait that has no clinical advantage with an excess cost they are powerless to influence. *Individual DGHs still have to cover the cost of hundreds or even thousands of unnecessary bed-days each year, incurred through patients waiting for cardiology transfer alone.* Some centres have improved their service in recent years, but most centres still operate services that are inefficient and centred around the preferred working practices of medical and nursing staff rather than the needs of the patient. Waiting lists and delays in providing definitive treatment have been entrenched in the NHS from its inception. This review has the opportunity to make a statement of intent that recognises the problem and aspires to emulate the most efficient of Health Services.

Review statement:

□ The average total pathway length for patients needing urgent CABG should not exceed 21 days.

□ The time between admission to the patient's local hospital and referral to a surgical unit should not exceed five days.

□ The time between referral and transfer to the surgical centre should not exceed five days.

□ The average length of stay at the surgical centre should be 11 days or less.

The reviewers acknowledge that the above recommendations are less than optimal.



There can be no good reason for recommending such excessive times and the numbers should be dramatically reduced.

A more appropriate recommendation would be that the total delay for the CABG pathway should not exceed 10 days and the time between referral and transfer should not exceed 2 working days.

3. The Mayday model for the treatment of acute coronary syndromes.

In 2005 Peter Stubbs and I set out to make radical changes to the Mayday cardiac services. The goal was to develop a model for treating cardiac and non-cardiac chest pain which was evidence-based and cost effective in the same way that we had developed the model for the treatment of STEMI patients, now adopted as the standard throughout the UK. The 7 point stated goals of the London review could be used as the stated goals for the Mayday model. To achieve those goals it was determined that we should provide:

1. A service that gives patients access to specialist advice at first contact
2. Access to all essential cardiac investigations on the day of admission
3. Invasive investigation and treatment within 24 hours of admission as appropriate
4. A coronary care unit and adjacent “cardiac zone” where all cardiac patients could be admitted and looked after by a consultant cardiologist, dedicated cardiac medical staff, trained cardiac nurses and technicians.
5. A first rate rehabilitation service in recognition that patients whose hospital stay was brief would need early support, education and risk factor management in order to improve outcome and two to avoid future readmissions.
6. A unit staffed by experienced well motivated doctors nurses and technicians driven by the desire to provide a high standard of care.
7. In principle, it was understood that any additional costs incurred by providing a higher standard of care could be offset by more efficient practices and a reduced hospital stay.

The service has been highly successful, and although it still does not run consistently to the standard that we aspire, it immediately resulted in the closure of a hospital ward and is estimated to save the trust/provider hundreds of thousands of pounds a year.

It would be interesting to calculate the cost savings achieved by adopting this model nationally and it would be difficult to envisage any saving leading to such an improvement in patient care.

In many ways the setting up of this service has involved similar changes to those we had to make when setting up the STEMI Service, in that it has involved similar changes to the working practices of doctors, nurses and technicians as well as the need to overcome the resistance of hospital and the NHS management who are traditionally resistant to any radical change. There is a need to have flexible working conditions that ensure staff are available when patients need treatment; a way of



working which is not enhanced by the current rigid and inflexible system of job planning. This is only achieved by having a common sense of purpose at all staffing levels.

The benefits to patients, the institution and the community of such a system are clear and the model should be considered as something that could be adopted more widely.

Conclusions

- 1 The provision of services for the management of cardiac chest pain cannot be separated from the management of other patients presenting with chest pain.
- 2 The service is most efficiently delivered in busy casualty departments close to the communities they serve. This applies to tertiary centres as well as to DGHs.
- 3 Access to specialist cardiac expertise at the consultant level is desirable 24 hours a day.
- 4 The immediate access to specialist cardiac investigations is essential.
- 5 NSTEMIs that are truly at high risk should be treated at heart attack centres and follow the NSTEMI protocol. These patients can rarely be identified in the ambulance and usually not until the initial treatment has failed.
- 6 The ability to perform early cardiac catheterisation is an essential part of treating acute cardiac ischemia as well as a non-cardiac chest pain.
- 7 Ambulance services should preferentially take patients suffering from chest pain without ST segment elevation to units that have cardiac catheterisation facilities, with consideration given to units that have specialist expertise available at first contact.
- 8 Seamless rehabilitation services that start on the day of admission and continue into the community following discharge.

Vascular surgery and cardiac surgery

I have not addressed the areas of vascular surgery and cardiac surgery and a number of points should be raised. In the interest of keeping this account concise I will only mention one:

The review concentrates on the more traditional important areas of vascular surgery. However it does not properly address the problems of lower limb ischaemia. This is a growing problem, particularly in diabetics and is huge cost burden for the NHS because of the cost of amputation and rehabilitation, and the need for extensive inpatient stays for patients who have chronic ischemia, ulceration and infection. There is a growing need for a model of care for these patients and it will almost certainly need to be centred proximal to the community it serves. There should be a proper cost evaluation of treating these patients as the reimbursement costs did not come anywhere near the true treatment costs.

Kevin Beatt



Appendix 6 – Response from London

Committee Services and Scrutiny
Bexley Civic Offices, Broadway
Bexleyheath, Kent, DA6 7LB
Tel: 020 8303 7777



www.bexley.gov.uk

Borough of Bexley

cardio-vascular@csl.nhs.uk.

Dear Sir or Madam,

London Cardiovascular Services: Proposed Model of Care – Consultation Response

Thank you for the opportunity to comment on proposals for the future model of care for cardiovascular services in London. We welcome any proposals to improve services provided to our residents.

Overall we consider the proposed model, if carefully implemented, has the potential to realise considerable improvements to clinical outcomes and patient care.

The consultation notes the need for cardiovascular treatment to respond to the growing demands of an aging population. Both Bexley and neighbouring Bromley boroughs have aging populations, with the 2001 Census showing that 16% of Bexley residents are aged 65 or over, which is higher than the Greater London average of 12%. When assessing need for cardiovascular services across London and in any subsequent mapping of services, it is therefore imperative the demography of our Borough is appropriately considered so that the needs of our aging residents can be adequately addressed.

We recognise that more specialised services may need to be delivered on fewer sites across London in order to improve patient care and clinical outcomes. We would be keen to learn more about how the proposed treatment networks would operate and how the different levels would interact across London to ensure a seamless patient journey from first contact to the end of treatment. We agree that intervention and care should reflect the clinical need of the individual patient, rather than being based on the services that might be operating at the time when the patient needs treatment.

We welcome the patient perspective that has influenced the consultation document. We feel that this perspective should continue be considered alongside clinical need as the proposals are further developed in order to achieve the best outcomes for patients.

We look forward to receiving further detailed proposals setting out how and where cardiovascular services may be delivered in future so that we can fully consider the impacts on Bexley residents.

Yours faithfully,

Councillor Ross Downing



Chairman of the Health Overview and Scrutiny Committee

Appendix 7 – Response from London Borough of Croydon

Mr M Hindmarsh
Senior Project Officer –
Cardiovascular Surgery
Commissioning Support for London
Stephenson House,
75 Hampstead Road,
London,
NW1 2PL

Appendix b
Chief Executive's Department
Democratic & Legal Services
5th floor Taberner House
Park Lane
Croydon CR9 3JS
Tel/typetalk: 020 8604 1234
Minicom: 020 8760 5797
Contact: June Haynes
June.haynes@croydon.gov.uk

29 October 2010

Dear Mark

Cardiovascular Surgery – Response to the Consultation

Thank you for your comprehensive & persuasive presentation on 11th October to members of Croydon's Health Scrutiny Committee of the proposed model for London cardiovascular services - also for pointing us towards the additional information on your web-site, which we have since reviewed. We are pleased to note that the proposals are supported by both clinicians & patients.

We fully support this proposed model of care, in terms of the anticipated improved outcomes it promises to achieve, bringing us into line with international good practice, as well as in terms of cost effectiveness.

Yours sincerely

Councillor Graham Bass
**Chairman - Health, Social Care and Housing
Scrutiny Sub Committee**



Appendix 8 – Response from London Borough of Havering



Health For North East London
Aneurin Bevan House
81 Commercial Road
London
E1 1RD

Andrew Ireland
Group Director
Social Care and Learning

London Borough of Havering
Town Hall
Main Road
Romford
RM1 3BD

Telephone: 01708 432488
Fax: 01708 434033

Andrew.Ireland@haverling.gov.uk

Date: 8TH October 2010

To Whom It May Concern

New models of care proposed by Commissioning Support for London Response

I write in response to your letter dated the 27th August with regards to the proposed new models of cardiovascular and cancer care.

The London Borough of Havering welcomes any developments in the way care is delivered and received that will improve outcomes for patients and their families.

It is essential that outcomes for patients are the catalyst for any proposed models of care. The new model for cancer services must focus primarily on early diagnosis which will in turn impact on life expectancy, improved health and outcomes for patients and their families. Prevention and education are essential in significant improving cardiovascular services and their delivery whilst streamlining the existing cardiac services to improve patient pathways.

Havering welcomes the sharing of information and best practise between existing sites and organisations to improve the outcomes of patients. The consultation process requires a cross organisational approach to implement the configuration of services so as even distribution of services can be achieved, for example, the distance a patient needs to travel to receive care is not disproportionate to any other ensuring equality. With the proposed centralisation of complex vascular surgery and certain specialist cancer treatments the patients ability to travel will need to be addressed.


The Queens Hospital, Romford which is in the London Borough of Havering is one of the proposed sites for the new model of care for vascular surgery. There are a few social care elements that need clarification if this proposal is to work in an effective and timely manner :

- It is essential that there is a robust discharge protocol in place which is agreed and adhered to by all Local Authorities and PCT'



Once again the London Borough of Havering welcome any changes to the current care system that will improve the health and wellbeing of patients and their families. With partnership working and transparency the proposed models of care will be a move in the right direction for those in need of specialist vascular or cancer care.

Yours sincerely

A handwritten signature in black ink, appearing to read 'A.P. Ireland', with a large, stylized flourish at the end.

Andrew Ireland



Appendix 9 – Response from London Borough of Merton

Thomas Pharaoh and Mark Hindmarsh
Commissioning Support for London
Stephenson House,
75 Hampstead Road,
London,
NW1 2PL



CC: Rt Hon Andrew Lansley CBE, MP

Scrutiny Team
London Borough of Merton
Merton Civic Centre
London Road
Morden SM4 5DX

Dear Tom and Mark

I write of behalf of the Healthier Communities and Older People to thank you very much for visiting on the 1st November 2010 ; succinct presentation.

There are one or two points I would like to feed back to you. I note at this stage the NHS has only provided funding for the proposed model of care for London cardiovascular and cancer services.

It is extremely disappointing that no provision has been made to produce models of care for preventative work e.g. cancer screening and programmes to provide healthy living for the residents of London.

It seems these models of care are rather “after the horse has bolted” and it would be much better to educate the residents e.g. talking bus stops and advertisements in buses and tubes and to inform residents as to the benefits of participating in screening projects. Not only would there be benefits to the residents e.g. lower death rate but a distinct benefit to the London taxpayer.

The panel also felt that money ought to be invested in the existing Information Technology systems to ensure that they are compatible amongst all users across the NHS.

I do hope that these suggestions can be taken on board

Finally, we would welcome sight of your report once you have completed your round of all participating boroughs

Yours sincerely

A handwritten signature in black ink that reads "Gilli Lewis Lavender".

Councillor Gilli Lewis Lavender

Chair, Healthier Communities and Older People Overview And Scrutiny Panel.



Appendix 10 – Response from Londonwide Local Medical Council

Professor Nick Cheshire
Stephenson House
75 Hampstead Road
London
NW1 2PL



1 October 2010

Dear Professor Cheshire

London Cardiovascular services: proposed model of care

Our team of Medical Directors here at Londonwide LMCs found it very helpful to meet Professor Toy and you to discuss London Cardiovascular services: proposed model of care. We can entirely understand the case for concentrating specialist services in a fewer number of hospitals. We note that no specific proposal has been made to identify the hospitals concerned. We can also confirm that when our individual Local Medical Committees, across London discussed the original Healthcare for London proposals, there was strong support for the concept for concentrating specialist services in fewer hospitals.

We have an initial meeting of the London GP Commissioning Council next week. This will bring together GPs from across London and we shall report on your very interesting work to our colleagues, after which I will feed in any additional comments.

Yours sincerely

Dr Tony Stanton

Joint Chief Executive

Londonwide LMCs is the brand name of Londonwide Local Medical Committees Limited Registered and office address: Tavistock House North, Tavistock Square, London WC1H 9HX. T. 020 7387 2034/7418 F. 020 7383 7442 E. info@lmc.org.uk www.lmc.org.uk Registered in England No. 6391298. Londonwide Local Medical Committees Limited is registered as a Company Limited by Guarantee **Joint Chief Executives:** Dr Michelle Drage and Dr Tony Stanton



Appendix 11 – Letter from The North West London Hospitals NHS Trust

The North West London Hospitals 
NHS Trust

Trust Headquarters
Northwick Park Hospital
Watford Road
Harrow
Middlesex
HA1 3UJ

15 April 2010

Via Email

Caroline Taylor
SRO
Cardiovascular Services Project

Professor Matt Thompson
Clinical Lead
Cardiovascular Services Project

Dear Caroline and Prof Thompson

HfL Case for change for cardiovascular services

Thank you for sending me a copy of HfL's case for change which I have been reviewing with clinical colleagues. I appreciate that the case is not strictly out to consultation but I wanted to raise some important points that I hope will be considered as part of the development of the subsequent model of care.

Vascular services

While I appreciate the clinical arguments for providing surgical care in a high volume hospital by a specialist team we have some concerns how major acute hospitals (MAHs) will be able to support high levels of acute demand with potentially no on site vascular support. The case for change rightly emphasises the need for clear pathways for i) patients from hyper acute stroke units (HASUs) requiring carotid endarterectomy surgery and ii) trauma patients requiring specialist emergency vascular services. It makes no specific reference, however, on the expectation that MAHs will provide a comprehensive emergency surgery service to catchments of potentially 1m people. We think that the case for change needs to make reference to the specific role of major acute hospitals and their inevitably close relationship with the arterial surgery centres. Similarly we think it is important that any subsequent model of care clearly explains how services could be configured to ensure that the

large number of patients presenting at MAHs with vascular needs receive optimal care.

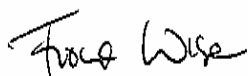
Cardiology

The need for greater clarity about the role of MAHs applies also to the cardiology case for change. MAHs could foreseeably be supporting 35,000 emergency medical admissions pa and will be required to run busy cardiac services. We fully endorse the key message that patients suffering from an NSTEMI event should have an angiogram within 24 hours and anticipate that all MAHs will need to be able to deliver this level of service. We also anticipate that elective PCI should be undertaken at MAHs able to support a minimum 400 elective procedures PA.

We believe that as long as units can meet this critical mass, then patients can benefit from a local interventional service. We would not like to see a return to the past when patients often waited weeks in hospital for PCI at the tertiary centres.

We hope that by clarifying the role of the major acute hospital in the delivery of high quality cardio-vascular services will address the concerns raised.

Yours sincerely



Fiona Wise
Chief Executive
North West London Hospitals NHS Trust



Appendix 12 – Project response to the letter from The North West London Hospitals NHS Trust



Commissioning Support for London

Healthcare for London cardiovascular project
Commissioning Support for London
18th Floor
Portland House
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London
SW1E 5RS

Wednesday 5th May 2010

Fiona Wise
Chief Executive
North West London Hospitals NHS Trust
Northwick Park Hospital
Watford Road
Harrow
HA1 3UJ

Dear Fiona

HfL Case for change for cardiovascular services

Many thanks for your letter dated the 15th April 2010 responding to the cardiovascular case for change document. It is worth clarifying the project scope and remit of the cardiovascular review first before going on to address the detail of the issues you raised around vascular surgery and management of non-ST elevation acute coronary syndrome (NSTEMI) patients.

The review focused on improving outcomes for patients undergoing cardiovascular surgery and interventional procedures. The purpose of the review was not to attempt to define the services that should go into a major acute hospital (MAH) site. To that extent, the review has made a series of recommendations that relate to how a quality service should look, what the essential clinically dependent cardiovascular services are and what standards an excellent cardiovascular service should be meeting. It does not address the issue of where these services should be provided.

It is our intention that the documentation will help inform discussions between providers and commissioners in each of the sectors so that all patients have access to an excellent cardiovascular service. As you point out however, there are obvious implications for MAH sites which will need to be worked through within each of the sectors.

In relation to the point you made around the provision of vascular surgery at MAH sites, your concern is that with the centralisation of vascular



surgery onto fewer sites, there will not be enough vascular surgery provision to support emergency surgery at all of the MAH sites. When the model of care is published following the election, it will recommend that there should be a maximum of five sites in London that provide arterial vascular surgery. The project clinical groups felt that this number of sites would be the most likely to deliver the improvements in patient outcomes we want to see. Sectors and providers will need to come together locally, supported by CSL, to work through how this can be achieved and what this means for individual units.

The project team at CSL will continue to work with sectors to ensure that the Healthcare for London pathways and sector strategies can be aligned and are delivered.

In relation to services for high risk non NSTEMI patients, we have again not described the type of hospital that this should take place in. However we will clearly outline the markers that will deliver patients an excellent service. It is likely that in order to deliver the changes in service described, that hospitals will need to work together, and that access to some advanced and complex services will form a key part of that.

We trust this information is useful and look forward to working with you and sector colleagues as we progress with the implementation of the review.

Yours sincerely



Caroline Taylor
Senior responsible officer, Healthcare for London cardiovascular project & chief executive, NHS Croydon



Prof Matt Thompson
Clinical director, Healthcare for London cardiovascular project & consultant vascular surgeon, St Georges Healthcare NHS Trust



Appendix 13 – Comments on mitral valve surgery from University College London Hospital NHS Foundation Trust

Our belief is that mitral valve repair surgery for degenerative valve disease should be in the armamentarium of 2-3 specific surgeons in each surgical group whose performance should be monitored. However exclusive designation of this technique in all circumstances is to the overall detriment of general cardiac surgery delivery and the designation should not be exclusive.

