President's update 13/08/2020

We are just over 4 months into the CV19 crisis. The general lockdown has been lifted across Great Britain and Ireland; however more recently local lockdowns have been re-imposed in certain areas where there is a rising prevalence of the virus. With the first wave having passed, vascular units are attempting to restart elective surgery both expeditiously and safely. However, the restarting of all surgery has proven to be at least as challenging as the shutdown.

CV19 Timeline for Vascular Surgery

March: At the beginning of lockdown, the VS Executive agreed guidelines on the way in which we thought it was most reasonable to reduce the immediate demand for vascular surgery, taking into account the need provide care for the large number of CV19 patients.

April/May: By late April-early May, the VS put forward suggestions on how to begin start to re-open vascular surgery.

June: In late June, GIRFT, the vascular clinical reference group, the VS, BSIR the SVN, the SVT and the VASGBI collaborated on the final GIRFT/VS 'Guidance on resumption of vascular surgery'.

July/August: By mid-July, the CV19 situation had continued to evolve, and the VS Executive felt it was time to review the CV19 advice. We also thought it was important that any change in the advice should be informed by up to date information.

A simple electronic survey of the VS membership was run between the 2-6th August to assess the current provision of vascular services. Although the questionnaire was deliberately short, it has provided key information regarding the available vascular facilities and working patterns. The results of the survey will be uploaded to the private members area of the VS website in the next few days.

Overview of the August VS Survey

There is huge regional variation in the way in which vascular surgical resources have been restored. The snapshot is time sensitive, and the situation continues to develop, and consequently will requiring updating.

Geographical location of the responders: There were over 85 responses from England, 2 from Wales, 5 form Scotland and 1 from Eire.

Theatre capacity: Only 20% of units have restored their operating capacity to normal, and 30% of units have a theatre capacity that is currently less than 50% of normal or are running on NCPOD lists only.

AAA size: 75% of units are operating on aneurysms over 5.5cm, suggesting that with a marked reduction in CV19 prevalence there is a move towards using the same indicators for operative intervention for AAA as existed pre-CV19.

Green pathways and carotid surgery: Nearly 90% of units have a "green pathway' for elective surgery, and all units are offering carotid surgery for patients with symptomatic carotid disease.

Endovascular surgery during CV19: 70% of units said that they continue to offer open AAA surgery to their younger and fitter AAA patients. There was a 50/50 split on whether or not more endovascular surgery was being offered to patients with lower limb disease.

Resources for vascular surgery: To a direct question '*do you feel that the same resources have been given to the resumption of vascular surgery as has been given to other services e.g. cancer or cardiac?*'- the response suggested that 70% of the membership felt that the resource allocation appeared to favour certain patient groups over others.

Cancer services are mainly operating through 'green pathways' and frequently within the private sector. This possibly reflects that many cancer operation have a somewhat lower level of complexity and/or interdependence on other specialities such as ITU, interventional radiology and facilities such as hybrid theatres. As a result, it would appear many cancer services have been able to work in a more normal fashion for some while.

Delay to the restoration of team based integrated vascular services: The free text section of the questionnaire gave some illuminating comments. It was highlighted that although there had been restoration of theatre lists, the breakup of the vascular teams for the CV19 crisis had not been reversed in many units. Multi-disciplinary working is vital to delivering sustained complex vascular care.

Examples include

a) Vascular 'green pathways' where there was no dedicated vascular nursing staff.

b) Vascular lists that have no vascular anaesthetists or limited vascular scrub teams.

c) Pre-op assessment is compromised (for instance no CPEX).

d) Virtual clinics had not always been in the best interest of complex vascular patients.

e) Arterial surgery is predominately performed within an urgent and/or complex setting, and many urgent vascular patients are not suitable for a ‘green pathway’.

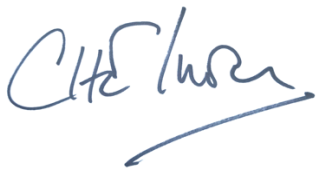
f) There is marked reduction in turnover of patients in theatre because of the need to use risks associated with CV19.

g) With the reopening of the NAAASP surveillance and screening programs, it can be predicated to add to the number of patients requiring complex interventions. This will accentuate the issue that the 8 week target to surgery has been breached by almost all units since the start of the CV lockdown.

The survey data has given important indicators as to how the restart of vascular surgery is going and also where the bottlenecks and challenges lie. Aspects of the anonymised data is being used to inform discussions around service provision.

I really appreciate the membership’s support of the survey and I hope this will continue as I feel this is the best way of highlighting the evolving needs and the challenges that our patients, vascular surgeons and multi-disciplinary teams face.

Finally, I hope everyone is getting the opportunity to take a break after the most difficult few months that any of us are likely to have faced. My own plans are some family time in the Welsh hills, and then maybe a foray north of the border to hunt down a Munro or two.



Chris Imray

President of the VSGBI