Health and Social Services Group
Welsh Government

SPECIAL MEASURES INTERVENTION
Betsi Cadwaladr University Health Board

Llywodraeth Cymru
Welsh Government

VASCULAR QUALITY REVIEW PANEL REPORT
Betsi Cadwaladr University Health Board assurance work

Submitted: 26 March 2024

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Note on Appendices: *Throughout the report, references are made to a set of appendices. These include confidential patient information and have been removed in full.*

1.0 EXECUTIVE SUMMARY

1.1 A 'hub and spoke model' for the delivery of vascular services via a network across North Wales by Betsi Cadwaladr University Health Board (BCUHB) was implemented on 10 April 2019. Following the commencement of the new delivery model, concerns have been raised about its effectiveness and several reviews have been commissioned to gain assurance that the service is delivering in line with clinical standards. There have been several incidents relating to the service and matters of concern raised by HM Coroner including the investigation of incidents, development of actions plans and delays implementing learning and actions.

1.2 BCUHB has developed a Vascular Improvement Plan (VIP) which has been expanded to take account of recommendations from both the various reports and other affiliated work.

1.3 On 27 February 2023, the Minister for Health and Social Services announced that she was escalating the Health Board to Special Measures with immediate effect. Various components of improvement and assurance work are taking place via the Special Measures programme in line with the agreed special measures framework for year one. This work in relation to BCUHB vascular services has been commissioned as a supportive piece of work undertaken in collaboration with the Health Board, the NHS Executive and Welsh Government to undertake an assurance assessment of quality of vascular services and other related services that are involved in the pathways of care.

1.4 This review provides an assessment of 40 case notes aligned to a number of different vascular procedures undertaken during the time period of ***1 August 2022 to 31 July 2023*.**

1.4.1 In reporting their findings in relation to this timeline, the Panel aims to support wider assessment of the extent to which recommendations from various previous reviews and reports have been implemented and are operationally in place. This is in addition to providing information which can be used by the Health Board as part of their ongoing improvement work.

1.5 The report which accompanies this executive summary sets out the scope of the work, and the randomised sampling methodology. It is also underpinned by several appendices which provide detail in relation to the assessment outcomes. *Appendix two*, sets out Panel discussion on each individual episode of care which led to a final grading of 'overall' care being agreed. *Appendix three* provides incredibly valuable feedback as told to members of the Patient Experience Team by patients and their families in response to the letter sent to them in *Appendix one*.

1.6 Assessment has been made on the information available at the time of the review being undertaken and therefore conclusions are drawn with the appropriate caution and caveats aligned to this. It is also likely that further information could exist within the Health Board which may provide additional information, if this is the case, they were not made available to the Panel at the time of the review being undertaken.

1.7 The findings of the Panel are that 38 out of 40 of a number of different vascular procedures undertaken during the time period of ***1 August 2022 to 31 July 2023***. have been graded as overall *acceptable*. Taking into account, the timeline of this assessment work, it is considered by the Panel that this demonstrates an ongoing positive trajectory of improvement within BCUHB vascular practice.

1.8 It is important to recognise that this progress forward is underpinned by many examples of good work happening across the Health Board. Several patients and their families highlighted that they were pleased and most appreciative of the care that they had received, and *Appendix three* sets out many examples where patients and their families identify good practice, compassionate care and express thanks to staff across all sites and different specialties. It is also clear from local vascular team representation on the Panel, that there is a strong desire to deliver optimal care to patients and their families.

1.9 However, at the same time, as identified within Panel discussion, and some of the patient and family feedback, there are also several areas where it is considered that improvements could be further addressed or strengthened. It should be recognised that these areas are not solely associated with the direct practice of the vascular service and include other related services and practice involved in the delivery of multi-professional pathways of care. Some of these areas have also been identified within previous reviews and this is reflected in the Panel's recommendations (*Table five*) and summarised below.

Please note findings, areas identified and associated recommendations are aligned to the timelines of assessment and are not in any specific order of priority.

Recommendations:

<u>Pathways of care:</u>

1. Agree what constitutes a contemporary and evidence based diabetic foot pathway, with the same approach and pathway implemented immediately across all the BCUHB sites.
2. Identify opportunities to work across the Health Board as an integrated service model strengthening links between primary and secondary care within areas such as the management of diabetes; and implement to avoid patients having to see 'duplicate' health professionals or experience delay.
3. Confirm what constitutes the palliative care pathway, and disseminate what that structure consists of, including over weekends and public holidays.
4. Ensure robust links between the palliative care team and the vascular service.
5. Formally set up a vascular pain management pathway, particularly in the management of neuropathic pain.
6. Evaluate the stroke referral pathway and implement subsequent findings across all the relevant multi-professional teams.

Multi-Professional workings and support:

1. Agree psychology input as a standard component of vascular care with dedicated, protected, sessions of psychological support available for those vascular patients who require it.
2. Provide dedicated, protected, sessions of micro-biological support for the relevant vascular patients who require it.
3. Ensure availability of a Care Of The Elderly (COTE) consultant and their clinical team for daily input as required for vascular patients.

Fundamentals of care:

1. Ensure a focus on mitigation of the risk that vascular patients, and in particular amputees, may specifically face regarding falls, with an updated plan of management.

Infrastructure enabling the delivery of care:

1. Review what constitutes good and safe discharge planning in relation to the BCUHB guidance being provided regarding 'out of hours' discharge timing and associated risk assessment. This should be part of a general review of the Discharge Policy which the Panel understands was due for review in 2018 but could not identify evidence of it being updated.
2. Review the Did Not Attend (DNA) policy and guidance on when DNA might potentially become a safeguarding issue to ensure that all staff are aware of this and the actions to take.
3. Consent training should be mandatory, for junior doctors as part of their induction into BCUHB and ongoing training
4. If the healthcare professional is not fluent in the patient's preferred language, an interpreter should be used for seeking consent from the patient.
5. Letters to patients should be more individualised in relation to certain conditions.
6. Consider whether the practice of completing Individual Patient Funding Requests (IPFRs) for Direct Oral Anticoagulants (DOACs) when they are widely available, remains reasonable and whether this should be continued.
7. All staff should be reminded and supported in their professional accountability to maintain high standards of records and record keeping.

1.10 It is recognised that this report does not capture the totality of the vascular service, but nonetheless important components of the wider vascular services work are identified which continue to be undertaken across the Health Board. It is hoped that the findings and associated recommendations of this review help to demonstrate where improvements have been made and put additional focus on areas where work is still required. This aims to assist in ensuring that the vascular service is on a robust foundation of monitoring, assurance and maintaining an ongoing positive trajectory of continuous improvement.

2.0 BACKGROUND AND CONTEXT TO VASCULAR QUALITY REVIEW PANEL ASSURANCE WORK

2.1 A 'hub and spoke model' for the delivery of vascular services via a network across North Wales by Betsi Cadwaladr University Health Board (BCUHB) was implemented on 10 April 2019. The three BCUHB acute hospitals; Ysbyty Wrexham Maelor, Ysbyty Glan Clwyd and Ysbyty Gwynedd continue to have a consultant surgeon available to provide the following clinical services: vascular clinics, diagnostics, interventions including renal access, varicose vein procedures, review of in-patient vascular referrals, and rehabilitation. Day-case peripheral angioplasty and simple stenting also continues at all sites. Ysbyty Glan Clwyd is the arterial centre for the BCUHB vascular network to provide all emergency and elective arterial surgery and complex endovascular interventions.

2.2 Following the commencement of the new delivery model, several reviews have taken place over the years. These include (*Table one*):

Review undertaken	Took place	Report issued	Findings
Invited Service Review (IRS) relating to vascular surgery by the Royal College of Surgeons England[1]	Held remotely using video conferencing facilities on 11-13 January 2021.	15 March 2021	First part of IRS; second part as below.
It was originally intended that a clinical record review of 50 cases would be incorporated within the January 2021 IRS; however, it was apparently not possible for the 50 sets of clinical records to be provided in advance of the IRS.	A successive, standalone clinical record review took place with a site visit on 19 July 2021[2].	20 January 2022	A number of findings raised questions in relation to the quality and consistency of care provided.
Independently chaired BCUHB Vascular Quality Review Panel convened following January 2022 RCSE report to review the findings and determine if the patient records contained the information, they would expect for the patient episodes of care. Additionally, a recommendation stated that there should be scrutiny of whether the necessary and appropriate follow up and aftercare plans were in place for a number of patients.	BCUHB decided that this scrutiny would be expanded to all of the clinical records associated with the RCSE July 2021 review and the Panel convened regularly until the relevant 47 records were examined in detail.	25 January 2023	Sets out a number of recommendations in relation to improvements in areas such as clinical pathways, clinical governance, person-centred care, multi-disciplinary team working, complex pain management, palliative care, and discharge[3]. The findings from the Panel also led to new information being identified for some

[1] Royal College of Surgeons England (RCSE) Report on the Vascular Surgery Service Betsi Cadwaladr University Health Board Review visit carried out on: 11- 13 January 2021 and Report issued 15 March 2021
[2] Royal College of Surgeons England (RCSE) Report on 44 clinical records relating to vascular surgery on behalf of Betsi Cadwaladr University Health Board Review visit carried out on 19 July 2021, report issued 20 January 2022
[3] Betsi Cadwaladr University Health Board Vascular Quality Review Panel Report Submitted: 25 January 2023

			patients, with four patients being referred by BCUHB to His Majesty's Coroner.
BCUHB vascular services had been in Targeted Intervention since May 2022, with Healthcare Inspectorate Wales (HIW) designating vascular services as a Service Requiring Significant Progress (SRSI) in March 2022.	HIW undertook an inspection of the service in November 2022[4].	29 June 2023	States that in recognition of the overall progress made against the RCSE recommendations, they had de-escalated the vascular service from the SRSI designation. They also stated that whilst they had seen improvements across the vascular services, they had made eleven recommendations to further strengthen the arrangements in place and that BCUHB must ensure measures are in place to assure itself that the improvements and processes implemented since the RCSE review, are sustainable now and in the future.
A Vascular Services Assurance Assessment was led by the Vascular Network and wider colleagues within NHS Wales Executive of vascular services and other related services that are involved in the pathways of care; and to assess the extent to which recommendations from various reviews have been implemented.	• Part one relating to quality assurance assessment of the vascular improvement plan commenced end of May 2023. • Initial observations were fed back at the end of June 2023. • Assurance assessment relates to the clinical governance mechanism and forms the basis in October 2023 report.	17 October 2023	Concluded that the BCUHB vascular service continued to improve. The report summary stating that the BCUHB vascular service shares many of the issues which affect the other networks across the UK, in that it is constrained by capacity issues, but has a clear aspiration to continue to improve and be allocated senior vascular trainees going forward. The report advised that the vascular

[4] https://www.hiw.org.uk/vascular-services-de-escalated-SRSI

			transformation team have been pivotal in bringing about the positive change in the BCUHB vascular service, but it is important the operational, nursing and therapy teams are more involved, which it was considered will help promote a cultural change across the entirety of the service and embed the changes made to date.

2.3 Since the re-organisation of BCUHB vascular services in April 2019 there have been a number of incidents relating to the service and matters of concern raised by HM Coroner including the investigation of incidents, development of actions plans and delays implementing learning and actions. This has led to a number of Regulation 28 and Prevention of Future Death reports.

2.4 On 27 February 2023, the Minister for Health and Social Services announced that she was escalating the Health Board to Special Measures with immediate effect. Various components of improvement and assurance work are taking place via the Special Measures programme. This BCUHB vascular services assurance assessment has been commissioned as a supportive piece of work undertaken in collaboration with the Health Board and Welsh Government to undertake an assessment of quality of vascular services and other related services that are involved in the pathways of care, to help assess the extent to which recommendations from various previous reviews and reports have been implemented and are operationally in place.

3.0 COMPOSITION OF PANEL

3.1 Panel meetings were held:

- 5 and 6 December 2023;
- 23 and 24 January 2024;
- 6 February 2024;
- 19 March 2024.

3.2 It is considered that the Panel membership (*Appendix five)* provides a range of expert professional vascular surgical experience and knowledge, alongside Panel members who would also expect to be able to understand and to comment on whether the components of care reach a reasonable generic standard, in relation to

their own specific knowledge base and area of practice, and/or other relevant background experience.

3.3 Consideration was given to ensure that a mix of local and independent membership was provided. Following one of the local vascular surgical experts being subsequently unavailable for the January and February 2024 meetings, and to avoid placing additional pressure on the local vascular surgical service, a second independent external vascular surgical expert joined the Panel. An additional local vascular surgical expert kindly volunteered to join the Panel for the small number of the cases (**N=3**) of which a potential conflict of interest had been identified in the January reviews, and of which the local vascular expert was recused from assessing. *Appendix five* lists which meetings were attended by the relevant Panel members.

3.4 The Panel was co-chaired by two Independent Advisors who were already supporting components of the Welsh Government's BCUHB Special Measures programme. One of the co-chairs had also previously independently chaired the Vascular Quality Review Panel convened following the January 2022 RCSE report as referenced in paragraph 2.2.

4.0 WAYS OF WORKING

4.1 This review provides an assessment of case notes (**N=40**) for a number of agreed different vascular procedures undertaken during the time period of **1 August 2022 to 31 July 2023** taking account of issues from the information available, such as, but not limited to:

- Complexity and pathway stage
- Clinical management, decision making and outcome of vascular practice
- Mortality and morbidity
- Potential sampling gaps in the previous review(s)
- Consideration of performance against UK National standards and National Vascular Registry (NVR) data

4.2 Several of the clinical records in the review are large and complex, as expected with the nature of the care delivered, and the additional co-morbidities often presented by the patients. A secure Portal was set up on the BCUHB SharePoint to hold the work of the Panel and provide electronic copies of the relevant episodes of care to be assessed. Confidential documents could only be accessed via password with access permissions in place.

4.3 The Panel did not have a responsibility to determine potential breaching of professional regulatory standards or performance issues. If any information was to arise which led to such concern, it had been agreed that this would be escalated via the independent Panel Co-Chairs to the BCUHB Executive Medical Director as the Senior Responsible Officer (SRO) for this work and would be separate to any Panel work or reporting. This was subsequently not found to be necessary during the work of the Panel.

4.4 All cases were of equal importance and treated as such. However, an order in which to undertake the assessment was required. Therefore, the scheduled cases were examined first, followed by the unscheduled cases.

4.4.1 There was also Panel agreement that there was a built-in flexibility should it be required, if any potential themes or risks should be identified, and/or a case required to be 'moved up' the order and re-classified within the agreed order of numbering. This methodology helped provide a more systematic approach to the order of reviewing the clinical records. Two cases identified as significantly complex following initial individual assessments were elevated to be assessed by the Panel as a priority on the days of assessment.

4.5 It must also be noted that assessment could only be made on the information available, and commentary and therefore that conclusions are drawn with the appropriate caution and caveats aligned to this. It is also likely that further information could exist within the Health Board which could provide additional information, although this was not easily found.

4.6 The scope of the work agreed:

4.6.1 *Scheduled care*
The Panel reviewed the last episode of care (relevant to the defined procedure*) within the specified time period (1 August 2022 to 31 July 2023) from admission to the ward up to the point the patient is discharged from the ward (post procedure).

4.6.2 *Unscheduled care*
The Panel reviewed the last episode of care (relevant to the defined procedure) within the specified time period (1 August 2022 to 31 July 2023) from the point at which the patient's care had been accepted by the multi-professional Vascular Team up to the point the patient is medically fit for discharge from the ward.

4.7 The agreed sampling methodology was that BCUHB confidentially and anonymously identified patients who had undergone the defined procedures (*Table two*) within the identified time frame as recommended by an independent vascular surgical expert and agreed by the Health Board's IHC Medical Director for the Central Area. These lists in chronological order, were made available to the Health Board's IHC Medical Director (Central) who randomised as per the procedures and timelines to be examined.

4.7.1 Randomisation was undertaken on a simple numerical basis and is set out within the Terms of Reference (*Appendix four*). The Vascular Panel considered all procedures performed during the one episode of care and assessed the quality of care during that period. *Table two*:

Scheduled **admission vascular case notes' sampling 'type' ***

Five elective Abdominal Aortic Aneurysm (open and EVAR)
Fifteen renal access patients, consisting of: • 5 below elbow (i.e. radio-cephalic fistulae) • 5 above elbow (i.e. brachio-ceplalic fistulae) • 5 complex (leg or PTFE), or peritoneal catheter insertion
Sub-Total: *Twenty*
***Unscheduled* admission vascular case notes' sampling 'type' ***
Five Carotid endarterectomy
Fifteen patients, consisting of: • 5 Ischaemic limbs (acute/critical) • 5 Urgent/emergent Abdominal Aortic Aneurysm (AAA) • 5 Surgical management of diabetic foot complications (such as sepsis)
Sub-Total: *Twenty*
Total: ***Forty***

4.8 At the Panel meetings, a summary presentation was given from a member of the internal BCUHB Vascular Quality Team. This was followed by the individual feedback of all Panel members, having prepared their own findings prior to the meeting; and then collective discussion. That collective discussion from Panel members, underpinned the consideration and then agreement of whether identified episode(s) of care are overall deemed:

1	*Acceptable*
2	*Cause for concern*
3	*Unacceptable*

4.8.1 These classifications are as suggested by the RCSE[5] within their structured template as assisting clinical reviewers when reviewing a patient's clinical records. The RCSE template proposes consideration of areas such as:

- Good Clinical Care – Assessment;
- Good Clinical Care – Investigations;
- Good Clinical Care – Treatment;
- Patients;
- Colleagues;
- Good Clinical Care – Other

4.9 From the information available, the Panel's process of review included considering the relevant evidence base, standards, and ways of working, at that specific time of practice.

4.10 Any information in relation to clinical records was as far as possible anonymised. Patient confidentiality was maintained to the maximum extent possible, and labelling of patient episodes using a system of anonymised numbering was instigated. Panel

[5] RCS Clinical record review template.pdf

members declared any possible conflicts of interest at the start of every meeting and were recused from being involved or present in relation to any associated assessment and decision-making of those cases.

5.0 THE VOICE OF THE PATIENT

5.1 The Panel considered that the ability to hear the patient's voice was a vital component of assessment, as well as helping the Panel members to consider if individual respect and dignity had been central to the delivery of the identified episodes of care. An offer was made to patients, and/or their family members from the Health Board to provide feedback if they wished to do so (*Appendix one*) which was then subsequently provided to the Panel via members of the BCUHB Patient Experience Team and by means of the relevant information governance process.

5.2 Only six of the vascular cases which were assessed by the Panel did not have views provided from patients and/or their families. This led to a significant amount of information being passed on to the Panel to enable them to hear the voice of the patient and understand what matters to them.

5.3 This feedback was found to be wide-ranging, with a number of patients pleased with their care, appreciative of staff, and feeling that they were listened to and involved in decision-making. However, a number of patients also expressed concerns and frustrations, often associated with system issues and broader communications.

5.4 Feedback is set out as told to members of the Patient Experience Team by these patients and families within *Appendix three*. The information provided is incredibly helpful in describing what matters to patients and their families, and what they consider is good compassionate practice; and importantly, what can still be improved. The Panel recommends that this information helps inform the Health Board's ongoing improvement work.

6.0 INDIVIDUAL ASSESSMENTS OF 41 CLINICAL RECORDS

6.1 Individual assessments as per the methodology set out within paragraph four were undertaken over the course of six individual Panel meetings. *Appendix two* sets out individual findings as per the consensus of the Panel and in relation to the information available. Please note confidential and potentially patient identifiable information is included within this appendix.

6.1.1 Each assessed episode of care within *Appendix two* includes a summary of the general points made by the Panel, and the more detailed points of discussion that arose. A final grade accompanies each case in relation to the overall outcome of the case review. *Table three* sets out the final results of overall assessment of episodes of care for patients receiving vascular care **N=40:**

***Overall* outcome of each episode of vascular care**	
Acceptable	Thirty-eight

Cause for concern	Two
Unacceptable	Nil

6.1.2 One further patient received care from the surgical team which was assessed as *acceptable* (see para 6.4) meaning that **N=40+1 [41]** in total.

6.2 As noted previously within this report, commentary and conclusions are drawn from the information available with the appropriate caution and caveats aligned to this. It is also likely that further information could exist within the Health Board which could provide additional information, although this was not easily found.

6.3 It should be noted that following randomisation, one patient occurred twice as a consequence of the randomisation process and was therefore assessed separately as *Case 06* and *Case 13* for different episodes of care.

6.4 Following randomisation, and the patient being sent a letter from the Health Board informing the patient of this review, it was subsequently identified that *Case 17* was not under the care of the BCUHB Vascular Service, but the BCUHB General Surgery Service. However, it was agreed by those who had commissioned this work, and the Panel, that to avoid any potential upset to the patient, that this case would proceed to be undertaken as aligned to the Terms of Reference and limited to assessment of the associated pathway, but to clearly highlight that this patient is a general surgical patient and the summary of assessment sits separately within this report. This case was graded *acceptable* in relation to the overall outcome.

6.5 Following randomisation, there was some minor confusion with the episode of care to be assessed for *Case 18* and subsequently two episodes of care had been assessed in Panel members' preparation. It was therefore decided that both episodes would be assessed and reported. It was also agreed that this would supplement the fact that Case 17 was subsequently identified as not being a vascular service case and ensure that **40 vascular service cases would still be reviewed.** It was therefore agreed that the Panel would review the 15 May 2023 episode of care and identify it as *Case 18 [a],* and then the 3 July 2023 episode of care and identify it as *Case 18 [b].*

7.0 GOVERNANCE, REPORTING and ESCALATION

7.1 This report has been submitted to the Welsh Government's Head of Performance, Escalation and Intervention; and to the Chief Executive Officer of Betsi Cadwaladr University Health Board, as the joint commissioners of this work.

7.2 As set out within the Terms of Reference (*Appendix four*) it was agreed should the Panel identify any immediate serious concerns in relation to vascular (or broader) safety and governance issues or concerns, those would be escalated as they emerged, to the Board of BCUHB (via the Executive Medical Director) and the Welsh Government's Head of Performance, Escalation and Intervention.

7.3 Three escalations were deemed as necessary (*Table four*):

Case No.	Panel concerns	Outcome of Panel's considerations
Case 13	On commencing assessment of this episode of care, the Panel queried a clinical point which it was considered could potentially inform a procedure which it understood was due to be undertaken for the patient that same morning. It was agreed that although separate to the episode of care which was being assessed as per the Terms of Reference, as a duty of care to the patient this point should be escalated to the BCUHB SRO.	The relevant discussions with the lead clinician for this patient were undertaken and the Panel was subsequently updated of the outcome. Further information is set out within *Appendix two* in this case summary. The overall assessment of the care was acceptable.
Case 30	The Panel considered that further information was required to understand the relevant decision-making processes and that no final decision could therefore be made at the assessments which took place at the Panel meetings on 23.01.2024 and again on 06.02.2024. An interim *cause for concern* was escalated to the BCUHB Executive Medical Director as SRO on 06 February 2024, as well as the Welsh Government lead being informed.	At the final Panel meeting on 19.03.2024, despite a number of attempts to seek further information, it was agreed by the Panel that there was no additional information available to the Panel at that point in time to enable them to understand the relevant decision-making processes. Therefore, it was agreed that this case should be designated as a cause for concern. Further information is set out within *Appendix two* in this case summary. This was formally escalated to the BCUHB Executive Medical Director as SRO, as well as the Welsh Government's Head of Performance, Escalation and Intervention as per the Terms of Reference.
Case 31	This case was reviewed on 23.01.2024 and again on 06.02.2024 and although further information was provided to the Panel, it was agreed that there was not considered enough evidence to explain the decision-making. Although the Panel considered the clinical outcome would have been unchanged for the patient, it was considered that this case should be escalated as a cause for concern.	On 06.02.2024 following further extensive discussion by the Panel, the Panel agreed that from the information available, that this case should be designated as a cause for concern. This was formally escalated to the BCUHB Executive Medical Director as SRO, as well as the Welsh Government's Head of Performance, Escalation and Intervention as per the Terms of Reference.

7.4 Multi-professional practice and care underpinned the focus of the work of the Panel. Therefore, it was additionally agreed at the start of this work, should any 'broader' practice issues be identified, and/or queried, such as in relation to standards of care which may be specific to a profession, service, or other specialty, then an executive was to be nominated as the accountable lead to receive any specific escalation(s).

7.5 The formal assurance governance reporting route of this work was agreed in the Terms of Reference to be via the BCUHB Quality, Safety and Experience Committee which is chaired by an Independent Member (IM). It is the Panel's understanding that this report will be taken before that BCUHB Quality, Safety and Patient Experience committee with appropriate recommendations to the full Board and access to the report.

8.0 RECOMMENDATIONS

8.1 The Panel is aware that the BCUHB Vascular Improvement Plan (VIP) has expanded over the last few years to take account of the recommendations from other reports and review work such as those referenced at the start of this report.

8.1.1 Therefore, the findings and associated recommendations within *Table five* are considered pertinent to the implementation of actions within the VIP in the ongoing improvement of quality, across both the vascular service, and other related multi-professional services which are involved in delivering the relevant pathways of care. Detail underpinning these recommendations are provided within the case summaries within *Appendix two.* As always, recommendations are set within the context of the information which has been available to the Panel.

8.2 *Table three* reports that 38 out of 40 of the episodes of care have been graded as overall acceptable. Taking into account the timeline of this assessment work, it is considered that this demonstrates an ongoing trajectory of improvement within BCUHB vascular practice.

8.2.1 However, at the same time, as identified within Panel discussion, and some of the patient and family feedback, there are also a number of areas where it is considered that improvements could be further addressed or strengthened, or do not appear to have progressed following previous recommendations being made.

Table five: please note findings, areas identified and associated recommendations are not in any specific order of priority:

Recommendations:

Area	Findings/Comments	Recommendations
Pathways of care		

Diabetic Foot Pathway	It was considered from the information available that there is ongoing confusion as to the functioning of the Diabetic Foot Pathway. In relation to diabetic care, an opportunity was identified when it was noted that a patient had asked for a FreeStyle Libre, Abbott USA (glucose monitoring device), but was told to wait to see his GP, even though they were in hospital for a number of months. The Panel undertaking the work in relation to these assessments considered that there is still improvement work to be undertaken in relation to ensuring that this pathway is fit for purpose across all sites. It is recognised that the previous Vascular Review Panel's Report published in January 2023 stated that "There is a requirement to ensure that the diabetic foot pathway is fit for purpose across all BCUHB sites, underpinned by a contemporary evidence base, and co-produced and delivered by all the multi-disciplinary professionals who are collectively required to ensure consistent outcomes of optimal patient care and experience, no matter what their speciality, role, and site base."	1. Agree what constitutes a contemporary and evidence based diabetic foot pathway, with the same approach and pathway implemented immediately across all the BCUHB sites. 2. Identify opportunities to work across the Health Board as an integrated service model strengthening links between primary and secondary care within areas such as the management of diabetes; and implement to avoid patients having to see 'duplicate' health professionals or experience delay.
Palliative Care Pathway	Panel members identified the immense value of working with a palliative care team, and the positive difference to care brought by that team when required. Although it was recognised that final outcomes were not likely to change irrespective of decisions made, a small number of cases demonstrated the need to recognise a particular time window when palliative care arrangements could be considered, discussed with the patient and/or family, and subsequently put into place. From the information available, the Panel queried the ability of the	1. Confirm what constitutes the palliative care pathway, and disseminate what that structure consists of, including over weekends and public holidays. 2. Ensure robust links between the palliative care team and the vascular service.

	palliative care team to provide consistency in response times and whether this was potentially due to capacity. It was considered that if so, it would be helpful to strengthen these resources. The Panel also agreed that it would be helpful to have clarification as to whether there is an 'official' palliative care pathway, particularly over weekends. The previous Vascular Review Panel's Report published in January 2023 stated that "It is recommended that there is a need for ensuring robust links between the palliative care team and the vascular service."	
Vascular Pain Management Pathway	It was recognised that vascular pain management continues to be challenging, particularly neuropathic pain management. It was noted from the clinical records that pharmacy colleagues were particularly helpful in relation to advising on choices of analgesia. The previous Vascular Review Panel's Report published in January 2023 stated that "It is recommended that there is a need for a vascular pain management pathway to be implemented across the Health Board."	1. Formally set up a vascular pain management pathway, particularly in the management of neuropathic pain.
Stroke Pathway	It was recognised that there is a stroke referral proforma and a vascular pathway for stroke patients which has been shared with the stroke team by the vascular team. However, local Panel members highlighted that there have been other cases which resulted in the vascular surgeons seeing the patients outside the recommended window of treatment. The previous Vascular Review Panel's Report published in January 2023 recommended that "an exploration of how well integrated the stroke and vascular teams are, in addition to what	1. Evaluate the stroke referral pathway and implement subsequent findings across all the relevant multi-professional teams.

	treatment options are available locally for acute stroke."	
Area	**Findings/Comments**	**Recommendations**
Multi-Professional workings and support		
The Psychology Service	The significant value of a psychology service supporting vascular patients was highlighted by the Panel, alongside queries as to why psychology input was not standard for a number of patients. These patients had expressed low mood and anxiety, which it was recognised was likely, as they were going through life changing events such as amputation or experiencing difficulties with pain management. The previous Vascular Review Panel's Report published in January 2023 stated that "the Panel considered that there was evidence of the significant psychological impact that vascular disease has on the lives of those affected."	1. Agree psychology input as a standard component of vascular care with dedicated, protected, sessions of psychological support available for those vascular patients who require it.
The Microbiology Service	The important role of the microbiologist was acknowledged by the Panel, and it was queried from the information available, the role that the microbiology team was able to undertake with vascular patients. Notes from a pharmacist were identified where it had been recorded on several occasions that any patient with a gangrenous foot needs microbiology review. Local microbiology capacity challenges were highlighted by local Panel members and the fact that communication on test results and clinical wound assessment between vascular surgeons and microbiologists is primarily discussed by phone. It was suggested that microbiology colleagues attending the ward round would be helpful but that this was not	1. Provide dedicated, protected, sessions of micro-biological support for the relevant vascular patients who require it.

	standard practice, most likely considered due to capacity challenges.	
Care Of The Elderly (COTE) Input	The Panel recognised that many vascular patients fit within an elderly and frail demographic, and the value of specialist input with their care and planning. Independent surgical Panel members advised that ideally good practice is to have a Care Of The Elderly (COTE) consultant and clinical team available for daily input as required. The previous Vascular Review Panel's Report published in January 2023 recommended "relevant daily geriatrician (Care of the Elderly) input into vascular surgical cases."	1. Ensure availability of a Care Of The Elderly (COTE) consultant and their clinical team for daily input as required for vascular patients.
Area	**Findings/Comments**	**Recommendations**
Fundamentals of care		
The Management Of Falls	It is considered that vascular patients are in the higher risk category of falls. This was due to many being within an elderly demographic, or patients undergoing amputation, have a change in their centre of gravity. One patient was noted as having had three falls over a short period of time. It was identified on a number of occasions that a patient had a history of falls or was at risk, but a lack of evidence of a falls assessment or plan. This was for both patients admitted as day cases, and longer-term admissions.	1. Ensure a focus on mitigation of the risk that vascular patients, and in particular amputees, may specifically face regarding falls, with an updated plan of management.
Area	**Findings/Comments**	**Recommendations**
Infrastructure enabling the delivery of care		
Patient Flow	The Panel acknowledges that this is not only a local challenge, with frequent day-to-day pressures of patient flow and the requiring of beds, however, issues were identified such as: • Direct patient discharge home from ITU on a couple of occasions. This	1. Review what constitutes good and safe discharge planning in relation to the BCUHB guidance being provided regarding 'out of hours' discharge timing and associated risk assessment. This should

	subsequently would have also had an impact on ITU bed use/vacancy. • The time of discharge (late in the day) for some patients, especially for those patients who were elderly and potentially going home to an empty house, a cold house, or to another potentially frail partner. • It was also noted that on occasion there needs to be more clarity with District Nurse referrals, in relation to what the actual request being made is. A few patients fed back regarding challenges associated with their discharge plans (*Appendix two).* From the information available, the Panel noted that the Discharge Policy stated that it was due for review in September 2018 but no evidence of it having been updated accordingly. A query arose around the policy addressing patients who 'Do Not Attend.' It was identified as part of this review work that a patient had not attended a significant number of appointments, and the Panel then facilitated the appropriate actions to be taken to mitigate identified risks.	be part of a general review of the Discharge Policy which the Panel understands was due for review in 2018 but could not identify evidence of it being updated. 2. Review the Did Not Attend (DNA) policy and guidance on when DNA might potentially become a safeguarding issue to ensure that all staff are aware of this and the actions to take.
Patient Information	It was noted that not all patients received information leaflets and there appeared to be a variation in the amount of information being received by patients. It was noted that Health Boards are assessed against the distribution of patient information leaflets. They are updated every year and also translated into Welsh. A variety of the information provided which was contained within consent forms, although considered acceptable, was at times identified as variable. It was noted that the use of translators is clearly set out within the consent policy and states that it is also	1. It is recommended that clinicians email patients and/or their nominated family member, information leaflets to ensure that they are always provided. Although this would require to be undertaken by means of the relevant information governance processes. 2. It is recommended that consent training should be mandatory, for junior doctors as part of their induction into BCUHB and ongoing training

	considered inappropriate to use children or family members to interpret patients who do not speak English. However, from the information available the Panel identified at least 2 patients who did not speak English as a first language and no evidence of a translator being used. The information within patient letters was noted as being too 'general' in approach, in particular with pre-op guidance on eating, drinking and usual medications. For example, issues such as the importance of patients awaiting a fistula procedure in avoiding becoming too dehydrated was highlighted as a risk of veins 'shrinking' which would also adversely affect the surgical procedure was highlighted. The importance of the role of patient advice on weight reduction and smoking cessation was considered to be important for the ongoing care and treatment management of vascular patients. However, there appeared to be variation in the availability of the relevant practitioners.	3. It is recommended that unless the healthcare professional is fluent in the patient's preferred language, an interpreter should always be used for seeking consent from the patient. 4. It is recommended that letters to patients are more individualised in relation to the following: • Invitation to surgery letters for "fistula" patients who plan to have a local anaesthetic. It is noted that many patients are diabetic, and/or elderly and that the content of the letter needs to reflect whether that *specific* patient due to age, condition or co-morbidities is allowed to continue eating and/or drinking throughout the day. • Invitation to surgery letters for a vascular procedure state to call the unit two days before the surgery if the patient is taking any medication. However, the Panel considered that this would not be enough time if the patient was taking Warfarin. It was discussed that if this is a standard letter to all patients then it is recommended that this should be reviewed to reflect *individual* medication regimens and timescales.

Records and Record Management	The Panel identified standards of record and record keeping as variable across all the professions, and at times this meant that records could be difficult to read and navigate. It was also noted that on occasion the patient notes were not available and being moved across different sites and the associated challenges concerning this. More detail is included within the summary presentations in *Appendix two* as to what the issues around standards of records and record keeping encompasses. However, it should be noted that unacceptable practice was also identified as the use of sticky notes within a number of clinical records, and a fax referenced as being in use. On a number of occasions it was identified that the electronic Discharge Advice Letter (eDAL) appeared not to have been completed on the Welsh Clinical Portal (WCP). It was unclear as to whether it had been completed in some other way but from the evidence available, it was considered that there was a gap in the communication to patients' GPs. A discrepancy in the recording of allergies was identified in a number of patients. On one occasion it was noted that a patient had an allergy to iodine but had an iodine dressing applied to their foot as the allergy had not been recorded. When electronic records were in use, such as the Welsh Nursing Care Record, there was a distinct improvement noted in the ability to follow the patient's care pathway and associated observations. The use of Datix, information being submitted and then updated is	1. It is recommended that all staff should be reminded and supported in their professional accountability to maintain high standards of records and record keeping, this includes: • The need for documentation to explain decision-making and demonstrate the delivery of safe and effective care. • The use of Datix as a professional responsibility to report on any issue which may compromise patient safety.

	considered as requiring strengthening as noted on a number of occasions: ▪ A number of incidents were identified such as falls, a lack of staff having an impact on the ability to deliver care, identification of pressure ulcers, and a hospital acquired Covid as not being logged on Datix. ▪ It was noted that at times it was unclear as to what measures had been undertaken following investigation. ▪ Additionally, a Datix concerning a Patient Advisory Liaison Service led piece of work did not have an outcome recorded and had been closed, therefore the Panel was unable to confirm what action the ward team had taken in response to the issue.	
Direct Oral Anticoagulants (DOACs)	The Panel noted that often the GPs of patients who are stabilised on Warfarin whilst in hospital, will often receive a request, when the patients are discharged from hospital for the patients to continue to 'warfarinise.' Local Panel expertise raised the appreciation of GP colleagues undertaking this practice; however, it was also highlighted that vascular surgeons within BCUHB must complete Individual Patient Funding Requests (IPFRs) for Direct Oral Anticoagulants (DOACs). It is recognised this may initially have been put in place because of cost but as they are now widely available, it is queried as to whether is it reasonable to continue this practice.	1. It is recommended that there is consideration of whether the practice of completing Individual Patient Funding Requests (IPFRs) for Direct Oral Anticoagulants (DOACs) when they are widely available, remains reasonable and whether this should be continued.
Infrastructure support to the Vascular Service	Ongoing capacity challenges in relation to the support to the vascular team for typing and administrative resource was raised, regarding issues such as the sending of patient letters within a certain timescale.	1. It is important to note that some recent improvements were recognised as having been made and that there was acknowledgement of the professionalism and work of the current

	It appeared at times that some letters were sent close to the day of surgery with some delay in sending, which might have had an impact on patient ability to attend or insufficient preparation time.	administrative team. However, it is recommended that capacity is evaluated again.

9.0 CONCLUSION

9.1 As highlighted at the start of this report, following the commencement of a new delivery model, a number of reviews of the BCUHB vascular service have taken place over the years.

9.2 The Health Board's Vascular Improvement Plan (VIP) has expanded over the last few years to take account of the recommendations from other reports and review work. Latterly external reviews have stated that whilst improvements have been demonstrated that the Health Board must ensure measures are in place to assure itself that the improvements and processes implemented, are sustainable now and further improvements made in the future as highlighted and suggested in this report.

9.3 The Panel has graded 38 out of 40 of the episodes of vascular care as overall *acceptable*. Taking into account the timeline of this assessment work, it is considered that this demonstrates an ongoing trajectory of improvement within BCUHB vascular practice.

9.4 It is important to recognise that this progress forward is underpinned by many examples of good work happening across the Health Board. Several patients and their families highlighted that they were pleased and most appreciative of the care that they had received, and *Appendix three* sets out many examples where patients and their families identify good practice, compassionate care and express thanks to staff across all sites and different specialties. It is also clear from local representation on the Panel, that there is a strong desire to deliver optimal care to patients and their families.

9.5 At the same time, as identified within Panel discussion, and some of the patient and family feedback, it must also be recognised that there are a number of areas where it is considered that improvements could be further addressed or strengthened. These areas are not solely in relation to the practice of the vascular service and include other related services and practice that are involved in the delivery of multi-professional pathways of care. Some of these areas have also been identified within previous reviews and this is reflected in the Panel's recommendations.

10.0 ACKNOWLEDGEMENTS AND THANKS

10.1 The Panel wishes to convey thanks to the patients and their families who took the time to provide the immensely helpful feedback. They also would like to thank the BCUHB Patient and Carer Experience Team who spoke with the patients and families and transcribed the provided feedback. **[END]**