Five Rivers Vascular Network

Health Scrutiny Committee - 20 January 2015

This document and supporting appendices have been prepared by NHS England and the Five Rivers Vascular Network to provide a response to the Suffolk Health Scrutiny Committee in respect of the 35 questions raised by the Committee below.

1. **On 2 July 2014 and 15 October 2104 the Suffolk Health Scrutiny Committee considered reports on the operation and performance of the Five Rivers Vascular Service. The Committee agreed to request a report for consideration at its next meeting on 20 January 2015 including the following information:**

What are the actions set out in the Five Rivers Vascular Network Action Plan?
The action plan with progress to date is attached at **Appendix 1** – good progress has been made in many areas and rated according to BRAG status i.e.

- Blue - action complete,
- Green - action complete but requires embedding/audit of effectiveness,
- Amber - action commenced but not complete
- Red - action not commenced

What progress has been made in addressing these actions to date?
Please see action plan progress as at the end of December 2014

What are the timescales associated with completing the outstanding actions?
Please see the action plan with progress and timescales for completion of the outstanding issues. Good progress has been made in many areas of governance and team relationships – areas of on-going work include movement of consultant contracts to CHUFT hence facilitating easier cross-site working.

What are the responses provided by NHS England and the Five Rivers Vascular Network to the questions put by the Chairman of the Suffolk Health and Wellbeing Board (listed below) and:
What evidence exists to demonstrate patient experience, broken down between Ipswich and Colchester patients?
The vascular service has developed an electronic inpatient satisfaction survey which combines the Friends and Family Question with 10 other questions that monitor areas of care such as quality, dignity, privacy, trustworthiness, communication, medications and safe discharge. For the period September 2014 to December 2014, vascular surgery patients report an average overall satisfaction rating of **96%**. In relation to the friends and family, vascular patients reported an average of **94%** for

the same period. This cohort is on average **73 %** are North East Essex residents and **27%** Suffolk residents (based on admissions).

In addition to the above the Chairman of the Suffolk Health and Wellbeing Board, who was a retired consultant, expressed concerns with regard to the content of the Royal College of Surgeons review (recommendations) including the need for better management and oversight of the service, and the need for consultants to change ways of working to ensure a good service was provided. The Committee suggested that the concerns of the Chairman of the Suffolk Health and Wellbeing Board be formulated into specific questions to put to NHS England and the Five Rivers Vascular Network and for the responses to these questions to return to the Committee for consideration. These 34 questions are listed below. *(Note the paragraphs referred to below are taken from Section 9 of the RCS Report to Colchester Hospital which was sent to the Health Scrutiny Committee for its meeting on the 15th October 2014* (see **Appendix 2**).

2. With regard to paragraph 2.1, why has no combined data been collected to indicate the outcomes, i.e.

Integrated data has been collected and available from October 2014 the latest integrated outcomes are set out below.

- **What is the current waiting time for elective aortic aneurysm surgery?**
  Average wait (as at December 2014) is 28 days (from OPD to admission). Please note all data may be subject to change due to CHUFT migration to a new clinical portal system in November 2014.
- **What is the length of stay for elective aortic aneurysm surgery?**
  Average length of stay (based on April to October 2014) is 6.6 days.
- **What is the mortality for elective aortic aneurysm surgery?** This is reported as zero for the period April to October 2014.
- **What is the 30 day mortality for elective aortic aneurysm surgery?**
  This is reported as zero for the period April to October 2014.
- **What is the 30 day readmission rate for elective aortic aneurysm surgery?**
  4.5% of total elective AAA admissions based on the period April to October 2014.
- **What are the comparative rates for open and endovascular procedures**?
  Published data from national vascular registry – overall mortality (5 year period dated to the end of 2013) is reported as 2.3% which is within the national average (within normal confidence intervals).
- **What is the 30 day mortality for ruptured aortic aneurysm surgery?**
  Based on the period April 2013 to October 2014, 45%of total emergency admissions for AAA.

- **What is the 30 day readmission rate for ruptured aortic aneurysm surgery?**
  This is reported as zero for the period April to October 2014.
- **What are comparative rates for open and endovascular procedures?**
  As above.
- **What is the current waiting time for elective carotid endarterectomy surgery?**
  As at December 2014, average wait is reported at 4 days (from OPD attendance to admission).
- **What is the length of stay for elective carotid surgery?** Average stay for the period April to October 2014 is 2.97 days.
- **What is the mortality for elective carotid surgery?**
  Reported as zero for the period April to October 2014.
- **What is the 30 day mortality for elective carotid surgery?**
  Reported as zero for the period April to October 2014.
- **What is the 30 day readmission rate for elective carotid surgery?**
  Reported as zero for the period April to October 2014.

3. **With regard to paragraph 3.1, why has an agreed ambulance transfer policy not been in action since the inception of the Five Rivers Vascular Service?**
   An ambulance transfer policy has been developed for transfer of patients from the Ipswich to Colchester site**.** The unit was one of the first to centralise in the country and there was no guidance available regarding ambulance transfers. It soon became apparent this was required and the network asked the ambulance service and IHT to provide a policy for our region soon after the set-up of the network. This policy is now fully operational.

4. **What is the mean transfer time for a ruptured aortic aneurysm diagnosed at Ipswich and transferred to Colchester over the past year? (arrival in A&E Ipswich to operating theatre doors Colchester).**
   A small audit was under taken and reports the following:

	Initial time see in A&E IHT	Time referred to on-call VSOC	Arrival time at A&E CGH	Time patient arrived in theatre CGH	Outcome
Patient 1	15:20	15:45	16:49	18:55	Survived
Patient 2	06:40	06:50	08:05	08:10	Died
Patient 3	17:30	18:30	20:20	20:30	Survived
Patient 4	01:40	03:00	06:00	06:25	Survived***1
Patient 5	12:52	Unknown	19:28	21:35	Survived***2

***1 Difficult diagnosis since previous EVAR elsewhere. CT scan done in IHT, transfer delayed.
***2 Patient diagnosied incidentally on CT scan for another reason. Patient was intially discharged home by IHT nad then called back as an emergency.

5. **With regard to paragraph 4.1, what are the differential waiting times for aortic/carotid and limb salvage surgery in the last year for Colchester and Ipswich patients?**
   In terms of elective AAA surgery – average waits reported as follows: Colchester patients 49 days, Ipswich patients 47 days. Elective carotid surgery reports the following average rates: Colchester 19 days, Ipswich 16 days. Please note all average waits relate to the period April to October 2014.

6. **With regard to paragraph 5.1, what is the current and planned vascular surgeon's rota at Colchester and Ipswich in terms of operating sessions, clinic sessions and on-call arrangements?**
   The details of the operating sessions are provided in the Standard Operating Policy, a copy of which was submitted to the Health Scrutiny Committee for its meeting on 2 July 2014. Given this, the document has not been included again with the papers for this meeting. However, a copy of the updated Standard Operating Policy can be obtained from: http://committeeminutes.suffolkcc.gov.uk/LoadDocument.aspx?rID=090027118161c39e. A hard copy can be made available upon request to Suffolk County Council Committee Services, Email: committee.services@suffolk.gov.uk; Tel: 01473 260855.

   During the set-up of the new network each surgeon agreed to undertake a number of vascular lists at CGH in accordance with their estimated vascular major surgical activity. Each vascular surgeon is also a part general surgeon and has a similar number of day surgery and minor procedure lists at CGH and IHT. Arrangements are in place to increase the number of pure vascular lists carried out in the hybrid theatre by an increased capacity in CGH daycase surgery in November 2014. Through a monthly job planning meeting with all of the consultants, additional lists and sessions can be allocated for CGH and IHT requirements. Mr Howard attends the diabetic foot multi-disciplinary (MD) ward round and clinic at IHT.

   The other consultants are in the process of arranging additional sessions at IHT as per the RCS action plan with completion date of 31/01/2015.

   The on-call arrangements for the vascular surgeon (VSOC) for the network and the vascular surgeon on ward cover at IHT (VSW) are also clearly defined in the Operating Policy.

7. **What is the length of stay of vascular patients in the vascular beds at Ipswich overall and those awaiting transfer for surgery at Colchester?**
   There are no designated vascular beds at Ipswich Hospital. A small number of patients (average of 3 patients) have had general surgical intervention by vascular network surgeons or are undergoing vascular rehabilitation on the general surgical ward. These patients are cared for by the VSW team. The length of stay for these patients has not been collated as many are general surgical or awaiting social discharge to Suffolk.

   Patients at the IHT site will often have complex medical needs under medical

team care and any vascular care is provided by the VSW team at IHT, if in unusual circumstances the vascular problem requires major acute surgery then transfer to CGH will be undertaken.

The length of stay at IHT of these patients is not related to their vascular problem. In terms of any delays in transfer for surgery these will be highlighted by the incident reporting system and discussed at the monthly governance meetings. The Network is currently in contact with IHT to be able to provide this data in the future to allow comparable data for both sites in the vascular network**.**

8. **What is the current process by which East Suffolk patients with critical limb ischaemia are diagnosed, assessed at Ipswich, admitted to Ipswich beds and then transferred to Colchester? Do Colchester surgeons have any input currently into the elective management of East Suffolk patients?**
   Diagnosis is made via GP and vascular outpatient clinics at both sites; imaging is arranged and discussed in the Network MDT on a weekly basis. Elective patients for angioplasty are admitted via IHT radiology, all other patients are admitted directly to CGH. Patients are therefore not admitted to IHT beds first if treatment/intervention is required at CGH. Yes – referral pooled at MDT for urgent patients, AH diabetes MDT clinic and ward round at IHT.

9. **Under what circumstances do Colchester surgeons travel to Ipswich Hospital?**
   The Colchester based surgeons travel to IHT to review urgent cases when VSOC and to undertake a diabetic MDT clinic and ward round. Colchester surgeons also attend the governance meetings which alternate between Colchester and Ipswich. The clinical lead also attends Ipswich for business meetings.

10. **With regard to paragraphs 5.2/5.3, why is the service only now agreeing which interventional procedures are appropriate to be carried out at Ipswich? If some emergencies are to be treated at Ipswich, why are specialist vascular beds not to be available for their post-procedure care? Are generic beds suitable for this care?**
    As a unit we disagree with the RCS recommendation and wish to have 3 general surgical/vascular rehabilitation beds at IHT as referred to in the Operational Policy.

11. **With regard to paragraph 5.4, why are pathways and protocols only now being agreed?**
    As a unit there had been initial basic pathways developed from the start of the network however with changes to clinical lead, governance lead, new appointments, new vascular ward and RCS recommendations it was necessary to provide more detailed pathways.

12. **With regard to paragraph 7.1, pre-operative assessment is vital in high risk vascular patients. What proportion of patients currently undergo formal high-level assessment?**
    All major vascular cases receive anaesthetic consultant pre-assessment at both sites.

13. **With regard to paragraph 8.1, critical care bed nursing capacity is less than required – what was the capacity at service inception, now and the actual requirements today and for the future?**
When the network was set up in July 2012, CGH had a critical care bed base of 12, this has been increased to 13 beds in 2013 with plans already underway to increase further to 14 beds in 2015. CGH also offers a 24hr extended recovery which provides additional support for high dependency (HD) care for vascular patients**.**

14. **With regard to paragraph 8.2, the Colchester consultant availability during working hours on the Ipswich site to cover emergency and urgent activity is indicated to be a problem of communications. Is this in fact the case? Is there a protocol with contact details available for junior staff, wards and switchboard operators?**
There are clearly defined protocols as detailed in the Standard Operating Policy.

With regard to paragraph 8.2, why is there no detailed transfer plan for emergency patients?
Please see guideline Ambulance Protocol for the Conveyance of Vascular Emergencies East of England Ambulance Service and Five Rivers Vascular Network and SOP for IHT ED and Inpatients **(Appendix 3/3a)**.

15. **With regard to paragraph 9.1, why have consultants not met and agreed pathways and protocols?**
The consultant team have on numerous occasions met via governance and business meetings since the RCS recommendations to discuss the new pathways. Please see RCS action plan (**Appendix 1**).

16. **With regard to paragraph 10.2, when is the Society of Anaesthetists to review the current procedures/protocols and plans?**
The service has decided to wait for the two new critical care consultants to start in January and February 2015 as both have extensive vascular experience and would like to have input into the suggested review prior to inviting the college.

17. **With regard to paragraph 11.1, what are the current infection rates for grafts/ wounds? What are the re-operation rates within a single admission? What is the readmission rate?**
The network is currently undertaking ongoing audits on graft infection and surgical site infections (SSIs) during 2014, with plans to continue for the whole of 2015. The latest results suggest a SSI rate of 16% in line with the rates in the literature for combined clean and dirty vascular case mix. The graft infection audit has reviewed all grafts admitted with infection and of these only 2 were from the surgeons in the new vascular network (July 2012 – July 2014), others were either historical or from other providers. The reoperations are discussed at the networks monthly mortality and morbidity meeting and recorded along with complications; the rate reported is very low. Please see responses to question 2 regarding readmission rates.

18. **With regard to paragraph 11.2, why are general surgical patients mixed with specialist vascular patients and what are the current arrangements that have led to mixed-sex problems?**

Wherever possible clean cases only are accommodated on the vascular ward at CGH site. The CGH vascular ward has had plans for redesign for a total vascular ward in 2015. At Ipswich wherever possible, patients with vascular issues are accommodated away from acutely infected medical patients, as set out in the Standard Operational Policy.

19. **With regard to paragraph 12.1, what are the current arrangements for the sharing of clinical and radiological records? What are the plans and timescale to improve these arrangements?**
Imaging can be viewed at IHT and the Colchester team have access to IHT PACS and evolve patient systems. There is a review underway with the introduction of the clinical portal system at CGH commencing in November 2014.

20. **With regard to paragraph 13.1, what is the current arrangement for consultant access to the hybrid theatre? What non-vascular procedures are currently performed in the theatre?**
A recent audit of cases through the hybrid theatre reported only 4 % of cases were non-vascular. This is expected to reduce further with the increased day case capacity at CGH introduced in November 2014.

21. **With regard to paragraph 13.2, why are trained vascular radiologists from Ipswich not given access to the hybrid theatre?**
The radiologists from IHT regularly carry out procedures at CGH Hybrid theatre for AAA EVAR stents and interventional hybrid procedures. When free sessions are available there are offered to the radiologists to use for pure Interventional Radiology.

22. **With regard to paragraph 14.1, what are the current arrangements for consultant input to diabetic foot care at both sites? How will the developing protocol change this arrangement?**
The diabetic service at both sites is NICE compliant. Mr Howard attends MD clinics at both sites and ward rounds. A new joint SOP for diabetic management DM vascular foot care is being developed by the IHT diabetic clinicians, podiatrists and Mr Howard to enable a network approach to care.

23. **With regard to paragraph 15.1, what have been the arrangements to date regarding multi-disciplinary team meetings at Colchester and Ipswich and what combined meetings have taken place?**
As per the RCS action plan (**Appendix 2**) all MDT meetings (weekly) are now held at the hub (Colchester site) however the consultants have agreed to use the telemed link when travel is not permitted to CGH due to clinical commitments before and after the MDT meeting. Other combined meetings include: Monthly Job-planning meetings (all consultants). Monthly Business meetings (all consultants). Monthly Journal Club meetings (all consultants). Monthly governance and audit meetings are alternated been sites. Quarterly joint vascular/critical care audit meetings at CGH.

24. **With regard to paragraph 15.2, why have decisions not been minuted and recorded at MDTs?**

All patient outcomes discussed at MDT's have always been recorded and saved on the network shared drive. Since June 2014 formal minutes have been taken and logged, this was also a recommendation on the RCS action plan **(Appendix 1)**.

25. **With regard to paragraph 15.3, why at MDTs is attendance not perceived as being clinically necessary if not compulsory?**
    The Standard Operational Policy clearly details attendance is not discretionary for vascular surgeons or radiologists performing EVARs.

26. **With regard to paragraphs 16.1/16.2, why have morbidity and mortality meetings not been properly recorded and actioned?**
    Attendance and Minutes are recorded and monitored by the Clinical Lead and vascular manager respectively since commencing post in September 2014 for the morbidity and mortality meetings. The actions from the complications and deaths are clinically based and have always been discussed with the vascular clinicians and teams involved.

27. **With regard to paragraph 17.1, what is being done to establish adequate audit links involving all relevant staff so as to track network performance?**
    All vascular clinical teams attend Audit and Governance meetings, take part in Audit projects and are all responsible for updating the national vascular registry (NVR) which provides detailed analysis. Further links with IHT need to be developed to allow network audit, however with developments in capacity via job planning at CGH the vascular service will be centralised to the Hub site which will enable centralised audit.

28. **With regard to paragraph 18.1, what training is being given to staff regarding the nature and reporting of significant adverse events?**
    Incidents and serious incidents are discussed at the network monthly governance meeting. All consultant's and clinical staff report on DATIX and are required to as part of the job plan process to be trained as datix investigators and undergo the relevant Trust training package and monitored via the Trust core training records.

29. **With regard to paragraphs 19.1/19.2, what is being done to address the Serious Untoward Incident reporting, resolution and implementing recommendations?**
    As per the RCS action plan (**Appendix 1**), clinical incidents and complaint themes are shared within the network governance forum with input from the IHT team.

30. **With regard to paragraph 20.1, what key performance indicators have been identified?**
    A dashboard has been developed and used over the last year, monitoring use has enabled modifications to be made and final changes were agreed by the consultants on 18.12.14. This will now ensure all necessary information is captured and is readily accessible in a timely and accurate manner from both sites.

31. **With regard to paragraph 21.1, how will the newly appointed manager implement changes necessary given the evident intransigence endemic in the consultant body?**
There has been positive progress in terms of team relationships and working practice. The role of the Network Manager with clear visibility and presence at IHT site has made a significant impact for the service and follow through of the necessary actions indicated from the RCS action plan. The consultant body feel that intransigence is not fair representation of their attitude and not stated as such in 21.1. The consultant team is unified and flexible to change with many projects and developments under way to monitor standards, continue good governance and expand the service together as a team.

32. **With regard to paragraph 22.1, when will the clinical lead be appointed and what support will he or she be given to implement the necessary change?**
As per RCS action plan, Mr Howard has now been appointed as has a substantive service manager Mrs R Burt to support the clinical lead. Support will also be provided by clinical colleagues, the divisional management team and Trust Directors with input from the Medical Directors at both sites.

33. **With regard to paragraphs 23.1/23.2, when will the magnitude and degree of breakdown in both communications and working practices be established so as to take a firm decision as to whether a move forward is at all possible?**
The magnitude and degree of which is hard to quantify in terms of % or risk scoring as the relationships issues that occurred prior to the RCS review in early 2014 have now been resolved. There are no communications or working practice issues now. This has been achieved by mediation sessions undertaken by several members of the team to resolve any issues and the appointment of a single Clinical Lead for the network.

34. **With regard to paragraphs 24.1, 24.2 and 25.1, when will the consultant contractual/job plan review take place, such as to establish proper working relationships and the provision of new consultant staff?**
Specialist commissioners have agreed that this should be reviewed with a view to commence by 1st April 2015. Legal employment advice has been sought and a letter to consultants has yet to be agreed by the Medical Directors at both sites. The consultant job plans are currently under review in order to provide more equal working practices, similar sessions and cover for IHT.

Appendices
Appendix 1 - RCS Action Plan
Appendix 2 - Royal College of Surgeons Recommendations
Appendix 3 - Ambulance Divert Protocol and Standard Operational Policy for Transfer.

A copy of the Five Rivers Vascular Network Operational Policy can be obtained from:
http://committeeminutes.suffolkcc.gov.uk/LoadDocument.aspx?rID=090027118161c39e. A hard copy can be made available upon request to Suffolk County

Council Committee Services, Email: committee.services@suffolk.gov.uk; Tel: 01473 260855.

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