GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

CONFIDENTIAL

Betsi Cadwaladr University Health Board Vascular Quality Review Panel Report

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1.0 Executive Summary

In July 2021, the Royal College of Surgeons England (RCSE) undertook an examination of forty-four clinical records relating to vascular surgery, on behalf of Betsi Cadwaladr University Health Board (BCUHB). They subsequently published a report in January 2022[1] setting out a number of findings and recommendations.

A number of findings within the January 2022 RCSE report raised questions in relation to the quality and consistency of care provided. The report stated that for a number of clinical records, the Health Board should review these comments, alongside the local information it holds, and determine if the patient records contain 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 an independently chaired, multi-disciplinary BCUHB Vascular Quality Review Panel was then convened to undertake this work.

An original aim of fifty represented the number of records for RCSE review in July 2021. However, only forty-four records were subsequently presented, and examined by the RCSE review team.

A BCUHB internal Vascular Quality Team who had also been brought together to aid review of the clinical records in detail and complementary to the Panel review, identified that within the original cohort of the fifty records, there were two duplicate records and two that did not exist. Therefore, clinical records belonging to forty-seven patients in total were to make up the review of the BCUHB Vascular Quality Review Panel. To ensure patient confidentiality, these records had previously been labelled and numbered for the RCSE review from A1 to A50, noting that A27 and A50 do not exist, and A31 is a duplicate record with A36.

The majority 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. However, due to significant navigation challenges, concerns were promptly raised by the Panel, as to the poor physical condition and arrangement of the paper records themselves, which led to assistance being required from the BCUHB medical records department.

Therefore, the Panel acknowledges that due to the challenges associated with the condition and arrangement of the records reviewed, that it is possible that further information exists in real time, or exists, and cannot be found, which would alter some of the findings. Consequently, judgment could only be made on the information available, and conclusions are drawn with appropriate caution and caveats aligned to this.

The process of review included appreciation of the timelines/dates spanned across the episodes of care, relevant evidence base and standards at that time. The Panel was conscious of the context of working within the pandemic and the associated restrictions that were in place

[1] Royal College of Surgeons' 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.

which may have had potential consequences or implications related to the delivery of care which were out with the usual practice of individuals. The Panel was also aware of recognising that at times there were different models, ways of working, or infrastructure in place, which may have also changed during some of the timelines of care. Additionally, the local knowledge of a number of Panel members enabled an understanding of the context of the delivery of care, particularly across different geographies. It was agreed that this did not preclude recommendations being made, but helped the Panel acknowledge the situation at the time, as relevant.

The Panel collectively brought a variety of knowledge, experience, and backgrounds and the role and scope of each Panel member was reiterated at the start of every Panel meeting, to clarify parameters of input, and what members were able, and just as importantly, unable, to comment on, in line with their knowledge and expertise. A blend of members ensured a mix of those both external and internal to BCUHB; with an independent Chair, an external vascular surgical expert, and an external vascular specialist nurse having no previous affiliation to Betsi Cadwaladr University Health Board (BCUHB) or to working within NHS Wales.

The Panel's inaugural meeting was held on 6 April 2022. It was acknowledged that areas of the RCSE report referred to standards of specialist vascular practice and that professional vascular surgical experience and knowledge were required in relation to understanding many of those issues raised within the RCSE report; and this expert Panel opinion would be provided by the external vascular specialists. However, it was also agreed that the majority of the Panel members should still expect to be able to understand and comment on the components of care as a reasonable generic standard, or in relation to their own specific knowledge base and area of practice. Final findings therefore consist of that collective approach to the review.

The appointment of an external vascular surgical expert took longer than expected, and an external expert commenced in mid-June 2022. Due to this later appointment, it was identified that Panel meetings were arranged for days on which he could not routinely attend due to his own theatre commitments. Therefore, he commenced his review separately as expert opinion in vascular surgical practice with agreement that an amalgamation of findings into final individual reports was to be held at the endpoint of the work, or if at any point deemed necessary. It was considered that this would also add an additional layer of assurance to the work.

Early on in the process, there was recognition that it was frequently difficult for the Panel to hear the vitally important voice of the patient and understand what matters to them, from solely reviewing the clinical records as the information that was available. Therefore, it was proposed and then approved via the Health Board's agreed governance process, that an offer would be made to patients, and/or their Next of Kin, to provide feedback if they wished to do so.

Following completion of the separate Panel and external vascular surgical expert reviews, a number of meetings were held to discuss and agree the amalgamation of findings. An individual case report, which also includes, when provided, patient and/or Next of Kin feedback, has been produced for each of the forty-seven records setting out these amalgamated findings.

The Panel acknowledged that initial opinions or findings might potentially alter when amalgamations were undertaken, should the Panel on coming together collectively then agree that a finding mitigated another, or, that understanding had been gained in an area of care or practice, which was previously not understood or identified. This did occur and is considered to

have brought further strength to the approach of the review and final reports reflect this collective way of working.

Commentary is predominantly based on vascular-related episodes of care, and it must be stressed that this work is only one component of the wider vascular services work being undertaken across the Health Board. The Panel aimed to be objective in their approach to the reviews with an intention to reflect both identified concerns, and good practice.

The Panel's deliberation was solely in relation to the review of the ***forty-seven cases***, and examining for each the following two questions:

1. *Whether the patient records contain the information expected for the patient episodes of care;*
2. *Were the necessary and appropriate follow up and aftercare plans put in place.*

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 Chair to the Executive Medical Director as the Senior Responsible Officer (SRO) for this work and would be separate to any Panel work or reporting.

The Panel was aware that their commissioned work was only one component of the work taking place across BCUHB's vascular services. Therefore, as the Panel progressed through the cases, they worked to the aim of a principle of a 'no surprises' approach. It was hoped that by doing so, that any specific points identified, whether historical or aligned to a more current timeline, would feed in contemporaneously to the relevant quality improvement work being undertaken across the Health Board rather than delay until this final report. Therefore, relevant points were escalated after each Panel meeting, with an aim of reducing the likelihood of recurrence and helping to inform any required changes to practice.

The Panel's principal deliberation remained in answering the two questions posed around whether the sample of patient records contain the information expected for the individual patient episodes of care, and, were the necessary and appropriate follow up and aftercare plans put in place, and recommendations which could be aligned. *Appendix three* contains the confidential detailed findings of each of the 47 cases. There was no formal analytical or statistical resource aligned to this work, nor was there regarded a need for it within the agreed Terms of Reference and defined parameters of this work.

However, as the number of records reviewed progressively increased, Panel members became conscious that some of their findings were repetitive and could be informally identified and proposed as a pattern or theme. Therefore, as the Panel was invited to do by BCUHB, this report also includes a number of recommendations, which the Panel considers could be helpful in relation to help inform the ongoing quality improvement work being undertaken across the Health Board. Again with the proviso, that due to the challenges with the navigation of the records, that conclusions are drawn with appropriate caution. It is considered always possible that further information is available which would alter some conclusions and by doing so also alter the relevant recommendations.

In no specific order, recommendations are made in relation to effectiveness of clinical pathways; clinical governance, including consent and decision-making, accountability, and,

professional practice; person-centred care; team working, including the multi-disciplinary team; complex pain management; palliative care; education and learning; and, discharge, and necessary and appropriate follow up and aftercare plans.

Findings underpinning these recommendations are set within a context of a lack of identified recorded evidence around areas such as the understanding of the function and oversight of the responsible clinician, ensuring best practice in decision-making and consent, MDT working, and ensuring a holistic approach to care includes the wider aspects of medical, psychological and social care.

Ultimately, the aim of the Panel was to produce a piece of work that would help inform the delivery of the provision of the best care, experience and outcomes for BCUHB patients, their families and carers. The Panel has worked diligently over several months to review the 47 cases in detail and to the central principle of supporting quality improvement and organisational learning.

2.0 Infrastructure of Vascular Services Betsi Cadwaladr University Health Board

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 commenced on 10 April 2019. This change was underpinned by the aim that the adoption of a hub and spoke model would mean that patients would have equal access to the best expertise, regardless of where in North Wales they live.

2.2 The BCUHB acute hospitals; Ysbyty Wrexham Maelor, Ysbyty Glan Clwyd and Ysbyty Gwynedd were to 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 was also to continue at all sites. Ysbyty Glan Clwyd became the arterial centre for the BCUHB vascular network to provide all emergency and elective arterial surgery and complex endovascular interventions.

3.0 Royal College of Surgeons' England Invited Review Mechanisms

3.1 The Royal College of Surgeons' England (RCSE) states that it is committed to providing assistance wherever this is required and to helping to ensure that patients receive good quality care[2]. If a healthcare organisation requires an external expert opinion, an Invited Review Mechanism (IRM) facilitated by the RCSE provides expert independent and objective advice via peer review processes.

3.2 The RCSE describes Invited Reviews (IRs) as being a highly valuable resource by providing healthcare organisations with independent expert advice and is a partnership between the RCSE, the specialty associations and lay reviewers representing the patient and public interest. The RCSE explains that three types of IR are available to assist healthcare organisations address a range of quality and performance issues. Those are, service reviews, individual reviews and clinical record reviews.

[2] https://www.rcseng.ac.uk/standards-and-research/support-for-surgeons-and-services/irm/

3.3 The RCSE sets out within its' guidance[3] that an IR can be initiated when a formal request is made by a healthcare organisation. To do this, a review request form is completed by the organisation's Chief Executive or Medical Director, returned to the RCSE Chair of the IRM with a covering letter, which includes confirmation of conditions set by the RCSE.

3.4 The Chair of the IRM and the relevant specialty member of the Invited Review Oversight Group will consider the IR request. A decision is made as to whether an IR is appropriate; if it is decided that an RCSE review is not appropriate, the RCSE states an explanation will be given and the RCSE will try to assist by providing advice on a suitable alternative course of action.

4.0 Background and Context to BCUHB Vascular Quality Review Panel

4.1 In September 2020, a former Medical Director for Secondary Care of BCUHB wrote to the RCSE Chair of the Invited Review Mechanism on behalf of the Health Board to request an Invited Service Review including a clinical record review of fifty cases relating to vascular surgery. An RCSE Invited Service Review is described as one to "assist healthcare organisations by providing independent, expert advice on surgical service delivery and how this might be improved". The RCSE state that this process has been "designed to provide a fair, independent professional review which will support - but not replace - existing local procedures for dealing with such issues"[4]. RCSE Clinical Record Reviews are described as "providing an independent, expert opinion on the management of one or more episodes of patient care and whether this meets College and Surgical Specialty Association standards".

4.2 This request was agreed by the RCSE with a subsequent IR of the vascular surgical service being held remotely using video conferencing facilities on 11-13 January 2021. It is reported that it was originally intended that the clinical record review of 50 cases would be incorporated within the January 2021 IR; however, it was apparently not possible for BCUHB to provide the fifty sets of clinical records in advance of the service review. Therefore, it was agreed that a successive, standalone clinical record review would take place.

4.3 A report of the January 2021 review was issued on 15 March 2021[5].

4.4 A subsequent site visit then took place on 19 July 2021 to review the clinical records provided to the RCSE review team by BCUHB.

4.5 A report of the July 2021 review was issued on 20 January 2022[6].

4.6 A number of findings within the January 2022 RCSE report raised questions in relation to the quality and consistency of care provided and BCUHB decided that an independently chaired Panel should be assembled.

[3] https://www.rcseng.ac.uk/standards-and-research/support-for-surgeons-and-services/irm/
[4] https://www.rcseng.ac.uk/standards-and-research/support-for-surgeons-and-services/irm/service-reviews/
[5] 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
[6] 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

4.7 This Panel named 'the BCUHB Vascular Quality Review Panel' and referred within this report as 'the Panel', was, in line with the RCSE January 2022 report recommendations, to principally determine *if the patient records contain the information they would expect for the patient episode(s)*; and, *scrutinise whether the necessary and appropriate follow up and aftercare plans were in place*.

4.8 The RCSE January 2022 report had identified a specific number of records with concerns and recommendations for further review. However, it was agreed by BCUHB that the same assessment and scrutiny should be applied to all of the clinical records presented to the RCSE review team, in addition to those that were not originally provided out of the originally intended sample of 50. It was identified that within that original aim of 50 records for review, that there were two duplicate records and two that did not exist, so clinical records belonging to **47 patients in total** were to make up the Panel's review.

4.9 The Panel was also invited to consider the provision of associated learning points and recommendations in relation to findings that may be identified within their review of the records as quality improvement work.

5.0 Terms of Reference

5.1 Terms of Reference (ToR) were drafted and subsequently ratified by the BCUHB Vascular Steering Group (VSG). The VSG is responsible for overseeing the implementation of the recommendations from both the RCSE reports. The VSG escalates issues to the BCUHB Quality, Safety and Experience Committee. The VSG includes the Community Health Council (CHC) representative and CHC patient and carer representatives.

5.2 An identification of a relationship to the Panel work, and the already established concept of redress and the duty placed on NHS Welsh bodies to consider whether harm has or may have been caused under the Putting Things Right (PTR) guidance[7] and regulations was also addressed. It was agreed that it would form part of the collaborative working with a BCUHB internal Vascular Quality Team who had also been brought together to aid review of the 47 clinical records in detail, complementary to the Panel review; and which it was considered could also offer another dimension to learning. The Panel's comments could then help inform the PTR decision-making to avoid potential duplication and offer further expertise or opinion if required.

5.3 The Panel was also invited to consider:

- An understanding of the methodology of how the sample of the clinical records was undertaken for the July 2021 IR.
- Whether additional independent sampling requires extending to other vascular patient clinical records.
- On conclusion of this work or if deemed urgent at any other point, any other recommendations to be made to the Executive Medical Director as the executive lead for this work.

[7] https://gov.wales/nhs-wales-complaints-and-concerns-putting-things-right and, Putting Things Right – Guidance on dealing with concerns about the NHS from 1 April 2011 - Version 3 – November 2013

- Identification of any opportunities to ensure that there is strengthening of staff being able to speak up as a central tenet to BCUHB working.

6.0 Panel Composition

6.1 The Panel held its' inaugural meeting on the 6 April 2022 and collectively brought a variety of knowledge, experience, and backgrounds *(Appendix 5)*. The role and scope of each Panel member was reiterated at the start of every Panel meeting, to clarify parameters of input, and what members were able, and just as importantly, unable, to comment on, in line with their knowledge and expertise.

6.2 Panel members brought experience and knowledge particularly within:

- Patient experience and ensuring that the voice of the patient is heard and listened to;
- Multi-professional professional standards and practice, including consent and decision-making;
- Vascular surgical and nursing practice;
- Safe working and wellbeing;
- Safeguarding;
- Consideration of any implications or consequences aligned to PTR.

6.3 The independent Chair has no previous affiliation to Betsi Cadwaladr University Health Board (BCUHB) or to working within NHS Wales.

6.4 To ensure a blend of members both external and internal to BCUHB, membership included an external Vascular Specialist Nurse. This external Panel member had no previous affiliation to Betsi Cadwaladr University Health Board (BCUHB) or to working within NHS Wales.

6.5 The appointment of an external vascular surgical expert, as expert vascular surgical opinion, took longer, and an external expert commenced in mid-June 2022. This external Panel member also had no previous affiliation to Betsi Cadwaladr University Health Board (BCUHB) or to working within NHS Wales.

6.6 It was acknowledged that areas of the RCSE report referred to standards of specialist vascular practice and that professional vascular surgical experience and knowledge were required in relation to understanding many of those issues raised within the RCSE report; and this expert Panel opinion would be provided by the external vascular specialists. However, it was also agreed that the majority of the Panel members should still expect to be able to understand and comment on the components around the delivery of care as a reasonable generic standard, and findings therefore consist of that collective approach to the review.

7.0 Ways of Working

7.1 The majority 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. However, due to significant navigation challenges, concerns were raised by the Panel, as to the poor physical condition and arrangement of the paper records

themselves, which led to assistance being required from the BCUHB medical records department. Consequently, as noted within the case reports, judgment was made on the information available and conclusions drawn with appropriate caution and caveats aligned to this. It is possible that further information existed in real time, or exists and cannot be found, which would alter some conclusions.

7.2 A secure Portal was set up on the BCUHB SharePoint to hold the work of the Vascular Quality Review Panel. Access permissions were in place and confidential documents could only be accessed via password.

7.3 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 Chair to the Executive Medical Director as the Senior Responsible Officer (SRO) for this work and would be separate to any Panel work or reporting.

7.4 All cases are of equal importance and treated as such. However, an order in which to undertake the assessment was required. Therefore, to attempt to mitigate risk, a Red, Amber, Green (RAG) stratification was mapped to the feedback comments allocated to each record within the RCSE January 2022 report.

7.4.1 A further ‘red/red’ allocation added to those records omitted from the RCSE review in July 2021 was to ensure that the Panel reviewed those records first, as there had been no previous review undertaken. This methodology although not an ‘exact science’ helped provide a systematic approach to the order of reviewing the 47 clinical records.

7.4.2 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 RAG allocation.

7.4.3 The external vascular surgical expert confirmed that the order of risk stratification met with his approval when he commenced his work.

7.5 The internal Vascular Quality Team brought together by BCUHB reported to the Assistant Director of Patient Safety, who was also a Panel member as the PTR lead. Each internal Vascular Quality Team member had been allocated a number of records from the sample total of 47.

7.6 At the Panel meetings, a presentation of their own investigation findings was given from the member of the internal Vascular Quality Team assigned the relevant clinical record that the Panel was reviewing. This was followed by individual Panel members whom having prepared their own findings prior to the meeting, fed back, followed by collective discussion, and Panel members considering:

1. *Whether the patient records contain the information expected for the patient episodes of care.*
2. *Were the necessary and appropriate follow up and aftercare plans put in place.*

7.7 The Panel's process of review included acknowledging the dates of the episodes of care and consideration of relevant evidence base, standards and ways of working at that specific time; as well as consideration of any aligned potential consequences or implications related to the Covid pandemic.

7.8 Any information in relation to clinical records was as far as possible anonymised. Patient confidentiality was maintained to the maximum extent possible and the labelling instigated by the RCSE review was retained. Panel members declared any possible conflicts of interest at the start of every meeting.

7.9 Due to the external vascular surgical expert being appointed later than had been originally expected, it was identified that Panel meetings were arranged for days on which he could not routinely attend due to his own theatre commitments. Therefore, he commenced his review separately with agreement that amalgamation of all findings was to be held at the end point of the work, or if at any point deemed necessary. It was agreed that this would also add an additional layer of assurance to the work.

7.10 The ability for the Panel to hear the patient's voice was identified early as an absolute requirement of understanding what matters to individuals, as well as ensuring dignity and respect is central to all care delivered. After the first couple of Panel meetings, it was recognised that it was difficult at times to hear the patient voice from only reviewing the clinical records. Therefore, it was proposed and then agreed through the VSG that contact could be made with patients whose records were being reviewed with an offer of gaining their feedback. The patients, and/or their next of kin, had previously been contacted to make them aware of the work of the Panel (*Appendix 1*). The offer and subsequent approach was undertaken under the usual parameters of the work of the BCUHB Patient and Carer Experience Lead who was also a Panel member. The feedback provided by patients and/or their Next of Kin is underpinned by verbal consent given solely for providing information to potentially assist the Panel's understanding of care delivery.

7.11 Following completion of the separate Panel and external vascular surgical expert reviews, a number of meetings were held to discuss and agree the amalgamation of findings. An individual case report, which also includes, when provided, patient and/or Next of Kin feedback, has been produced for each of the forty-seven records (*Appendix 3)* setting out these amalgamated findings.

7.12 The Panel acknowledged that initial opinions or findings might potentially alter when amalgamations were undertaken, should the Panel on coming together collectively then agree that a finding mitigated another, or, that understanding had been gained in an area of care or practice, which was previously not understood or identified. This did occur and is considered to have brought further strength to the approach of the review and final reports reflect this collective way of working.

8.0 Escalations

8.1 The commissioned work of the Panel has only been one component of the work taking place across BCUHB's vascular services. Therefore, as the Panel progressed through the cases, they worked to the aim of a principle of a 'no surprises' approach. It was hoped that by doing so, that any specific points identified, whether historical or aligned to a more current timeline, would feed in contemporaneously to the relevant quality improvement

work being undertaken across the Health Board rather than delay until this final report. Therefore, relevant points were escalated after each Panel meeting, with an aim of reducing the likelihood of recurrence and helping to inform any required changes to practice. Agreement with the SRO for this work, was should any points become repetitive, then their escalation should still continue, to help gain a sense of the extent of issues being raised *(Appendix 2).*

8.2 If a specific issue in relation to an individual patient was identified as to whether the patient records contain the information expected for the patient episodes of care, or, were the necessary and appropriate follow up and aftercare plans put in place; this was escalated separately to aim to prevent patients being identified *(Appendix 2).*

8.3 On commencement of the external vascular surgical expert, findings identified which he advised required escalation within his initially separate reports, again were escalated to the SRO via the independent Chair on the behalf of the external vascular surgical expert *(Appendix 2).*

8.4 As the review progressed, escalations continued from both the wider Panel and the external vascular surgical expert from their initially separate ways of working. Although it was agreed, if at any point, it was deemed necessary that early amalgamations of findings could be undertaken.

8.5 Meetings were held in August 2022 with the independent Chair, the external vascular surgical expert and the Executive Medical Director as SRO, the Vascular Clinical Governance Lead, the interim Board Secretary, and the Assistant Director of Communications and Engagement to discuss the escalations, which had been made from the external vascular surgical expert up to that point. This led to the agreement that the independent Chair would formally write to the SRO to aid/inform further executive discussion at BCUHB Cabinet (*Appendix 2).*

9.0 Governance and Reporting

9.1 Terms of Reference were ratified by the BCUHB Vascular Steering Group (VSG). Update reports from the Panel were provided as and when requested by the Chair of the VSG.

9.2 An update from the Panel's independent Chair was also provided to the BCUHB Quality, Safety and Experience Committee (QSE) in July 2022, and the Panel's independent Chair met with the QSE Chair as the governing committee to provide relevant updates on the progress of the work.

9.3 The Panel's independent Chair met with the Executive Medical Director as SRO as necessary to discuss escalations and progress of the work.

10.0 Panel Assurance Loop

10.1 On commencement of the work, discussion took place on behalf of the Panel between the Panel's independent Chair and the Executive Medical Director, as SRO as to how the Panel would receive assurance as to when and how potential escalations or issues raised would be addressed. The Panel's independent Chair also met with the SRO and the interim Board Secretary to discuss Panel assurance. This was confirmed as an additional

ability to approach the BCUHB Quality, Safety and Experience Committee (QSE) and/or Board Chair directly as a form of escalation if required due to any possible conflict of interest that might prevent the SRO from being approached, although this was never deemed necessary.

10.2 Escalations were promptly received and acknowledged by the SRO, and information given when available as to actions, which had been taken, or were in train.

10.3 The Vascular Network Director attended a Panel meeting on 13 July 2022, and explained and discussed with the Panel members present how the BCUHB Vascular Implementation Plan was acting as a conduit to implement a number of actions that were aligned to escalation points from the Panel.

11.0 Individual Assessments of 47 Clinical Records

11.1 As explained previously, it was identified that within that original aim of 50 records for review by the RCSE, that there were two duplicate records and two that did not exist, so clinical records belonging to 47 patients in total made up the Panel's review. The review was undertaken as described previously in an order of proposed risk stratification but individual reports are set out within *appendix 3* in chronological order for ease of navigation.

11.2 It is also reiterated that the information contained within the reports is made on the information available and conclusions drawn with appropriate caution and caveats aligned to this. It is possible that further information existed in real time, or exists and cannot be found, which would alter some conclusions.

11.3 The feedback provided by patients and/or their Next of Kin is underpinned by verbal consent given solely for providing information to potentially assist the Panel's understanding of care delivery.

12.0 Panel Response to Commissioned Questions

12.1 The Panel was invited by the Health Board to address the following as part of their work:

1	An understanding of the methodology of how the sample of the clinical records was undertaken for the 2021 RCSE IRM
2	Whether additional independent sampling requires extending to other vascular patient clinical records
3	On conclusion of this work or if deemed urgent at any other point, any other recommendations to be made to the Executive Medical Director as the executive lead for this work
4	Identification of any opportunities to ensure that there is strengthening of staff being able to speak up as a central tenet to BCUHB working

12.2 Regarding question 1: *An understanding of the methodology of how the sample of the clinical records was undertaken for the 2021 RCSE IRM*. Prior to the commencement of the Panel, the internal vascular quality team was provided with a PDF copy of a list of what was understood to be used by the vascular team to gather the records for the RCSE

review. This PDF is titled “Appendix 5 – Clinical Record Log” and appears to be the appendix of an RCSE document. The PDF includes the following headings:

- RCSE number allocated to the record;
- Hospital reference number;
- Patient initials;
- Gender;
- Reviewer (RCSE use);
- Type of procedure;
- Areas to consider i.e. team working, clinical performance, consent pathways. To be completed when Terms of Reference agreed.

12.2.1 The PDF document lists the following:

- Clinical management in the lower limb salvage service;
- Amputation (30-Day mortality);
- Last consecutive 10 amputations;
- Mortality on ITU following transfer from a spoke site;
- Ischaemic leg post #NOF fixation;
- Ischaemic leg;
- Haemorrhage;
- Arm laceration;
- Bilateral limb ischaemia;
- Last consecutive 10 AAA repairs.

12.2.2 The Panel is unaware of other supporting information to help understand how the sample of the clinical records was undertaken for the 2021 RCSE IRM. Therefore, the Panel cannot be assured that this was the definitive methodology.

12.3 Regarding question 2: *Whether additional independent sampling requires extending to other vascular patient clinical records.* It should be recognised that the Panel did not include professional analytical or statistical resources, so cannot formally or expertly comment on sampling size, although the Panel considers that the sample size of 47 appears relatively small and a broadening of case mix would allow a more comprehensive review of service if this should be required. It should also be noted that the external vascular surgical expert has highlighted that in his professional opinion there are ‘gaps’ in the sampling methodology which in his view would most typically represent a contemporary vascular service. Some of these he advises are significant in terms of the overall scope of practice. As the Terms of Reference of the review did not include reviewing additional cases beyond the 47, no conclusions or recommendations for quality improvement could be drawn.

12.4 In a broader point, the external vascular surgical expert highlighted that a number of bypass procedures were noted to have failed, that there was only one bypass procedure that lasted more than 30 days and that statistically, a bypass should have a 70%-80% patency at a year. He acknowledged it was not known how the sampling was undertaken and that either these were selected as cases in which it was already appreciated that there was a poor outcome, or known technical issues with surgery, or it represented

incomplete sampling. It is considered that a detailed thematic analysis of lower limb arterial bypass surgery would be required by the Health Board to understand the sampling and results in more granular detail and offer greater confidence in the findings.

12.5 Regarding question 3: *On conclusion of this work or if deemed urgent at any other point, any other recommendations to be made to the Executive Medical Director as the executive lead for this work.* These recommendations are included within the section on context and recommendations.

12.6 Regarding question 4: *Identification of any opportunities to ensure that there is strengthening of staff being able to speak up as a central tenet to BCUHB working.* Comments on this are included within the section on context and recommendations.

13.0 Proposed Patterns and Themes to Support Quality Improvement

13.1 It must be reiterated that there was no formal analytical or statistical resource aligned to this work, nor was there regarded a need for it within the agreed Terms of Reference and defined parameters of this work. However, as the number of records reviewed progressively increased, Panel members became conscious that some of their findings were repetitive and could be informally identified and proposed as a pattern or theme.

13.2 The Panel was aware that the RCSE had separately published two reports in relation to the 2020/21 BCUHB Vascular Service Invited Review Request. It was agreed that some of the patterns or themes, informally identified and proposed by the Panel, looked like they might potentially map across to some of the findings of the RCSE March 2021 report[8] which addressed areas such as clinical pathways, Multi-Disciplinary Team (MDT) working and clinical governance. A Panel meeting held at the end of June 2022 provided an opportunity to discuss these and following this, an escalation letter to the SRO highlighted synergies in a number of the Panel findings to the RCSE March 2021 findings.

13.3 The Panel's <u>principal</u> deliberation was answering the two questions posed around *whether the sample of patient records contain the information expected for the individual patient episodes of care*, and, *were the necessary and appropriate follow up and aftercare plans put in place*. However, it was agreed that as per the Panel's Terms of Reference, to offer relevant recommendations which could help the current quality improvement work taking place across BCUHB, that a number of themes which were agreed to be repetitive within the findings and associated patterns or themes could be proposed from the information available and recommendations then aligned to them. Although findings spanned various timelines, the Panel in undertaking a quality improvement approach agreed that all findings were useful.

13.4 In no specific order, these themes are proposed as:

- Effectiveness of clinical pathways;
- Clinical governance, including consent and decision-making, accountability, and, professional practice;
- Person-centred care;

[8] Royal College of Surgeons (RCS) Report on the Vascular Surgery Service Betsi Cadwaladr University Health Board Review visit carried out on: 11- 13 January 2021 and Report issued: 15th March 2021;

- Team working, including the multi-disciplinary team;
- Complex pain management;
- Palliative care;
- Education and learning;
- Discharge, and necessary and appropriate follow up and aftercare plans.

13.5 The ability to hear the patient's voice as to what matters to them was an important part of the information considered by the Panel. The Panel considered the broad range of feedback from patients and/or their Next of Kin including both from those who considered their care to be of a high standard, and were delighted with the care received and their associated outcomes, to those who regarded it as a poor standard and had at times previously submitted complaints. The Panel would particularly like to thank those patients and/or Next of Kin who provided this feedback and commentary.

13.6 The importance of actively involving patients and their family, unpaid carers, patient representatives and significant others regarding what matters to them was recognised as being central to the delivery of care and the following points were recognised by the Panel as being evident within the feedback from patients and/or their Next of Kin.

- Importance of effective and compassionate communication, particularly when speaking with families about a patient's poor prognosis;
- Importance of having knowledge and understanding of the care and treatment planning;
- Importance of listening to and respecting patient's wishes;
- The negative impact of the Covid pandemic;
- Importance of effective pain management;
- Importance of effective discharge planning;
- Importance of psychological support.

13.7 This feedback was solely obtained for providing information to potentially assist the Panel's understanding of care delivery. However, it is proposed that there are a number of issues raised that merit further investigation.

14.0 Context and Recommendations

14.1 Initially within this work, the Panel had considered whether it would be helpful to define learning points. However, it was agreed that a section complementary to the 47 individual case reports to provide the context underpinning recommendations is hopefully a more effective approach to supporting relevant quality improvement work. Again, there is a proviso as noted within all the case reports, judgment was made on the information available and conclusions drawn with appropriate caution and caveats aligned to this. It is possible that further information existed in real time, or exists and cannot be found, that would alter some conclusions and by doing so also alter the relevant recommendations. The Panel's varied membership enabled an understanding of cases where local knowledge was helpful or required in the understanding of the context of the delivery of care, particularly in relation to geographies. It was agreed that this did not preclude recommendations being made, but helped the Panel acknowledge the situation at the time, as relevant.

14.2 *Effectiveness of clinical pathways*: Clinical pathways across NHS Wales are in place with an intended outcome that patients' experience and outcomes are improved across the whole system[9]. At an individual patient level, healthcare pathways are described as detailed process maps showing how an individual patient may move through different parts of the system for the investigation, management and treatment of a condition[10]. It is also stated that there is an expectation that Health boards will localise national pathways in a way to reflect the needs of their populations and the characteristics of their workforce.

Context

The Panel identified a lack of recorded evidence around the consistent application of effective clinical pathways, particularly querying as to how staff were engaging and/or understanding the process across the Multi-Disciplinary Team (MDT). It was considered that this could potentially lead to a clinical service working to a model of care, which from both a patient and clinician perspective could be identified as sub-optimal.

The diabetic foot pathway was particularly identified as requiring clarity around structure and efficacy.

There were identified delays in the pathways of care, which might be due to the timing of certain cases during the Covid pandemic; however, it was also acknowledged that there was a risk that this might also be due to more established barriers to care.

Associated findings underpinning the proposed recommendations are:

- It is acknowledged that a process may be in place within BCUHB, however, the Panel, was unclear as to where the 'ownership' and clinical governance of clinical pathways sat/sit. The Panel also queried how clinical pathways were/are developed, implemented, embedded, and remain fit for purpose.

- The Panel identified a lack of clarity particularly around the diabetic foot pathway, as it appeared to vary across the Health Board, and there did not appear to be a definitively agreed pathway with all relevant staff understanding and/or engaged with an agreed model. A number of case studies prompted Panel discussion as to the fact that it remains unclear as to which part of the diabetic foot pathway goes where and the difficulty to understand specific stages of care across the different areas of the Health Board, particularly as to the delineation of care between a 'diabetic foot' and peripheral vascular disease.

- It was queried on a number of occasions as to whether the podiatry team could directly refer patients to the vascular team.

- The external vascular surgical expert in his role as expert Panel opinion explained that the role of vascular surgeons in trauma is only to manage defined major vessel injuries. This highlighted whether the current trauma model adequately addresses patients requiring vascular consultant assessment, and conversely patients where bleeding is present but do not require specialist vascular input.

[9] https://www.wales.nhs.uk/ourservices/unscheduledcareimprovement/pathwaysandoutcomemeasures
[10] Welsh Government (2021) National Clinical Framework: A Learning Health and Care System

- A Serious Incident Review (SIR), albeit historical, concluded that there was a lack of ownership of patient care with little evidence of holistic shared decision-making and adherence to the vascular pathway, with confliction of opinion between clinicians and sites noted. Several recommendations were raised; however, the Panel was unable to identify whether the action plan had been completed and the improvements that had followed.

- It is clear that a number of stakeholders out with BCUHB are involved in the use of the pathways, such as ambulance service colleagues. The Panel agreed that a wide approach to co-production in the development and implementation of pathways is essential.

- The Panel highlighted that the identification of transferring of a patient back to the Emergency Department simply for a urinary catheter as seeming very unusual within a modern pathway of care.

- On review of a number of the notes, patients were often recorded, as reporting anxiety and low mood, and post-amputation there appeared to be regular referral to liaison psychiatry, including at times sadly, for suicidal ideation. The Panel considered that there was evidence of the significant psychological impact that vascular disease has on the lives of those affected.

Recommendations:

1. There is a requirement to ensure that there is clarity, engagement and ownership across all BCUHB sites as to the workings of the vascular hub and spoke model. It is recognised that there will be different mechanisms required for elective and non-elective patients. Mechanisms for local review of patients, clear assessment, referral and transfer pathways within the vascular network, and standards for identifying patients who are unfit for transfer should be clarified. It is recommended that these should include audit of those who deteriorate in transfer to provide learning to help prevent unnecessary transfers, an exploration of how well integrated the stroke and vascular teams are, in addition to what treatment options are available locally for acute stroke; and, the psychological support offer to vascular patients.

2. 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.

3. It is considered that all clinical pathways should be the result of internal and external multi-disciplinary and lay co-production to ensure ongoing fitness for purpose, identification of any required staff training, and should ensure staff and patients have an ability to feedback on any associated opportunities or challenges as to their use within practice or on receipt of care.

14.3 *Clinical Governance:* The Welsh Government emphasises the importance of local organisations applying quality system methodology and the duties of quality and candour.

It reinforces the need for clinical teams to embed quality assurance cycles and clinicians to adopt prudent in practice behaviours. It highlights the importance of using data on what matters to patients and how the integrated healthcare system is working to guide service development[11]. Clinical governance is a well-established principle in NHS organisations and was historically described for NHS Wales as having an aim of ensuring that the clinical care, patient's experiences and outcomes provided by organisations are of the highest quality. It brings together existing strands of quality initiatives to form a cohesive quality monitoring and improvement programme[12].

Consent and decision-making

Context:

In a number of cases, the Panel could not find documented evidence of adequate discussion of all the significant and material risks, benefits and alternatives of treatment(s) required for a patient to provide fully informed consent. The panel also identified cases where, on the basis of available information, appropriate ceilings of treatment, including Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) and critical care admission could have been considered at an earlier stage. It was also noted that decisions about ceilings of treatment were sometimes initiated by the medical and ITU outreach teams in crisis situations.

Associated findings underpinning the proposed recommendations are:

- From the information available, the Panel considered there was a lack of clarity in several cases as to whether all treatment options including conservative treatment, had been considered by the Multi-Disciplinary Team (MDT) and discussed with the patient in the subsequent consent dialogue.

- A number of patients within the review sample were identified as being elderly, and some patients were also identified to be confused, or had an established diagnosis of cognitive impairment. Whilst understanding that there is a presumption of capacity, and capacity may fluctuate, in some cases the panel wondered whether formal capacity assessments should have been undertaken where treatment decisions were being made or consent obtained, and there was reason to doubt the decision-making capacity of the patient. It is acknowledged that relevant assessments may have been undertaken, however, no supporting documentation could be found in the medical records. It should be noted that the Panel also identified cases where the best interests' decision-making framework was appropriately applied and recorded.

- It was noted that a number of debridement procedures were undertaken in clinic for which no consent forms could be identified. The external vascular surgical expert explained that this is not atypical for debridement of a neuropathic foot in clinic where the patient is not sedated and not under a block or anaesthetic. The Panel agreed that it is good practice to confirm that consent was obtained verbally in the procedure note.

[11] Welsh Government (2021) National Clinical Framework: A Learning Health and Care System
[12] http://www.wales.nhs.uk/Publications/clinical-governance-e.pdf

In some cases, debridements were performed, but no related documentation could be identified within the medical records.

- In several cases, the Panel considered admission assessments and related documentation to be limited in scope, failing to provide a holistic and comprehensive overview of patients' medical problems and social circumstances, focusing instead on the affected limb. The panel considered that more holistic assessments may have informed subsequent discussions with patients about treatment options, anticipated outcomes and appropriate ceilings of treatment,

- The Panel noted that on a number of occasions, patients' faces were inappropriately visible in medical photographs of limbs with a lack of evidence of consent forms relating to these, or recognised compliance with Information Governance.

- The Panel noted the good practice of patient information leaflets available for EVAR and open AAA and routinely given out at the Pre-Operative Assessment Clinic (POAC), and with the invitation letter for surgery.

Recommendations:

4. It is recommended that the Health Board undertake an ongoing review of consent processes within the organisation so that assurance can be provided in that practices are consistent with the legal and regulatory frameworks, and any necessary quality improvement can be undertaken. All staff should be aware of the BCUHB consent policy and ensure that consent processes are consistent with this policy. This should include an understanding that consent relates to all aspects of patient care and treatment, and is not just about specified procedures; there should be evidence of an ongoing dialogue with the patient – shared decision-making - within the medical records.

5. It is recommended that the Health Board ensures that relevant training is provided to all clinicians about the application of the Mental Capacity Act (2005)[13] in clinical practice, including the assessment of mental capacity and best interests' decision-making.

6. It is recommended that a comprehensive and holistic assessment of patients' medical problems and social circumstances is routinely undertaken in all cases on admission to hospital. It may be appropriate to undertake regular audits of medical documentation to provide related assurance.

Accountability, Oversight and Continuity of Care

Context:

The Panel queried as to who had the overall accountability and oversight of care of patients during their whole admission, and the potential impact identified on areas of care if this was unclear. These included examples where:

[13] https://www.legislation.gov.uk/ukpga/2005/9/contents

- A patient was being cannulated frequently and the Panel identified a need for oversight of recognising that a stage has been reached where insertion of a long-line may be a more viable and comfortable option;
- Delays identified in moving towards a robustly agreed plan, resulting in extended lengths of stay and for some, repeated interventions;

The Panel acknowledged that models may differ in organisations and countries and that one size may not always fit one. However, questions arose as to understanding how the function and oversight of the responsible clinician worked in relation to areas such as decision-making and consent, including ceilings of treatment and end of life care, leadership and supervision, and effective use of the wider MDT; particularly with patients who had extensive co-morbidities and several specialities involved in their care.

Associated findings underpinning the proposed recommendations are:

- It was agreed that there appeared to be a risk of a potential lack of co-ordination of care for patients as different specialities that may need to be involved might not be aware that a patient under their care has been admitted.

- A number of patients had several Datix submissions logged for them individually, and while Datix submissions positively support the principle of a learning organisation, the Panel questioned as to how oversight of this collective data was provided for individual patients and what might trigger the realisation that a possible pattern or risk was escalating. Cases were identified for example, with a high number of falls, or a number of pressure ulcers, and it was considered that there should have been a process in place for proactively recognising this and recording actions then taken, with subsequent monitoring and evaluation.

- The external vascular surgical expert discussed the procedure for the reporting of death and the understanding that, as per local practice, a death within the acute hospitals is not routinely reported, unless there is an incident associated with it. The external vascular surgical expert considers that for an elective death, especially an elective aortic surgical death, that there would be an expectation of a Datix to be completed, as it is an unexpected death, thus demonstrating the seriousness of this. The process within BCUHB is that an unexpected death within the theatre setting would be reported via the Datix system, however, if the death occurred post-surgery on ITU (for example), then the death is more than likely not considered to be unexpected and a Datix report would not be raised unless there was a perceived incident. It is also probable that this is likely a condition of the Wales Abdominal Aortic Aneurysm Screening Programme (WAAASP).

Recommendations:

7. There is a requirement for clear arrangements to be in place to agree who has the overall accountability for a vascular patient, particularly within the ‘spoke’ hospitals. This should include agreement as to what kinds of cases are suitable to sit outside the hub as in-patients. The external vascular surgical expert explained that within the ‘spokes’ the vascular surgeons will be visiting specialists and not present every day and the construct must take account of this and be supported by roles such as Clinical

Nurse Specialists within the 'spokes' to provide continuity of care and daily review. It is considered that vascular patients in the 'spokes' should be under the overall care of another team such as diabetology, general surgery or orthopaedics. This is a matter of local agreement to agree and different models exist and are successful. This should also include an identified process to ensure oversight of collective data for individual patients and the triggering of possible pattern or risk escalating.

8. There is a requirement to ensure care is progressed rather than delayed to wait for a weekly MDT meeting. It is considered that this should be underpinned by relevant daily geriatrician (Care of the Elderly) input into vascular surgical cases, sufficient critical care capacity to support major vascular cases in co-morbid patients, and robust links with the palliative care team. Sufficient capacity and expertise in interventional radiology, or vascular surgeons with an independent endovascular practice, is critical to advance care and avoid the delays in care observed in some cases.

Standards of Documentation

Context:

It is fair to say that for practically every record reviewed within this piece of work, that the poor physical condition and arrangement of the paper records themselves caused significant challenges around ease of navigation and the ability to view the patients' care, present and past. Consequently, as noted within all the case reports, judgment was made on the information available and conclusions drawn with appropriate caution and caveats aligned to this. It is possible that further information existed in real time, or exists and cannot be found, that would alter some conclusions.

This poor record keeping and administration was a significant finding of the review, as there were often gaps in the records, and on several occasions further searches undertaken and additional clinical records then identified. If this occurs during day-to-day clinical business then this could be a potential risk to patient care, not to mention a significant inconvenience and inefficiency, to be frequently searching for additional records.

The Panel's local knowledge enabled an understanding of some of the processes across the Health Board which clinicians have been dependent on, such as a radiology report often shared via paper and the potential delays that may come with this. Additionally, the process of requesting ultrasound scans on paper could also take additional time. It is acknowledged that some of those processes have now changed; however, the Panel agreed that it was important to recognise historical process.

Additionally, the external vascular surgical expert queried whether the vascular team might lack suitable administrative support for the M&M and MDT processes.

Associated findings underpinning the proposed recommendations are:

- The Panel escalated on a weekly basis a number of repetitive issues around the standards of documentation. The Panel was aware of the importance of the provision

of clear records and plans for the delivery of contemporary care, as well as for possible retrospective scrutiny[14].

- Notes from Occupational Therapy (OT), Physiotherapy, Podiatry, Orthotics, and Dietetics were considered to be of a good standard, although they are held separately from the main clinical records. It was considered that data sitting separately on the application 'Therapy Manager' could be considered a risk if it is not available to other clinicians. A similar concern was raised around documentation being potentially placed within a POAC file, or a patient review documented on a separate anaesthetic chart. The Panel is aware that read-only access is now available to non-therapists to review the notes.

- Allied Health Professional documentation was consistently in line with expected standards of practice[15] and it was explained that there is a particular structure used nationally across the AHP professions – SOAP. 'S' is the subjective, which is anything a patient tells the therapist, or what the therapist has observed. The 'O' is the objective, which is the measurable information, which includes test results, range of movement and something that is quantifiable. 'A' is assessment or analysis and covers what the therapist has found from their review of a patient. 'P' is the plan for a patient.

- The external vascular surgical expert raised that there seemed to be an inappropriate delay between clinics occurring and letters being typed/approved.

Recommendations:

9. The use of an electronic health record across all BCUHB sites would be of significant assistance in improving the quality, governance and accessibility of medical documentation, including the use of the appropriate observations, and access to patient diagnostic results. The Panel recognises that there is work in progress. An electronic health record is recognised as an important single place for documentation from all medical, nursing and allied health professional staff. It is considered that moving to electronic notes would make keeping matters chronological and legible an easier task and is proposed as a priority. It would reduce risk in the system and improve accountability. Similarly, it is considered that having a single source of records for the professions would be more useful, and safer, than multiple parallel systems or entirely separate notes.

10. The Panel acknowledged that they have a lack of understanding as to process within the vascular department and the levels of administrative support provided. However, it was agreed that letters should be dictated, typed, approved and sent out in a timely fashion. Experience within other organisations demonstrates that modern voice-to-text dictation systems or electronic dictation outsourcing has helped achieve this task with electronic workflows and can provide a cost-effective, highly efficient and governable

[14] General Medical Council (2020) Good medical practice; and, General Medical Council (2020) Leadership and management for all doctors. And, Nursing and Midwifery Council (2018) The Code Professional standards of practice and behaviour for nurses, midwives and nursing associates.
[15] https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/

service that brings with it entirely digital workflows. Either option have been the standard of care in many hospitals for many years and if not in place already should be explored with urgency to help improve communication.

11. The provision of a signature stamp to registered healthcare professionals is recommended to ensure that they can more easily demonstrate who has reviewed the patient within the records. It is considered that this requirement would be removed by electronic health records in which every entry is digitally stamped in any event.

12. It is considered that more co-ordination on an MDT level in terms of documentation is required. The Panel considered within a network environment, an MDT co-ordinator was a crucial ln important role for the sustainability of a network, and the requisite documented MDT evidence required on a weekly basis. It is recommended that if this role is not in place already BCUHB should seek to recruit to such a position as a priority.

14.4 *Person-centred care*: The National Clinical Framework (Welsh Government 2021) highlights the importance of using data on what matters to patients and how the integrated healthcare system is working to guide service development[16]. The Framework raises the importance of understanding the patient's perception of symptoms, treatment, rehabilitation and its outcomes, as well as supporting a more individualised service.

Context:

The Panel recognised that patients have different things that matter to them as individuals, and that what matters to patients is often transitional as they move through their journey of care[17].

Associated findings underpinning the proposed recommendations are:

- There was evidence of service user engagement and shared decision-making provided within the feedback from a number of patients and/or their Next of Kin. However, within the majority of the information that was available to the Panel there was a lack of recorded evidence of this; including capturing of individual person-centred needs, such as cultural, spiritual and lifestyle, and the impact this might have on a patient's illness and condition.

- The recording of patient-centred goals was absent on occasions, with a lack of details surrounding options, associated clinical reasoning and diversity of views.

Recommendations:

13. It is considered that there is a need for all staff to understand the importance of person-centred care to link with patient communication, choice, empathy, active listening decision-making and carer involvement.

[16] Welsh Government (2021) National Clinical Framework: A Learning Health and Care System
[17] Social Services and Well-being (Wales) Act 2014

14. It is recommended that a more systematic way should be put in place for communicating with families to keep them informed, particularly in challenging times such as the pandemic.

14.5 *Team working, including the multi-disciplinary team*: MDT working is defined within the Welsh Government Standards (2020)[18] for public services in relation to 'Providing a good service' as a team of people with a diverse mix of skills and expertise. It also states that 'it's important that people who make decisions are part of the team, so they're accountable, and so that the whole team can respond quickly to user needs'.

Context:

From the information available, the Panel considered that there was often a lack of evidence identified and/or recorded of multi-disciplinary team working and clinical leadership to ensure a collective, holistic and compassionate approach to the delivery of patient assessment and care within several cases.

Associated findings underpinning the proposed recommendations are:

- The Panel considered that on occasions there appeared to be related implications of the maturity of teams when interacting with other services. Additionally, having a clear 'chain of command' within services from FY1 to registrar to consultant was considered important, especially from a support and learning perspective, and this could be identified when it was working well.

- The Panel debated the use and definition of 'MDT' in use throughout the review. The Panel concluded that the descriptor was often referring to a specific specialty model of a MDT, such as vascular surgeons. Terminology which is often used can be open to interpretation in relation to the term 'MDT', and suggest a range of professions and opinions have been involved in a discussion, which then in practice appeared to reflect a much smaller defined group of professionals. It was agreed that it is important to differentiate between these different models. It was also agreed that MDTs should include broader professional representation, and without this, it was not truly a 'holistic' MDT.

- The lack of a broad multi professional MDT has been recognised as having potential implications for a number of patients. This has included identified issues such as the risk of not including podiatry and prosthetics professional opinions, which then could have implications for the future ability to tolerate or indeed be able to have a prosthetic limb applied.

- It was noted on several occasions that the daily input of a geriatrician (Care of the Elderly) could have helped the overall medical course of certain patients as it is recognised the role this position has in strengthening links to other teams such as the palliative care and the stroke teams.

[18] https://gov.wales/6-have-multidisciplinary-team

- The external vascular surgical expert explained that Charcot foot is rare and requires very specific expertise. There would be a benefit in establishing a defined lower limb MDT with membership of experienced individuals in the management of the Charcot arthropathy and deformity. It was suggested that this is undertaken at a supra-regional level as it would be unrealistic to consider that North Wales has a sufficient population of patients with Charcot foot to hold an MDT around this in isolation and so it may be that links further afield are sought.

- It was noted that a vascular specialist registrar (SpR) was required to call the radiology consultant on call to approve a CT scan, and that this was explained by the expert vascular surgical expert as a very old-fashioned model of care, which should be discouraged. He advised that CT scanning should be available '24/7/365' to patients that require it and although it is acknowledged that no resistance is recorded regarding requesting the scan in question, it is suggested that there could be a more streamlined mechanism possible for out-of- hours CT scanning.

- It is considered that the policy and practice of bypass graft imaging intra-operatively and post operatively needs to be reviewed. The external vascular surgical expert from his own professional experience recommends that there should be a clear Standard Operating Procedure (SOP) for intra-operative completion imaging with on table angiography in combination with handheld Doppler. Post-operatively patients with bypass grafts should have a duplex scan before discharge and then be entered on a formal graft surveillance programme with appropriate administrative support. Similarly, patients undergoing EVAR or lower limb endovascular stenting procedures must be entered into a defined surveillance programmed. The external vascular surgical expert acknowledges that this may be in place but is not apparent for bypass, there was no clear evidence of completion imaging, and surveillance imaging appeared to be uncoordinated and done on an ad hoc basis.

- The Panel is aware that the RCSE provides guidance on Morbidity and Mortality (M&M)[19] meetings for what the college describes "as a key activity for reviewing the performance of the surgical team and ensuring quality". The college describes a surgical M&M meeting having "a central function in supporting services to achieve and maintain high standards of care". The Panel identified a lack of recorded evidence in the information available of M&M discussion in a number of cases; this led to the perception of an associated lack of professional reflection or discussion of learning or future planning in these cases. It is also considered that M&M meetings should discuss deaths, whether elective or non-elective cases, to ensure learning.

- It was identified that a number of patients spent some months waiting for their leg ulcers to heal with an apparent lack of consideration of the cardio-respiratory and muscular impact that prolonged periods of rest may lead to. The Panel considered that a strengthened holistic MDT approach would help ensure that patients retained their physical fitness to ensure that they are in the best possible position to have significant surgery and engage in rehabilitation afterwards.

[19] https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/good-practice-guides/morbidity-and-mortality-meetings/

Recommendations:

15. It is recommended that there could be a more streamlined mechanism possible for out-of- hours CT scanning. It is considered that in practical terms a vascular hub requires an on-site CT radiographer in and out of hours to undertake these scans with the required urgency. Included within this recommendation is a need to review the model for vetting scans to ensure that it is appropriate for current practice and workloads.

16. It is recommended that the policy and practice of bypass graft imaging intra-operatively and post operatively needs to be reviewed. It is recommended that there should be a clear Standard Operating Procedure (SOP) for intra-operative completion imaging with on table angiography in combination with handheld Doppler. It is acknowledged that this may be in place but is not apparent.

17. It is recommended that there would be a benefit in establishing a defined lower limb MDT with membership of experienced individuals from the wider MDT such as podiatry and orthotics in the management of the Charcot arthropathy and deformity.

18. It is recommended that there needs to be consideration of the make-up of any speciality 'MDT' meetings to ensure they have the correct diverse mix of medical and non-medical skills and expertise.

19. The daily input of a geriatrician (Care of the Elderly) into vascular surgery is recommended through a consultant geriatrician/Care of the Elderly being embedded within the vascular unit.

14.6 *Complex Pain Management*: It is recognised that patients with vascular disease frequently experience significant pain and management is complex due to the nature of the pain, as well as patients often have a number of co-morbidities, which should influence the prescribing of certain analgesics.

Context:

The Acute Pain team was highly commended by the Panel, both for their identified practice and their documentation. However, it was agreed that there were still many challenges identified in relation to the complex management of vascular pain.

Associated findings underpinning the proposed recommendation are:

- Post-amputation a number of patients appeared to be discharged on multiple analgesics with no identified reduction plan in place despite the cause of the pain being removed. It was noted that often it could be left to the GP to undertake this difficult task and often these are powerful drugs, which have significant side-effects, which could interfere with rehabilitation.

- It is identified that many patients had escalating doses of strong opiates. It is considered that for larger doses the risks of side-effects outweigh the potential analgesic benefits. The risks of opiate induced hyperalgesia does not always seem to be recognised. Many patients were noted to be on multiple types of anti-neuropathic

agents such as amitriptyline and gabapentin with no obvious benefit identified but these appear to be carried on.

- It was noted that within a number of cases when the limb became critically ischaemic that the pain seemed to switch to being more neuropathic in nature and appears almost impossible to control. It is considered that at this point those delays should be particularly avoided to prevent suffering rather than administering escalating doses of opiates that do not provide analgesia.

- It was noted that post-amputation a number of patients appeared to be discharged on multiple analgesics with no identified reduction plan in place despite the cause of the pain being removed.

Recommendation:

20. It is recommended that there is a need for a vascular pain management pathway to be implemented across the Health Board.

14.7 *Palliative Care:* Palliative care is the active holistic care of patients with advanced, progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments.[20]

Context:

The Panel identified from the information available within a number of cases, that a recurrent theme was the under-utilisation of palliative care and that the palliative care aspect and/or options appeared to be considered/actioned late in a number of cases.

Associated findings underpinning the proposed recommendation are:

- There were a number of cases where it was considered that palliative options should have been discussed along with the significant risks of post-operative cognitive decline and rapid physical deterioration and the implications for independent living and quality of life.

- The need for robust links between the palliative care team and the vascular service was identified on a number of occasions.

- The Panel commended the practice of the palliative care team when it was demonstrated within a number of cases.

Recommendation:

[20] References | Palliative care - general issues | CKS | NICE

21. It is recommended that there is a need for ensuring robust links between the palliative care team and the vascular service.

14.8 *Education and Learning*: NHS Wales Shared Partnership Services describe a learning organisation as one where people continually expand their capacity to improve[21]. The National Clinical Framework: A Learning Health and Care System (2021)[22] states that a learning healthcare system can use continuous data collection and analysis to determine which models work best or where service needs to improve.

Context:

The Panel considered on a number of occasions there was a lack of evidence of professional reflection and evidence of discussion of learning or future planning identified.

This also led to a query as to how the service was utilising a process of quality assurance to meet the required standards such as audit and embracing quality improvement within the wider quality management system for assurance.

Associated findings underpinning the proposed recommendation are:

- The Panel identified on occasions there was a lack of identified recorded assurance that actions from investigations such as Serious Incident Reviews were being undertaken, evaluated and embedded. The Panel queried as to how the SIR findings were shared with the relevant teams once the report was available as it was considered that the Health Board should have assurance that this was completed and learning shared. An update has been provided that as a result of changes in investigation processes and a change in the Datix reporting software, all Investigation Officers are required to produce evidence that all actions have been completed and evidence that learning has been shared. The Patient Safety Team logs actions on Datix, and only when they have closed any outstanding actions can the Datix be closed.

- From the limited recorded information available, there was a perception of a lack of outcomes or content from Morbidity and Mortality (M&M) meetings and associated professional reflection and learning.

- The external vascular nursing expert questioned on a number of occasions the lack of evidence of use of a number of vascular specific observations and highlighted that if not already in place, that education and training for staff such as in the recognition of an ischaemic leg, and the associated documentation of that process would be helpful.

- Findings identified various education opportunities with significant opportunity for clinical learning if the appropriate supervision is in place. At times the information available appeared to point to long ‘across-hospital’ ward rounds taking place, with the pressure to complete jobs in the afternoon, as seen by the times the junior doctors entered times in the patient notes.

[21] https://nwssp.nhs.wales/a-wp/governance-e-manual/being-a-learning-organisation/
[22] Welsh Government (2021) National Clinical Framework: A Learning Health and Care System

- The external vascular nursing expert on the Panel with her specialist experience identified a number of areas where education and training might be required. These are:
    - The use of neurovascular observations as part of regular observations by nursing staff;
    - The use of thrombolysis guidelines to check puncture/sheath sites for possible bleeding and to aid nursing staff looking after the patient;
    - The use of guidelines for the monitoring of Iloprost;
    - The use of the Rutherford Scale, or equivalent, in relation to limb ischaemia;
    - The use of a MUST (Malnutrition Universal Screening Tool) for A30's nutrition intake and weight, and the association of how a patient's weight plays into consideration of an amputation.

Recommendations:

22. It is considered that the BCUHB education and training programme includes updates for staff in areas of vascular practice and monitoring, such as the recognition of an ischaemic leg, and the associated documentation of that process.

14.9 *Discharge, and necessary and appropriate follow up and aftercare plans:* The RCSE report recommended that scrutiny should be applied of whether the necessary and appropriate follow up and aftercare plans were in place for a number of patients. This was expanded to all 47 cases and each individual case report has specific detail aligned to its' own review.

Context:

The expectation for early safe discharge within NHS Wales is that health and social service partners agree and implement processes, which facilitate early safe discharge following unscheduled admissions. The intended outcome is that patients have an appropriate length of stay and are discharged in a planned co-ordinated way with suitable support services[23].

The Panel also recognised that the consequences of the pandemic might also have heightened the risk of the unintentional discontinuation of care, or potential lack of referral.

Associated findings underpinning the proposed recommendations are:

- The Panel identified the subsequent consequences of a lack of identified effective discharge planning resulted in an extended hospital stay.

- The importance of good communication regarding discharge and follow up plans, whether via discharge letters to GPs and podiatrists or other communication with primary or community care organisations were also identified as important.

- It was also considered that even if a service is under pressure, discharge should be safely assessed and documented with the relevant mitigation put in place to reduce

[23] http://www.wales.nhs.uk/ourservices/unscheduledcareimprovement/dischargeplanning

any possible safety risks. If this is not possible then staff should escalate as appropriate.

- Careful consideration of timings of discharge were also identified as important, as this could present associated risk, particularly for the frail and elderly, and/or those who may live alone. The Panel acknowledged that internal pressures can adversely and urgently affect patient flow, however, advised that the assessment of risk must underpin all decision-making by healthcare professionals and the Panel queried whether clear guidelines are in place to ensure this, require updating or review.

- The Panel identified that in relation to patients who 'Did Not Attend' that there was also a correlation to a high or low risk classification, however, it was unclear how the assessment of any required intervention or safeguarding risk was applied. Expert Panel safeguarding membership confirmed that there was BCUHB work in the stages of being completed addressing this, based on regional engagement with Local Authority.

- There was some evidence of effective discharge planning liaising with single point of access (SPOA) and Therapies identifying ambulatory issues with provision of home appliances and adaptions to the patients' properties.

- There was recognition that ward staff liaised with nurses working within the community such as the following up of wound checks and dressing changes. It was also recognised by the Panel that there was evidence of lower limb wound review follow up in the ward clinic with some evidence of open access.

Recommendations:

23. A review of discharge pathways and guidelines is recommended to ensure they remain fit for purpose. It is considered that this should include board rounds involving the broad MDT, early discharge planning with an expected date of discharge (EDD) decision on admission, and special consideration of patients undergoing amputation who may need assessment of future appropriateness of accommodation and potential appliances required. Guidance on discharge at times of acute pressure and assessment of risk underpinning all decision-making by healthcare professionals should also be included.

24. It is recommended that 'What matters' documentation must be completed for all vascular patients to enable personal wishes to be heard, with evidence of sharing this information if relevant with the appropriate authorities prior to discharge.

14.10 As noted within this report, a number of escalations were previously made in relation from both the wider Panel and the external vascular surgical expert within their initially separate ways of working *(Appendix 2*). There were three specific recommendations that stand and are included within this report for completeness. These are:

25. The aortic MDT should be held in conjunction with a large regional complex aortic unit for all aortic cases.

26. Dual consultant surgery is the standard of care for major vascular surgery and job planning and services should be configured to make this routine practice. It is considered for most vascular 'hubs' this is now the standard of care.

27. The Health Board should source an experienced specialist aortic surgeon who is currently able to be present for aortic cases.

Table three sets out the recommendations collectively: again, there is a proviso as noted within all the case reports, judgment was made on the information available and conclusions drawn with appropriate caution and caveats aligned to this. It is possible that further information existed in real time, or exists and cannot be found, that would alter some conclusions and by doing so also alter the relevant recommendations.

RECOMMENDATIONS	
1	There is a requirement to ensure that there is clarity, engagement and ownership across all BCUHB sites as to the workings of the vascular hub and spoke model. It is recognised that there will be different mechanisms required for elective and non-elective patients. Mechanisms for local review of patients, clear referral, assessment and transfer pathways within the vascular network, and standards for identifying patients who are unfit for transfer should be clarified. It is recommended that these should include audit of those who deteriorate in transfer to provide learning to help prevent unnecessary transfers, an exploration of how well integrated the stroke and vascular teams are, in addition to what treatment options are available locally for acute stroke; and, the psychological support offer to vascular patients.
2	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.
3	It is considered that all clinical pathways should be the result of internal and external multi-disciplinary and lay co-production to ensure ongoing fitness for purpose, identification of any required staff training, and should ensure staff and patients have an ability to feedback on any associated opportunities or challenges as to their use within practice or on receipt of care.
4	It is recommended that the Health Board undertake an ongoing review of consent processes within the organisation so that assurance can be provided in that practices are consistent with the legal and regulatory frameworks, and any necessary quality improvement can be undertaken. All staff should be aware of the BCUHB consent policy and ensure that consent processes are consistent with this policy. This should include an understanding that consent relates to all aspects of patient care and treatment, and is not just about specified procedures; there should be evidence of an ongoing dialogue with the patient – shared decision-making - within the medical records.
5	It is recommended that the Health Board ensures that relevant training is provided to all clinicians about the application of the Mental Capacity Act (2005) in clinical practice, including the assessment of mental capacity and best interests' decision-making.
6	It is recommended that a comprehensive and holistic assessment of patients' medical problems and social circumstances is routinely undertaken in all cases on admission to hospital. It may be appropriate to undertake regular audits of medical documentation to provide related assurance.
7	There is a requirement for clear arrangements to be in place to agree who has the overall accountability for a vascular patient, particularly within the 'spoke' hospitals. This should include agreement as to what kinds of cases are suitable to sit outside the hub as in-patients. The external vascular surgical expert explained that within the 'spokes' the vascular surgeons will be visiting specialists and not present every day and the construct must take account of this and be supported by roles such as Clinical Nurse Specialists within the 'spokes' to provide continuity of care and daily review. It is considered that vascular patients in the 'spokes' should be under the overall care of another team such as diabetology, general surgery or orthopaedics. This is a matter of local agreement to agree and different models exist and are successful. This should also include an

	identified process to ensure oversight of collective data for individual patients and the triggering of possible pattern or risk escalating.
8	There is a requirement to ensure care is progressed rather than delayed to wait for a weekly MDT meeting. It is considered that this should be underpinned by relevant daily geriatrician (Care of the Elderly) input into vascular surgical cases, sufficient critical care capacity to support major vascular cases in co-morbid patients, and robust links with the palliative care team. Sufficient capacity and expertise in interventional radiology, or vascular surgeons with an independent endovascular practice, is critical to advance care and avoid the delays in care observed in some cases.
9	The use of an electronic health record across all BCUHB sites would be of significant assistance in improving the quality, governance and accessibility of medical documentation, including the use of the appropriate observations, and access to patient diagnostic results. The Panel recognises that there is work in progress. An electronic health record is recognised as an important single place for documentation from all medical, nursing and allied health professional staff. It is considered that moving to electronic notes would make keeping matters chronological and legible an easier task and is proposed as a priority. It would reduce risk in the system and improve accountability. Similarly, it is considered that having a single source of records for the professions would be more useful, and safer, than multiple parallel systems or entirely separate notes.
10	The Panel acknowledged that they have a lack of understanding as to process within the vascular department and the levels of administrative support provided. However, it was agreed that letters should be dictated, typed, approved and sent out in a timely fashion. Experience within other organisations demonstrates that modern voice-to-text dictation systems or electronic dictation outsourcing has helped achieve this task with electronic workflows and can provide a cost-effective, highly efficient and governable service that brings with it entirely digital workflows. Either option have been the standard of care in many hospitals for many years and if not in place already should be explored with urgency to help improve communication.
11	The provision of a signature stamp to registered healthcare professionals is recommended to ensure that they can more easily demonstrate who has reviewed the patient within the records. It is considered that this requirement would be removed by electronic health records in which every entry is digitally stamped in any event.
12	It is considered that more co-ordination on an MDT level in terms of documentation is required. The Panel considered within a network environment, an MDT co-ordinator was a crucial In important role for the sustainability of a network, and the requisite documented MDT evidence required on a weekly basis. It is recommended that if this role is not in place already BCUHB should seek to recruit to such a position as a priority.
13	It is considered that there is a need for all staff to understand the importance of person-centred care to link with patient communication, choice, empathy, active listening decision-making and carer involvement.
14	It is recommended that a more systematic way should be put in place for communicating with families to keep them informed, particularly in challenging times such as the pandemic.
15	It is recommended that there could be a more streamlined mechanism possible for out-of- hours CT scanning. It is considered that in practical terms a vascular hub requires an on-site CT radiographer in and out of hours to undertake these scans with the required urgency. Included within this recommendation is a need to review the model for vetting scans to ensure that it is appropriate for current practice and workloads.
16	It is recommended that the policy and practice of bypass graft imaging intra-operatively and post operatively needs to be reviewed. It is recommended that there should be a clear Standard Operating Procedure (SOP) for intra-operative completion imaging with on table angiography in combination with handheld Doppler. It is acknowledged that this may be in place but is not apparent.
17	It is recommended that there would be a benefit in establishing a defined lower limb MDT with membership of experienced individuals from the wider MDT such as podiatry and orthotics in the management of the Charcot arthropathy and deformity.
18	It is recommended that there needs to be consideration of the make-up of any speciality ‘MDT’ meetings to ensure they have the correct diverse mix of medical and non-medical skills and expertise.

19	The daily input of a geriatrician (Care of the Elderly) into vascular surgery is recommended through a consultant geriatrician/Care of the Elderly being embedded within the vascular unit.
20	It is recommended that there is a need for a vascular pain management pathway to be implemented across the Health Board.
21	It is recommended that there is a need for ensuring robust links between the palliative care team and the vascular service.
22	It is considered that the BCUHB education and training programme includes updates for staff in areas of vascular practice and monitoring, such as the recognition of an ischaemic leg, and the associated documentation of that process.
23	A review of discharge pathways and guidelines is recommended to ensure they remain fit for purpose. It is considered that this should include board rounds involving the broad MDT, early discharge planning with an expected date of discharge (EDD) decision on admission, and special consideration of patients undergoing amputation who may need assessment of future appropriateness of accommodation and potential appliances required. Guidance on discharge at times of acute pressure and assessment of risk underpinning all decision-making by healthcare professionals should also be included.
24	It is recommended that 'What matters' documentation must be completed for all vascular patients to enable personal wishes to be heard, with evidence of sharing this information if relevant with the appropriate authorities prior to discharge.
25	The aortic MDT should be held in conjunction with a large regional complex aortic unit for all aortic cases. This recommendation was previously escalated (*Appendix 2*).
26	Dual consultant surgery is the standard of care for major vascular surgery and job planning and services should be configured to make this routine practice. It is considered for most vascular 'hubs' this is now the standard of care. This recommendation was previously escalated (*Appendix 2*).
27	The Health Board should source an experienced specialist aortic surgeon who is currently able to be present for aortic cases. This recommendation was previously escalated (*Appendix 2*).

14.11 *Speaking Up:* The Panel was invited to consider whether staff were able to be confident in their position, no matter their role, or where they work, to speak up. The Panel discussed this on a number of occasions and agreed it was difficult to ascertain from the information available as to whether staff were able to do so or not. There were only a very small number of instances identified as recorded within the notes available, which demonstrated this.

- A member of staff raised in October 2017, that they did not consider themselves competent in managing thrombolysis when the patient they were caring for, required it to be undertaken. The Panel commended the staff member for self-identifying and raising the lack of skillset in order to protect the patient. However, the Panel questioned an apparent lack of follow-up information around what had been done to ensure that the relevant patient care was delivered, as well as how the staff member had been supported in that situation.

- The Panel was also concerned regarding the content of notes in relation to the insertion of a PICC line in 2015. A quote from the clinical records stated 'we agreed that despite the nurses on the ward not having all completed the CVP training, the risk of not proceeding with a PICC line in this case was greater, I have also discussed this with patient, and he also agrees'. The Panel could not identify any further information as to whether staff spoke up as to concerns around this, albeit historical.

- Datix submissions are identified as being submitted by vascular consultants in 2019 and 2020 querying some aspects of previous practice. Action states, "Since

implementation of the vascular centralisation in North Wales, all similar cases are now discussed in a Multi-disciplinary meeting which allows for a broad-based consensus opinion to be reached". It also states, "the ways of working are being addressed through the pathway workstreams which is within the remit of the Vascular Task and Finish Group".

14.11.1 The Panel therefore agreed that it was difficult from the information available to say definitively if staff did or did not speak up when relevant to do so and if they were working in a culture where staff are comfortable and actively encouraged to provide safety related information reflecting a just culture. The Panel is familiar with structured opportunities such as during the WHO surgical checklist process, ward rounds, handovers, MDT meetings, M&M meetings, safety huddles, and speak out safely guardians; it is also recognised that a component of the BCUHB ward accreditation programme addresses leadership and an ability to speak up, no matter how senior another colleague may be. However, the Panel was unable to identify patterns or themes from the information available to enable other specific recommendations to be made.

15.0 Conclusion

In conclusion, the findings of the BCUHB Vascular Quality Review Panel are mainly consistent with the RCSE review findings. Although in some instances, the Panel was privy to further identified information, and members' local knowledge explained additional context.

As stated within the executive summary, ultimately, the aim of the Panel was to produce a piece of work that would help inform the delivery of the provision of the best care, experience and outcomes for BCUHB patients, their families and carers. It is hoped that the associated recommendations can be further refined by the relevant clinical teams, within a culture of ongoing learning, clinical effectiveness, audit, and quality assurance. In addition to using patient feedback as a key measure of success.

Finally, the external vascular experts on the Panel provided within discussion, information from their own roles, which may also be of interest to those reading this report. They have highlighted that a significant amount of work has been undertaken on the impact of frailty, cognitive decline, benefits of care of the elderly specialist input, and comprehensive geriatric assessment (CGA) in vascular surgery.

The use of clinical coding and outcomes as routine data being used such as frailty, homelessness, living alone is also considered to likely be recorded alongside co-morbidities, interventions and outcomes in the near future.

Additional references and information are provided in *appendix 6*.

Acknowledgements and Thanks

The Panel would particularly like to thank those patients and/or Next of Kin who provided their feedback and commentary, and for the sensitive support provided by the Patient Advice and Liaison Service, led by the BCUHB Patient and Carer Experience Lead who was also a Panel member, to help them to do so. **[END]**