**Thames Valley SCN Vascular Network Group**
**The Oxford Belfry Hotel**
**15th April 2016 14:00 to 16:00**

**Minutes**

**Attendees:**

[redacted] Vascular Network, OUH
Vascular Surgeon (OUH)
Vascular Surgeon, BHT
[redacted] Vascular Surgeon, BHT
[redacted] Specialised Commissioning
vascular surgeon OUH
interventional radiologist, RBH
[redacted]
Interventional radiologist, OUHT
[redacted]
Surgeon, BHT
[redacted]

Update of Actions from previous meeting:

1. SOPs to be prepared for next meeting. Pathways from SCAS: The Flow Chart from June 2014 needs updating. DNAR needs to be added to AAA Pathway, Patient on ward step needs fleshing out. [redacted] **to make the minor amendments to then be signed off by group.** [redacted] **and** [redacted] **to circulate to ED's in trusts.**
2. Spec Comm to see if there is support for running the vascular network, in the model of the Trauma Network. [redacted] informed there is no support for our patch. [redacted] **to raise with** [redacted] **the amount of support required.**
3. Pathway for follow up developed adapting what is in place for RBH and circulated. Much discussion on the requirement of a smooth transition between trusts. OUHT have access to images on inhouse database JANUS
   - **Group to agree minimum data set**
   - **Remote access to JANUS via OUHT laptops at all BHT sites plus sending of data from JANUS via nhs.net accounts.** [redacted] **to liaise with** [redacted] **and** [redacted]
4. Repatriation issues and issues between sharing of microbiology results between trusts.
   - **TV wide repatriation policy in place but COO looking at incentives – feedback at next meeting.**
   - **Discussion needed between microbiology units in RBH and OUHT**

**Vascular Steering Group**
Following model from Wessex and Dorset trusts, the South Central Medical Director [redacted] brought the group together. Initially meetings will be held on a monthly basis with the next meeting on 21.4.16. [redacted] outlined the actions from the previous meeting (see notes).

**Feedback from HASC Discussion**
GP met with Angela McPherson (HASC Chair, Bucks) to discuss what level of consultation is needed to transfer CEA's from Bucks to Oxford.
[redacted] has been tasked with a briefing document which will become a public facing document. Short time line to present at next HASC meeting in May.
**ACTIONS:**

- **All to read through document and send any comments to [redacted] by C.O.P. 19.4.16. [redacted] to send report to Neil Dardis by 21.4.16 and to Angela McPherson by 25.4.16.**
- **[redacted] to send [redacted] documents and links to aid data sets.**
- **[redacted] to coordinate from OUHT and [redacted] from BHT to include most up to date time to surgery data.**

**Clinical Lead**
Discussion around the logistics of the role. OUHT paying I PA and SCN paying 1 PA for a transitional one year period. Will be accountable to NHS England South (South Central) Medical Director.
**ACTION: [redacted] to tailor the clinical lead description for a vascular role.**

**Patient Experience/PROMS**
Presentation by [redacted] on the approach that is being used for this. Discussions are happening with many stakeholders in groups including patient groups in OUH and the Patient experience lead.
**ACTION: All feedback to be emailed to [redacted]**

**PA Cover**
[redacted] gave an update. Meeting with BHT to iron out issues, work out longer term CEA and what SLA will look like.
**ACTION: [redacted] and [redacted] to discuss and requirements.**

**Any Other Business**
There was none.

**Next Meeting**
Friday 17th June 2pm – 4pm

**Thames Valley SCN Vascular Network Group**
**The Oxford Belfry Hotel**
**17th June 2016 14:00 to 16:00**

**Minutes**

**Attendees:**

[redacted] Vascular Network, OUH FT
Vascular Surgeon (OUH FT)
Vascular Surgeon, BHT
Vascular Surgeon, BHT
Interventional radiologist, RBH FT
[redacted]
Interventional radiologist, OUH FT
[redacted]
Surgeon, BHT
[redacted]

Update of Actions from previous meeting which were not an agenda item:

1. [redacted] and [redacted] have taken to ED's in trusts. RBH ED department happy with them. BHT has it as an agenda item at July Directorate meeting. **Sign off at next meeting after testing in the system.**
2. Pathway for follow up developed adapting what is in place for RBH and circulated. Much discussion on the requirement of a smooth transition between trusts. [redacted] EIDDs charge summaries sending via email and working well. Two laptops available for access to JANUS database.
3. Repatriation issues and issues between sharing of microbiology results between trusts is always a challenge. [redacted] reported some work to be done at RBH, experiencing difficulties with infection control team. RBH have a new head of infection control from Oxford, so he is aware of the issues and keen to find a solution. Optimistic that microbiology issues will be resolved.
[redacted] – repatriation delays report March – May 8.6 day delay, this was 11 days – hence a reduction already. [redacted] **to email data to** [redacted] **to share with** [redacted] **and Infection Control Lead.**

**Vascular Steering Group**

[redacted] presented the action notes from the April and May teleconferences to aid transparency between the two groups. Geoff Payne is retiring 30.6.16 and there will be a time without a Medical Director so in the interim Rachel Pearce (DCO, NHS E South Central) has agreed to step in to keep the programme moving forward.

**Feedback from HASC Discussion**

The HASC Chair has changed from Angela MacPherson to Cllr Brian Roberts. [redacted] and [redacted] have a meeting with him on 28.6.16. [redacted] met with Steve Baker, MP for High Wycombe on June 10th. He understands the basis of the proposed move.

**Assurance Process**
29.6.16 NHS England Stage 2 Service Change Assurance meeting. Panel had a pre meet and have shared a list of questions (KLOE). The questions were discussed in detail at the meeting giving [redacted] good collective thinking to feedback.

**ACTION: Various network members to share information to support the stage 2 meeting.**

**Clinical Lead**
[redacted] presented job description to group, with feedback given from the group. The post will be taking responsibility for the whole network ensuring it operates to the highest possible standards. Line Manager will be the Medical Director for NHS England South (South Central)

**ACTION: Feedback any comments to [redacted] by 24.6.16. [redacted] will present to [redacted]. Then to go to advert via NHS England, supported by OUH FT.**

**Patient Experience/PROMs**
[redacted] presented to the group, explaining the face to face interviews (hoping to begin in July, 15-20 patients over two months) and written questionnaires (all inpatients). The interviews will continue until no new issues are thrown up.

Focus piece in due course to look at patients for whom English isn't their first language.

The questionnaire has been adapted and changed following feedback from various groups and has been trialled with patients in the ward.
**ACTION: Trusts to find 1-2 patients in each group who fit the criteria and ask them if they would like to take part.**
**[redacted] to give a broad overview at the next meeting.**

**Operational Updates**
**BHT:** [redacted] reported that there are a few hiccups which are being worked through. MDT information is now being provided by 12noon on Thursdays to ensure a smoother transition.
[redacted] reported that the use of instruments between BHT and OUH FT is causing slight issues as the ones at OUH FT are unfamiliar.

**OUHT:** [redacted] reported that room 11 is out of action whilst being re equipped, though this won't affect the theatre lists, but it will have an effect on inpatient lists – [redacted] offered help from Stoke Mandeville to relieve the pressure.
[redacted] reported that there is inefficiencies in the interim before carotid come across to OUH FT. Theatre time is not being used efficiently nor is surgical time.
**ACTION: [redacted] to pull information on theatre lists re the inefficient use of resources during this transition period to present at the Stage 2 assurance meeting..**

**Any Other Business**
[redacted] asked the group of the process for informing patients at BHT that their operation will take place at OUHT. The patient will be told at time of consultation and will stay will the same consultant. Pre op assessments for major surgery will take place at the same location as the operation. There is an information sheet in process to make pathways clear.

[redacted] asked if Berkshire patients could opt to have their operation at Frimley Park.

**Next Meeting**
Friday 16th September at OUH FT 2pm – 4pm. [redacted] to book room and inform group

**Thames Valley SCN Vascular Network Group**
**John Radcliffe Hospital, Oxford**
**16 September 2016 14:30 to 16:00**

**Minutes**

**Attendees:**

[redacted]
Vascular Surgeon, BHT
[redacted]
Consultant Interventional radiologist, OUHFT
[redacted]

**Apologies:**

[redacted] Vascular Network, OUH FT
Vascular Surgeon (OUH FT)
Vascular Surgeon, BHT
Interventional radiologist, RBH FT
[redacted]
Interventional radiologist, OUH FT
[redacted] Surgeon, BHT
[redacted]
Vaughan Lewis, Clinical Director, Specialised Commissioning, NHS England
[redacted]

**1. Minutes and Actions arising**

Minutes from 17 June were approved.

**Update of Actions from previous meeting which were not an agenda item:**

1. Standard Operating Procedures to be finally checked before sign off. Sign off at next meeting after testing in the system.
2. Conversations taking place around repatriation of patients back to Reading and trying to have cohort of vascular patients on one ward. (Currently need to go into side ward due to infection control concerns). Optimistic will be resolved.
3. Actions in advance of assurance meeting all completed.

**2. NHS England Assurance Process**

[redacted] commended the good process undertaken and noted Stage II has been delivered on time and on budget. He thanked everyone for all the work undertaken to achieve this. [redacted] also highlighted that it was a thorough process. The previously circulated letter from NHS England South regional office providing Stage 11 assurance was reviewed and outstanding actions discussed:

1) Written confirmation and assurance from OUHFT received (PB letter circulated)
2) [redacted] confirmed all contract variations in place for OUHFT.
   **Action: Need to check all in place for Bucks.**
3) Documents from Wessex had been shared and helped inform comms response to HASC
4) [redacted] advised [redacted] of Berkshire West CCGs of the changes from 1 September. She has asked for impact on ambulance transfers and John Black of SCAS has been asked to provide this. Those present felt that the impact will be minimal.
   **Action: SCAS response to be presented at next meeting.**
5). Only outstanding finance issues are relatively small around non-recurring costs – eg Buckinghamshire kit transfer. All recurring costs issues sorted.

The team highlighted that the service in Milton Keynes needs to be given consideration as patients come into the TV network area and have a degree of responsibility for them.

**3. Communications and Engagement**

[redacted] presented the team with a pack of the communications documents which had been developed to support the Stage II transfer. These included posters, press release and briefing for the Buckinghamshire HASC. BHT and Bucks CCGs comms team had helped distribute comms material. Unfortunately the move was not picked up by the local media but this was probably due to the small numbers involved.

[redacted] noted that a meeting had taken place with the HASC Chair in June and he supported the view that it would be disingenuous to go out to full public consultation but a comms plan for all stakeholders was important. A meeting had also taken place with Steve Baker MP and he was supportive of this approach. Healthwatch Bucks had additional questions around transport but were generally supportive.

'Save Wycombe Hospital' campaign had many questions and it was decided to arrange a meeting with Vaughan Lewis to discuss concerns. However, they did not turn up to this meeting or to the HASC meeting with took place on 6 September. At the HASC meeting [redacted] presented on patient experience and this was well received by the committee. The meeting generally went well and the HASC were supportive. They have asked for a presentation on the results of the patient experience work in six months.

The team were asked if they had heard locally of any concerns around the transition. [redacted] noted there had not been any negative feedback from GPs although there was some slight anxiety from stroke physicians about the availability of vascular surgeons to review patients in Bucks.

**4. Clinical lead appointment**

[redacted] had not received any further comments on the Job Description. She had received a request from [redacted] for OUHFT to advertise the post and was happy to do this with the understanding that the NHS England Medical Director would continue to be the accountable person. She agreed to progress this by sending to all clinicians who are eligible to apply and ask them to apply by a certain date (once final confirmation of the JD received from NHSE Medical Director). It was suggested that there should be a rep from OUH, RBH, BHT and a CCG on the interview panel along with the medical director.
**Action: [redacted] to confirm advertisement can now be circulated and to consider make up of interview panel**

The team highlighted the importance for the clinical lead to have some leverage on Trusts who are not performing, so who they report in to is important. The distinction between the clinical lead at OUHFT as responsible for the service at OUH and the network clinical lead as responsible for the wider service across Thames Valley and independent of any organisation was stressed.

[redacted] asked how the objectives of the post would be agreed as it was a broad agenda. This was discussed and it was felt that objectives would be agreed with NHSE MD after discussion at the network to define the priorities for delivering the vision (every pathway working in functional way across the patch).

[redacted] asked about linking with AAA screening lead as important for this group that screening effective in reducing numbers. [redacted] highlighted that the screening programme will not impact for many years but the Clinical Director will need to link.

**5. Operational update**

**Ward capacity:** Discussions ongoing to relocate vascular ward. [redacted] confirmed commitment for provision of planned bed numbers (modelling showed 4 extra from Bucks).
**Room 11:** This room has been equipped but there is an issue with staffing due to lack of radiographers. Radiographers are often attracted to London and there is a piece of work across BOB STP looking at how can attract and retain staff. [redacted] highlighted importance of looking to see if can do service differently.

**Consultant of the week:** The Registrars have said this has made a huge difference and in fact need to consciously ensure they are getting exposure to ward rounds as these are consistently now being done by consultants. Nurses have said there is an improvement in patient flow but this has not been confirmed by metrics yet.

**BHT diabetic foot clinic:** There is some concern around vascular surgeon cover at BHT and RBH. Diabetologists are increasing foot clinics but no vascular surgeon input.
**Action: Need to review this and feedback at next meeting.**

**New consultant post:** [redacted] confirmed that this is nearly ready to be advertised. There is agreement about where theatre sessions are but just one issue to be resolved by BHT leads as job plan is for 11 PA but role needs to be 10PA.

**Operational issues following 1 September:** [redacted] noted generally happy and no patient has been cancelled. Trying to cover inpatients at BHT while spending so much time at OUH can be a problem. There are minor issues around the pre-op assessment pathway which need to be sorted. [redacted] noted that regular meetings (every 2 months) are held with Berkshire around operational issues and meetings will be set up for Bucks. In future it is thought this meeting could be used for operational issues.

**6. Patient Experience/PROM**

[redacted] had provided a briefing to update the group. She noted that the response rate was high and interviews carried out with 9 patients and 5 family members. She outlined the plan for discussion of the major themes at the next meeting. The team commended the work and noted that the vascular society are interested in her approach. [redacted] was thanked for his input.

**7. Seven day Services briefing**

The network confirmed that the service has evolved to some extent but more changes needed. Any emergency work is being dealt with 7 days but discussions needed around what is 'urgent'. Any feedback to be provided to ;[redacted].

**8. Any Other Business**

**Next Meeting**

Friday 21 October at OUH FT 2pm – 4pm. (SSIP seminar room).

**Thames Valley SCN Vascular Network Group**
**John Radcliffe Hospital, Oxford**
**21 October 2016 14:00 to 16:00**

**Minutes**

**Attendees:**

[redacted]
Vascular Surgeon, BHT
[redacted]
Vascular Network, OUH FT
Vascular Surgeon (OUH FT)
[redacted]
Patient rep
OT, OUHT
Physio, OUHT
[redacted]

**Apologies:**

[redacted]
Consultant Interventional radiologist, OUHFT
[redacted]
Vascular Surgeon, BHT
Interventional radiologist, RBH FT
[redacted]
Interventional radiologist, OUH FT
Surgeon, BHT
[redacted], OUH FT
Vaughan Lewis, Clinical Director, Specialised Commissioning, NHS England

**1. Patient Reported Outcomes Measures presentation**

[redacted] thanked the contributors and explained the purpose of the patient interviews undertaken, the method used and some of the key findings around attitudes towards networked care and how care is experienced by patients (according to criteria they considered important). The findings were grouped around patient pathway and staff. The key messages were highlighted by [redacted] for discussion – see attached document.

Those present recognised the value of the information and thanked [redacted] for all her work. The following points were highlighted by the group:

1) Value of calls from the surgeon to patient's family after surgery (with patient permission)
2) Need to speak to patients cancelled on the day
3) Importance of consistent discharge instructions wherever discharged to
4) [redacted] noted often little OT handover from other hospitals (patients may come from any ward) so have to start from scratch. However, vascular OT link being developed with named contact. This is very established with RBH but needs further development with BHT.
5) The computer link between RBH and OUH is good so info can be shared but this is not the case with BHT where there is an issue around information governance which is preventing easy sharing. **Action: [redacted] agreed to follow up BHT info governance issue as resolution would improve patient care.**
6) Patients repatriated to the RBH will soon go to a specific ward but this is not the case in Bucks as patients could go to Stoke Mandeville Hospital or Ward 12 at Wycombe.
7) There is sometimes an issue when patients could be repatriated directly home from Oxford but need to go back to local hospital first to have wheelchair access visit. ? whether could be done

earlier before treatment.
8) [redacted] asked whether carotid or aneurysm patients could be interviewed in a future iteration as their experience may differ from those surveyed here.
9) It was suggested that there is value in doing ward rounds with families (or other nominated individual) present so that key messages are absorbed
10)? whether patients could use Skype to communicate with relatives and prevent need to visit

**Next Steps:**
[redacted] highlighted the importance of actions resulting from the survey, including discussions with lead clinicians in each area.
***Action:*** [redacted] ***to undertake discussions at OUH and*** [redacted] ***agreed to pick up in BHT.***
[redacted] proposed an audit at Jan 17 Vascular network meeting to ensure actions identified and undertaken with a follow up review in 12 months.

The results of the initial questionnaire are also expected to be presented at the Jan meeting. [redacted] highlighted the importance of an ongoing questionnaire with analysed results being presented to the network as part of the governance structure of the meeting. It was emphasised that the questionnaire needs to be framed carefully and the new clinical lead should be involved in this.

**2.. Minutes and Actions arising**
Minutes from 16 September were approved.

**Update of Actions from previous meeting which are not an agenda item:**
1. **Standard operating procedures** final sign off
***Action:*** [redacted] ***agreed to follow these up and provide update for next meeting.***
2. **Contract variations for Bucks**
***Action: Request for confirmation send to*** [redacted] **–** [redacted] ***to chase***
3. **Impact of repatriations on SCAS**
SCAS had been contacted regarding impact of change of service from 1 Sept and increased repatriations. They were not able to identify this cohort of patients (apart from through NHS number or receiving ward) but it was not believed to be significant.

**3. Clinical lead recruitment**

The job description has been approved and is with [redacted] to send out to potential candidates.
***Action:*** [redacted] ***to obtain an update on recruitment timetable***

The interview panel was discussed and it was agreed there should be a transparent process with a representative from RBH, BHT, OUHT and Shahed Ahmed, Medical Director at NHS England South Central.
***Action:*** [redacted] ***to discuss proposed panel with*** [redacted] ***and Shahed Ahmed and then*** [redacted] ***to contact panel members to invite and confirm interview date***

**4. Operational Update**

**Diabetic foot clinic - RBH**
There has been improved communication with primary care around diabetic prevention in Berkshire West and improvements are now spreading across Thames Valley. [redacted] highlighted that there has been a lack of a diabetologist in Reading for a while but the podiatrists are very good and he had taken on the role to ensure the service continued. A substantive diabetologist has now been appointed.

**Diabetic foot clinic – BHT**
Following last month's meeting an update on the service had been requested but not yet received. It was planned that there would be regular vascular input at a face to face rather than virtual clinic.

***Action:*** [redacted] ***and*** [redacted] ***to discuss whether an audit could be undertaken to assess how each area is doing in relation to this.***

**Operational issues**

**Stroke Physician:** [redacted] noted that a stroke physician at Bucks felt that communication within the network could be improved and there was a need for stroke physicians to feed in patients directly to Oxford.
***Action:*** [redacted] ***to send stroke physician the pathway to identify where the problem lies.***

**Second interventional room:** Although the room is available there is an issue around obtaining radiographers and anaesthetists to staff this. It was noted that work is underway across the BOB (Bucks, Oxon, Berks West) STP to address workforce issues and prevent staff moving from one Trust to another.

**Bed capacity in OUHT**
As part of a wider reconfiguration of beds, it is planned that vascular beds will move from 6a to Level 2 in the West Wing from 1 Feb. This will provide 24 beds plus there will be an additional 4 beds and 2 triage beds on Level 0. (currently 24 beds plus 1 triage) Ongoing discussions are taking place with clinicians around this and a clear plan will be presented to the network and to the senate (31Jan).

**5. Any Other Business**

**Performance:** [redacted] noted that there had been a huge improvement in carotid endarterectomy (CEA) within 14 days.

**Frimley Health:** [redacted] had received a query around vascular surgery at Frimley. The network confirmed that patients previously treated at Wexham Park are now being treated at Frimley Park which is a fully compliant service.

**Next Meeting**
Friday 20 January at OUH FT 2pm – 4pm.
Friday 21 April 2pm – 4pm (venue tbc)

# Thames Valley Vascular Network Group
# John Radcliffe Hospital, Oxford
# 20 January 2017 14:30 to 16:00

## Minutes

**Attendees:**

[redacted]
Vaughan Lewis (VL) , Clinical Director, Specialised Commissioning, NHS England (by phone)
[redacted] Vascular Network, OUH FT
[redacted]
Interventional radiologist, RBH FT
Vascular Surgeon (OUH FT)
Interventional radiologist, OUH FT
[redacted]

**Apologies:**

[redacted]
Vascular Surgeon, OUH,
Medical Director, RBH
Vascular Surgeon, BHT
[redacted]
Consultant Interventional radiologist, OUHFT
Vascular Surgeon, BHT
[redacted]
Surgeon, BHT

**1. Minutes and Actions arising**

The minutes from 21 October 2016 were approved.

The following actions were discussed:

**1) BHT IT** – [redacted] noted that she had discussed this with Head of IT. OUH have 'virtual desktops'. BHT have considered this but needs a lot of infrastructure and changes. At the moment the only way to have secure access to BHT network is via laptop and VPN. It is on the list of IT projects for 2017. ***Action:*** [redacted] ***agreed to find out the expected date for this to be in place and to discuss with*** [redacted] ***and*** [redacted] ***as identified as a potential patient risk.***

**2)SOP and BHT contract variation** – The new SLA has not yet been drawn up.
***Action:*** [redacted] ***to discuss with*** [redacted]

**3) Clinical Lead recruitment** – application date has now passed and interviews planned for 21 February.

**4) Diabetic foot** – it was agreed to defer the discussion until the next meeting. [redacted] noted that a bid had been submitted for a multidisciplinary diabetic foot team which would boost vascular input. The results will be discussed at the next meeting. It was noted that a diabetic foot meeting with

[redacted] taking place in Reading on the morning of 22 February. ***Action:*** [redacted] ***to circulate invite***

**5) Stroke physician concern** – the issue had been forwarded to OUH to deal with the individual case.

**2. Patient reported outcome measures –** [redacted]

[redacted] presented on the TVVN patient feedback questionnaire results from May –Oct 2016.

The response to the questionnaires had been higher than anticipated at 38%. 53% of the respondents were from Oxfordshire, 24% from Berkshire and 22% from Bucks with the remainder from out of area.

The responses to the first 8 questions in the survey had been very encouraging with little variation in response from those from different counties.

There was variation in response on Q9 around pain management and Q10 and Q11 around informing patients who to contact and when their next appointment is post discharge. The response to Q12 which asked 'if your family wanted to talk to a doctor did they have an opportunity' showed that 47.5% said yes, definitely but 26.5% said yes, most of the time and [redacted] felt this should be looked at.

Of the 166 surveys received only 4 of them included comments on travel (2 positive/2 negative).There were some negative comments around follow-up appointment waiting times and [redacted] explained that there is to be an increase in clinics which will reduce delays. There were also some negative comments around discharge processes.

As a result of the responses, [redacted] cited the following recommended actions:

1) Revise some of the wording on the questionnaire to ensure clarity

2) Look at informing patients of the anticipated wait for follow up appointments and explore possibility of fixing appointments before discharge. The medical secretaries would have responsibility of tracking follow up appointments.

3) Develop a handout to give to patients on discharge. This would include contact numbers, and answers to FAQs such as when can I drive, how long should wound take to heal etc.

[redacted] explained that she is leaving and her role is being split between a vascular and trauma network manager and a vascular services manager. She anticipated the PROM work of processing the feedback and producing a monthly report for the clinical services unit and the monitoring of the action plan would be picked up by the network manager. The administration of the responses is in place.

It was highlighted that the Buckinghamshire HASC have asked for an update on this work on 24/1. (Following this meeting the network have been asked to provide a further update at 19 September meeting.)

***Action:*** [redacted] ***to ensure this date is in appropriate diaries***

***Action:*** [redacted] ***to inform*** [redacted] ***of the replacement persons for*** [redacted].

**3. Seven day services update –** [redacted] **and** [redacted] **(by phone)**

[redacted] went through the previously circulated slides and noted that emergency vascular services is one of the 5 specialist urgent network areas which need to achieve the four priority clinical standards for seven day services by Nov 17. She asked for input from the network as to how achievement of these standards can be measured and noted there is a regional webinar to discuss on 25 Jan.

***Standard 2: Time to consultant review: all emergency admissions must be seen and have thorough clinical assessment by suitable consultant at latest within 14 hours of admission.*** [redacted] highlighted the case of somebody presenting at 5pm and the need to evidence that they had

been assessed within 14 hours. [redacted] asked when the clock starts as a patient may present at ED in a local hospital and then need transferring to Oxford – does the clock start when they are admitted in Oxford? [redacted] agreed to follow up this query.

***Standard 5: Diagnostics: inpatients must have scheduled 7 day access to consultant-directed diagnostic tests and completed reporting will be available 7 ds a week within 1 hr for critical pts and 12 hrs for urgent pts.*** This is already in current protocols and there is 24 hour access to CT scanning.

***Standard 6: Consultant directed interventions: inpatients must have 24hr access to consultant-directed interventions that meet relevant specialty guidelines, either on site of through formally networked arrangements.*** The only issue is interventional vascular cover. [redacted] explained that 2 nights a week there is no paid service to cover stenting although there are ad hoc arrangements provided out of good will and there is a rota. Emergency aortic stenting is not explicitly included in requirements for 7ds but it is implied and needs to be stated and to go on risk register [redacted] to flag these ad-hoc arrangements to NHSE.

***Standard 8: On-going review in high-dependency areas: all pts with high-dependency needs should be reviewed twice daily by a consultant and all other pts should be reviewed once daily 7days a week.*** *There is a daily consultant ward round but this does not always take place on a Sunday. People with greater need can be seen 2 or 3 times a day.*

The meeting discussed how they might evidence the standards. For standard 2 it was unclear how the requirement to be seen within 14 hours could be evidenced as times are not electronically recorded and it would mean a laborious task of going through patient notes which may not always include dates and times. [redacted] stressed the need to prevent additional reporting. It was agreed that it should be standard practice to record date and time but assurance is going to be difficult to provide until there is a mature digital system in hospital. It was suggested that it could be more of a CQC style assurance process and the evidence should be the inclusion in unit protocols and SOPs which describe the expectation of ward rounds and timeliness of investigations where critical to determine ongoing care and to ensure patient care is not different at weekends. The first step is to make sure standards are enshrined in SOPs and departmental guidelines. For Standard 6 the rota could provide the evidence.

**Action: Review of SOPs to be undertaken by Clinical Lead to ensure these are adequately reflected.**

**4. AAA screening – for information only**

The presentation provided by the Screening team was circulated.

**5. Performance – NVR report**

It was agreed to defer this to the next meeting and for any more recent data from the OUH to also be included in the discussion. ***Action: [redacted] to discuss with [redacted] before next meeting***

**6.Clinical Lead recruitment update**

The application date has now passed and interviews are planned for 21 February.

**7. Operational update**

This item was deferred until the next meeting.

**8. Any Other Business**

**Presentation at Thames Valley Senate**

The Senate has asked for the Vascular network to provide an update on the implementation of the vascular pathway at their meeting on either 21 March or 30 May. It is proposed that the new Clinical Director and the patient representative attend this meeting.

***Action: [redacted] to confirm attendance at this meeting.***

**9. Next meeting date: 24th March 2:00 – 4:30pm Jubilee House, Oxford**

Thames Valley
Strategic Clinical Network

# Thames Valley Vascular Network Group
## Jubilee House, Oxford
## 31 March 2017 14:00 to 16:30

## Minutes

**Attendees:**

[redacted]
Vascular Surgeon (OUH FT)
Patient rep

**Apologies:**

[redacted]
Vascular Surgeon, BHT
Consultant Interventional radiologist, OUHFT
Vascular Nurse, BHT
Surgeon, BHT
Vaughan Lewis (VL) , Clinical Director, Specialised Commissioning, NHS England
Interventional radiologist, RBH FT
Interventional radiologist, OUH FT

**1.Welcome**

[redacted] was welcomed in his new role as Clinical Director for the Thames Valley Vascular network. He explained that a new Clinical Lead for OUH will be sourced.

**2.Minutes and Actions arising**

The minutes of the meeting on 20 January were approved.

The following actions were discussed:

**1) BHT IT –** [redacted] noted that she had discussed this with Head of IT. OUH have 'virtual desktops'. BHT have considered this but needs a lot of infrastructure and changes. At the moment the only way to have secure access to BHT network is via laptop and VPN. It is on the list of IT projects for 2017. ***Action:*** [redacted] ***agreed to find out the expected date for this to be in place and to discuss with*** [redacted] ***and*** [redacted] ***as identified as a potential patient risk.***

**2) Vascular network manager:** [redacted] explained that the role had been split: vascular services manager and network manager (for Vascular, Trauma and Plastics). [redacted] is the interim service manager and the network manager post is being recruited. The network manager would be the link with the other hospitals and continue the PROM work. A PROM update would be prepared for the next Bucks HASC meeting on 19 Sept. [redacted] Registrar had presented the PROM work at a SW Vasc Soc meeting. ***Action:*** [redacted] ***to inform the meeting of the details of the network manager when recruited***

**Repatriation:** Concerns were raised around delays in repatriation to RBH and BHT. It was suggested that [redacted] becomes a member of the RBH vascular steering group run by [redacted] to aid communication. ***Action:*** [redacted] ***to contact*** [redacted] ***re this.***

**7 day services requirements update**

***Standard 2: 14 hour requirement for consultant review and assessment for all emergency admissions.*** It was agreed that the network would assume that the clock starts from arrival at the JR as arterial centre. [redacted] asked what would happen if the standard is not being met and whether the network will be assessed on a % of cases where the time met. (It was noted that in some cases there is no clinical need for this review within this timescale).

**Action: [redacted] *to inform* [redacted] *that this is the assumption being made and to ask how the standard will be measured.***

**Action: [redacted] *to undertake a snap audit of how often the time is recorded in notes***
***Action: [redacted] to talk to the consultants about the audit, the need for recording and a follow up audit to be undertaken in June.***

***Standard 5:*** The network has 24 hour radiology cover although this is being delivered on a goodwill basis.

***Standard 6 and Standard 8:*** In order to have 24 hour 7 day access to consultant review, a ward round needs to be introduced on Sunday and job plans are being amended to reflect this to ensure in place for November.

***Action: The SOPs need to be updated by Clinical Lead to reflect the changes and to provide assurance that the requirements are being met. To be discussed at next network meeting.***

***AAA screening***
This had not been discussed at the previous meeting so was deferred to this meeting. [redacted] provided updated data showing 37 patients had been referred to surgery up to end Jan 2017. He highlighted that initially it was thought that around 4% of population screened would need referral but it has been found nationally to be less than this. [redacted] confirmed that the programme is cost effective to prevent ruptures occurring. It would be good to increase uptake particularly in areas of deprivation. There had not been any false negatives locally.

**3. Feedback from Senate Council meeting presentation on vascular**

[redacted] fed back to the network about the vascular presentation to the March Senate Council. She noted that the Council had previously assessed the centralisation of vascular service to the OUH and had made a recommendation to NHS England South that it be approved which had enabled the move to take place. This recommendation was predicated on 3 points: 4 additional co-located beds to be provided at OUH, consistent high standards of care to be provided, communication with stakeholders to be undertaken.

The presentation at the Council meeting had highlighted that the 4 beds noted in the business case had not been provided and there was concern raised around patient outcomes and experience and clinical effectiveness and efficiency. There was considerable anxiety at the Senate about this and a wish to understand the situation and the impact on patients. A Senate member intimated that if the situation was not resolved the move may need to be reversed. The Senate will write to the OUH management about their concerns and will ask for an update and commitment to the delivery of the beds before their next meeting on 30 May.

[redacted] described the issues with the estate that had led to the delay in the beds being provided and highlighted that a paper is due to go to Divisional management exec for approval on 21 April with a revised proposal which involves use of a bay in 6B, the neighbouring ward. The budget for staff is agreed so the issue is solely the physical space.
***Action: [redacted] to be copied in to the Senate letter so it can be attached to the above paper.***

[redacted] stressed that the issue is about co-location not capacity and beds have been made available for vascular patients in different wards when needed.

The meeting agreed that work needs to be done to ensure that the Senate is assured of the commitment to deliver the 4 additional co-located beds and that patient outcomes have not been negatively impacted. [redacted] suggested that the effect of this be captured as well as specific information collated as an evidence base

would be asked for.
***Action:*** [redacted] ***– to set up a meeting with OUH managers and clinicians to discuss how to prepare the assurance for the Senate. Any paper would be needed 10 days before. Discussion with*** [redacted] ***as appropriate.***

**4. Performance – National Vascular Registry results 2016**

[redacted] introduced the previously circulated presentation highlighting that the data was from 2015. The key areas where there were opportunities for improvement were discussed:

**Carotid endarterectomy**

**Case ascertainment rates:** The rates of cases reported to the NVR for OUH are low at around 77%. [redacted] agreed that this needs to be discussed with the network clinicians.
**Action:** [redacted] **to discuss importance of reporting cases.**

**Time from symptom to surgery:** Oxford is below national average for surgery within 14 days (41.5% compared to 57% average) and the time has deteriorated since 2014. The surgeons noted that referrals are often delayed and sometimes not received until Day 12. The importance of communication and escalation of this was highlighted.
***Action*** [redacted]***: It was proposed that a meeting be set up with neurology/stroke colleagues across the network on a quarterly basis to discuss specific delayed cases and to smooth pathways.***

Difficulties of repatriation was highlighted as an issue causing delay and [redacted] noted that a paper analysing this had gone to a recent A and E delivery board. There is now dedicated resource in place to help smooth this and it is hoped it will have a positive result.

**Elective infra renal AAA repairs**

**Case ascertainment rates:** These were again low at 78%.

**Time from assessment to surgery:** Although this was within typical range at 68 days it was highlighted that the aim is to meet 8 weeks (56 days) which is the AAA screening to surgery target.

**% of repairs done by EVAR:** The number of elective repairs by EVAR is below the national average at for ruptured AAAs is very rare. Although an increased length of stay the clinicians were adamant that clinically open repairs usually have better outcomes and pointed to the low in-hospital mortality rate to evidence this.

It was agreed that although OUH data on 14 day CEA rates and on exceptions and on AAAs is regularly discussed locally within OUH, it is valuable that a discussion on performance takes place at network meetings to ensure wider awareness and discussion of any emerging themes.

***Action:*** [redacted] ***and*** [redacted] ***to review more recent data and to decide if there are themes which should be brought to network meeting for discussion.***

**5. Operational update**

This item was deferred until the next meeting.

**6. Any Other Business**

**Future meetings**

[redacted] noted that NHS England would continue to lead the next two meetings (June, Sept) and this would then be reviewed.

It was suggested that the membership of the group could be widened to include Stroke Physicians, AHPs across network.
***Action:*** [redacted] ***to inform*** [redacted] ***of contacts for those to be invited.***

[redacted]
to be invited to all future meetings. (complete)

**7. Next meeting date: Friday 16 June 2:00 – 4:30pm Conference Room B, Jubilee House, Oxford**