West Yorkshire Vascular Service | WYVaS

West Yorkshire Association of Acute Trusts

NHS

WYVaS Regional Clinical Pathways and Urgent Vascular Assessment Clinic

West Yorkshire Vascular Service

1. MEMBERSHIP

Chairs

Jonathan De Siqueira – Vascular Surgery Specialist Trainee and Clinical Lead for the Pathways Group

Clare Vickers, Regional Head of Nursing for WYVaS

Contributors

Nasim Akhtar – Vascular Advanced Care Practitioner, Bradford Teaching Hospitals NHS Foundation Trust

Leanne Atkin – Vascular Nurse Consultant, Mid Yorkshire Hospitals NHS Trust

Jonathan Barber – Consultant Interventional Radiologist, Bradford Teaching Hospitals NHS Foundation Trust

Neeraj Bhasin – Regional Clinical Director, WYVaS and Consultant Vascular Surgeon, Calderdale and Huddersfield NHS Foundation Trust

Kate Clough – Leadership Fellow, WYVaS

Jacqui Crossley – Head of Clinical Effectiveness, Yorkshire Ambulance Service

Matthew Harris – General Practitioner, Leeds West

Paul Jennings – Consultant in Emergency Medicine, Airedale NHS Foundation Trust

Christina Leddie – Matron for Vascular Surgery, Leeds Teaching Hospitals NHS Trust

Rossella Locci – Consultant Vascular Surgeon, Bradford Teaching Hospitals NHS Foundation Trust

Chris Miller – Consultant Interventional Radiologist, Leeds Teaching Hospitals NHS Trust

Rob Moisey – Consultant in Diabetes, Endocrine and Medicine, Calderdale and Huddersfield NHS Foundation Trust

Amanda Pine – Consultant in Emergency Medicine, Calderdale and Huddersfield NHS Foundation Trust

Sarah Stead – Lead Clinical Pathways Manger, Yorkshire Ambulance Service

David Russell – Consultant Vascular Surgeon, Leeds Teaching Hospitals NHS Trust

Julie Thackray – Vascular Nurse Specialist, Leeds Teaching Hospitals NHS Trust

Max Troxler – Consultant Vascular Surgeon and Clinical Lead, Leeds Teaching Hospitals NHS Trust

2. GOVERNANCE PROCESS

This outlines the structure through which the pathways have been created, reviewed and approved

Date	Meeting/Individuals
30th September 2019	Clinical Working Group
11th November 2019	Neeraj Bhasin, Amanda Pine, Jonathan De Siqueira, Clare Vickers
25th November 2019	Clinical Working Group
12th December 2019	Clinical Pathways Group
6th January 2020	Clinical Working Group
6th February 2020	Clinical Pathways Group
24th February 2020	Clinical Working Group
18th May 2020	Neeraj Bhasin, Paul Jennings, Clare Vickers
1st June 2020	Neeraj Bhasin, Jonathan De Siqueira, Clare Vickers
4th June 2020	Neeraj Bhasin, Jonathan De Siqueira, Clare Vickers
8th June 2020	WYVaS Programme Board
15th June 2020	WYVaS Clinical Pathways Group
19th June 2020	WYVaS Clinical Leads
26th June 2020	CHFT Vascular Operational Delivery Group
10th August 2020	Clare Vickers, Jonathan De Siqueira, Matthew Spencer
25th August 2020	CHFT Vascular Operational Delivery Group
7th September 2020	ANHSFT/BTHFT/CHFT Clinical Meeting
14th September 2020	Clare Vickers, Jonathan De Siqueira, Matthew Spencer
17th September 2020	Clare Vickers, Jonathan De Siqueira, Matthew Spencer
17th September 2020	WYVaS Documentation and Process Governance Meeting
23rd September 2020	Clare Vickers, Jonathan De Siqueira, Matthew Spencer
15th October 2020	LTHT/MYHT Clinical Governance Meeting
19th October 2020	ANHSFT/BTHFT/CHFT Vascular Reconfiguration Steering Group
26th October 2020	WYVaS Programme Board

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Management of Symptomatic AAA,

Management of Acute Rupture AAA

See RCR/RCEM guidance

Diagnosis of symptomatic or ruptured AAA

- **Known AAA + pain**
- **Low BP with abdo/back pain**
- **Age >60 with abdo/ back pain**

Assessment:

- Bloods including Clotting/VBG
- US in ED if available

Can CT be performed and reported locally within 30 minutes?

Yes: Urgent CT

- No AAA
- Unruptured AAA <4cm
- Unruptured AAA >4cm but other radiological diagnosis evident

Consider alternative diagnosis

No

Ruptured AAA
or
AAA >4cm with no other pathology on CT/bloods

Call Vascular Registrar or Cons at Arterial Site

Special considerations:

- **Age >85**
- **Severe comorbidities**

Vascular registrar to discuss with consultant prior to transfer

TRANSFER to ARTERIAL SITE

- **Immediate time critical transfer: IFT level 2 (IFT2)**
- DNACPR order should be completed prior to transfer in radiologically confirmed rupture, but not delay it
- PACS image transfer (if CT performed, local clinician to arrange)

ALERT – *Whilst in transit,* Vascular Reg/cons alerts:

- (Vascular Consultant), Vascular IR, Acute Anaesthetist, Acute Theatres (Vascular/Hybrid)
- On-call Radiology (if CT not performed at referring hospital)

ARRIVAL

- X-match – *Major Haemorrhage Protocol*
- CT (*EVAR protocol*) if not performed and patient stable
- Treatment decision: EVAR/Open Repair/Palliation

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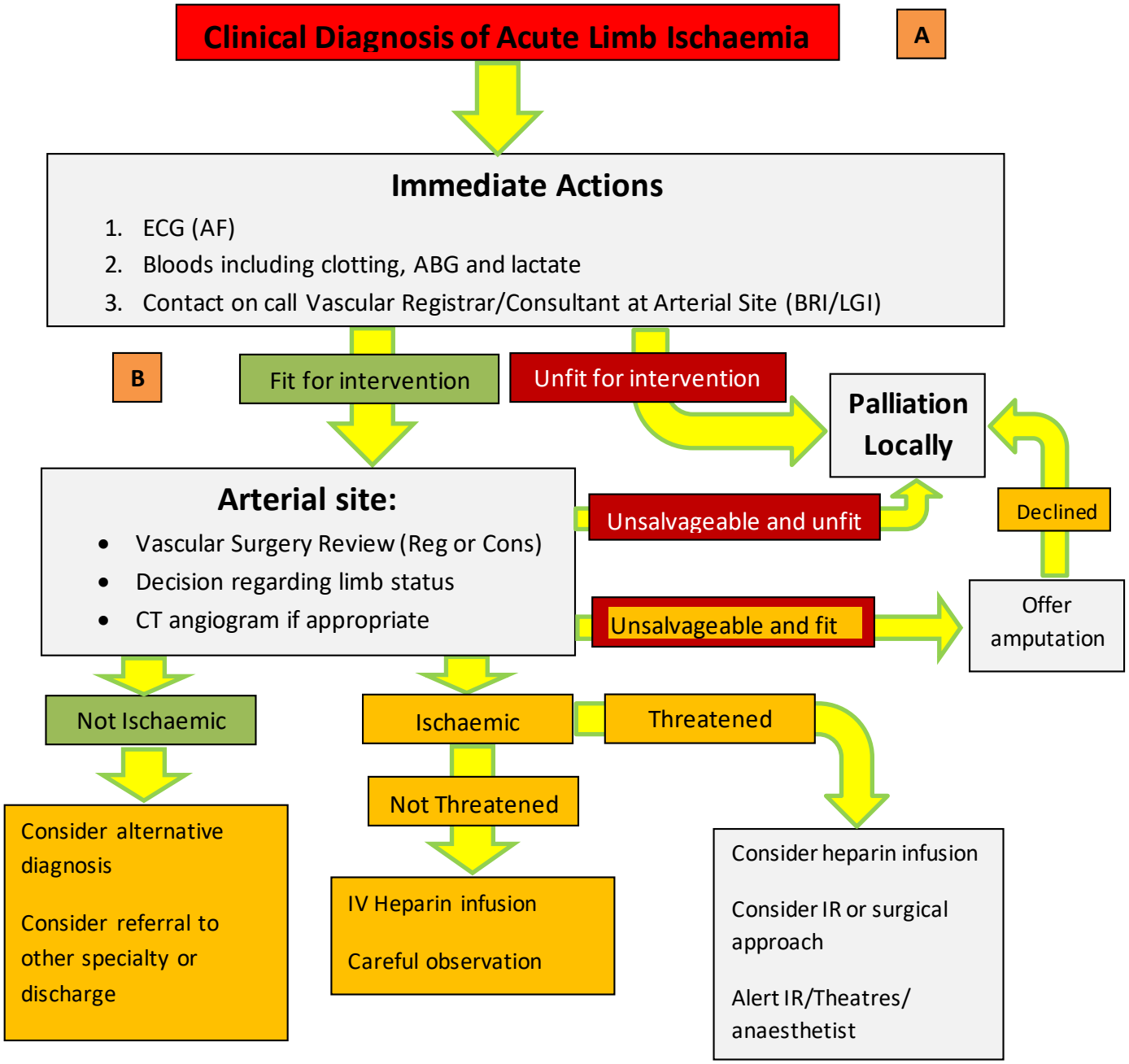
Management of Acute Limb Ischaemia

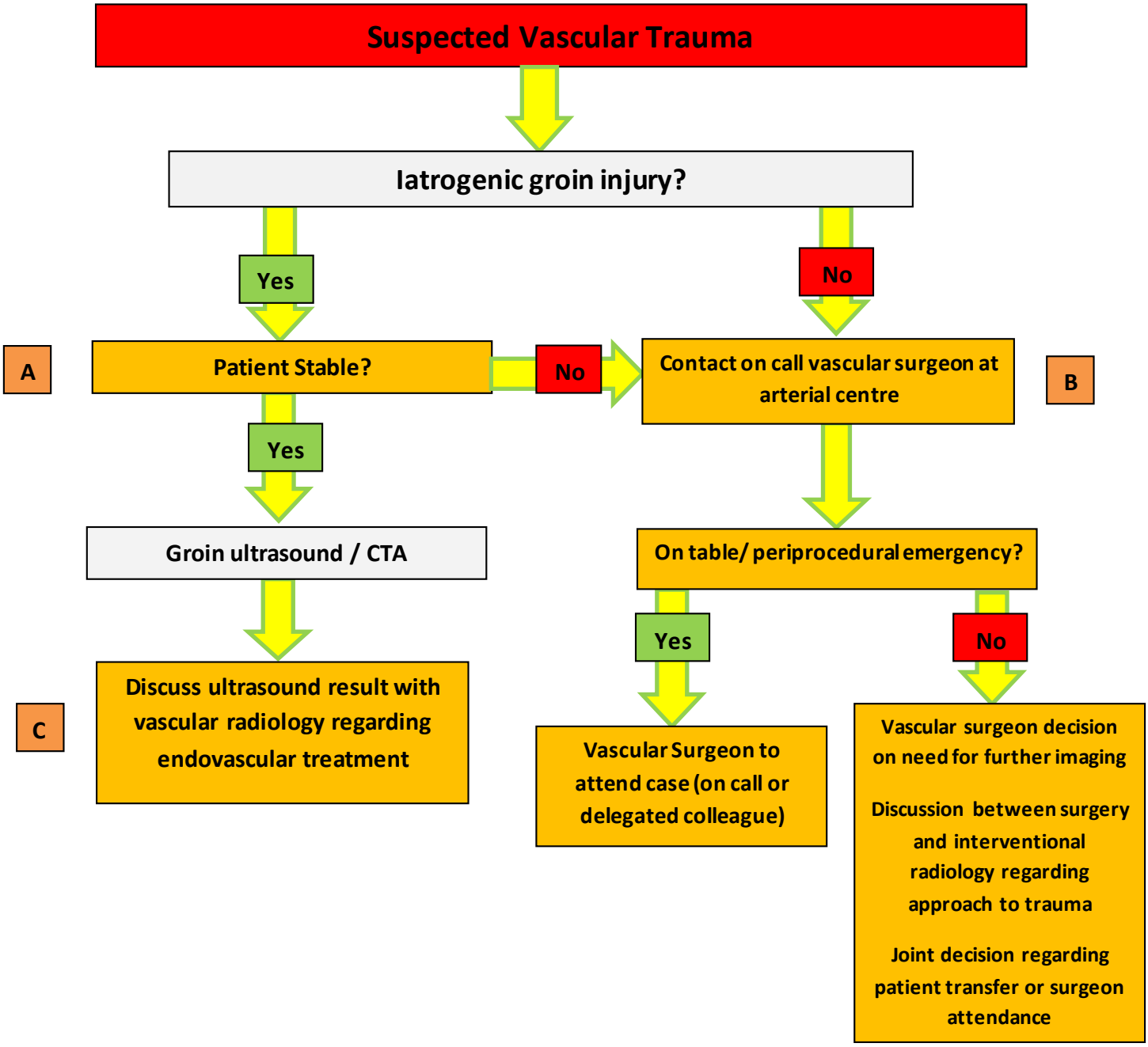


Notes

A. **Tips/criteria on diagnosis of Acute Limb Ischaemia**
   1. **Pain**
   2. **Pale, Cold extremity**
   3. **Absent distal pulses**
   4. **New neurological symptoms (sensory/motor)**
   5. **Less than 2 weeks duration**

B. **Inter-facility Transfer Level 2 (IFT2). Definitive diagnosis and timing of treatment should be led by the on call vascular consultant.**

Isolated Vascular Trauma



Notes: ***Polytrauma should be managed according to network Major Trauma protocols***

A. **Patients can only be considered stable if they have sustained haemodynamic parameters and no expanding haematoma**

B. **Vascular pseudoaneurysms not amenable to endovascular treatment will need to be discussed with vascular surgery**

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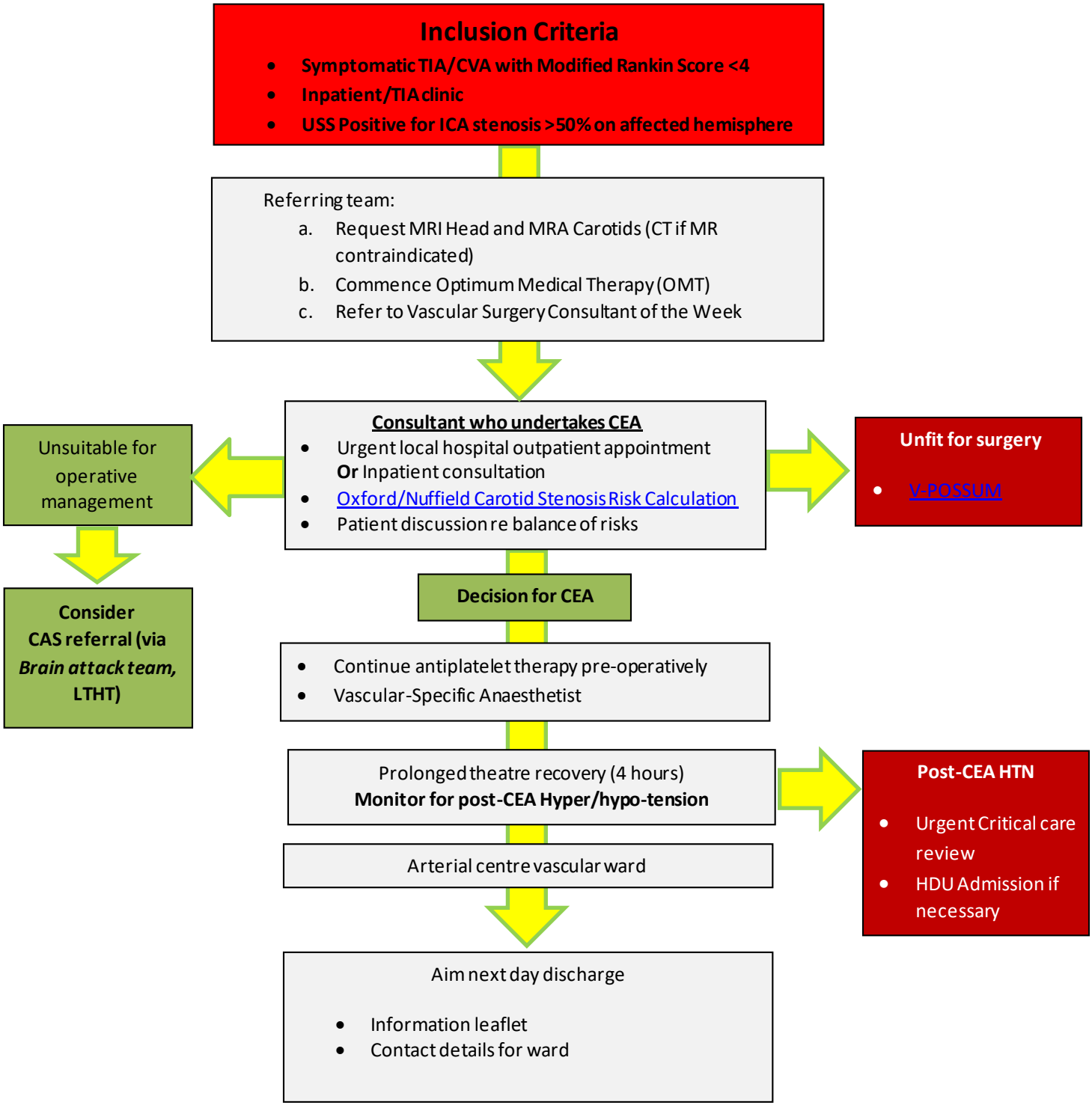
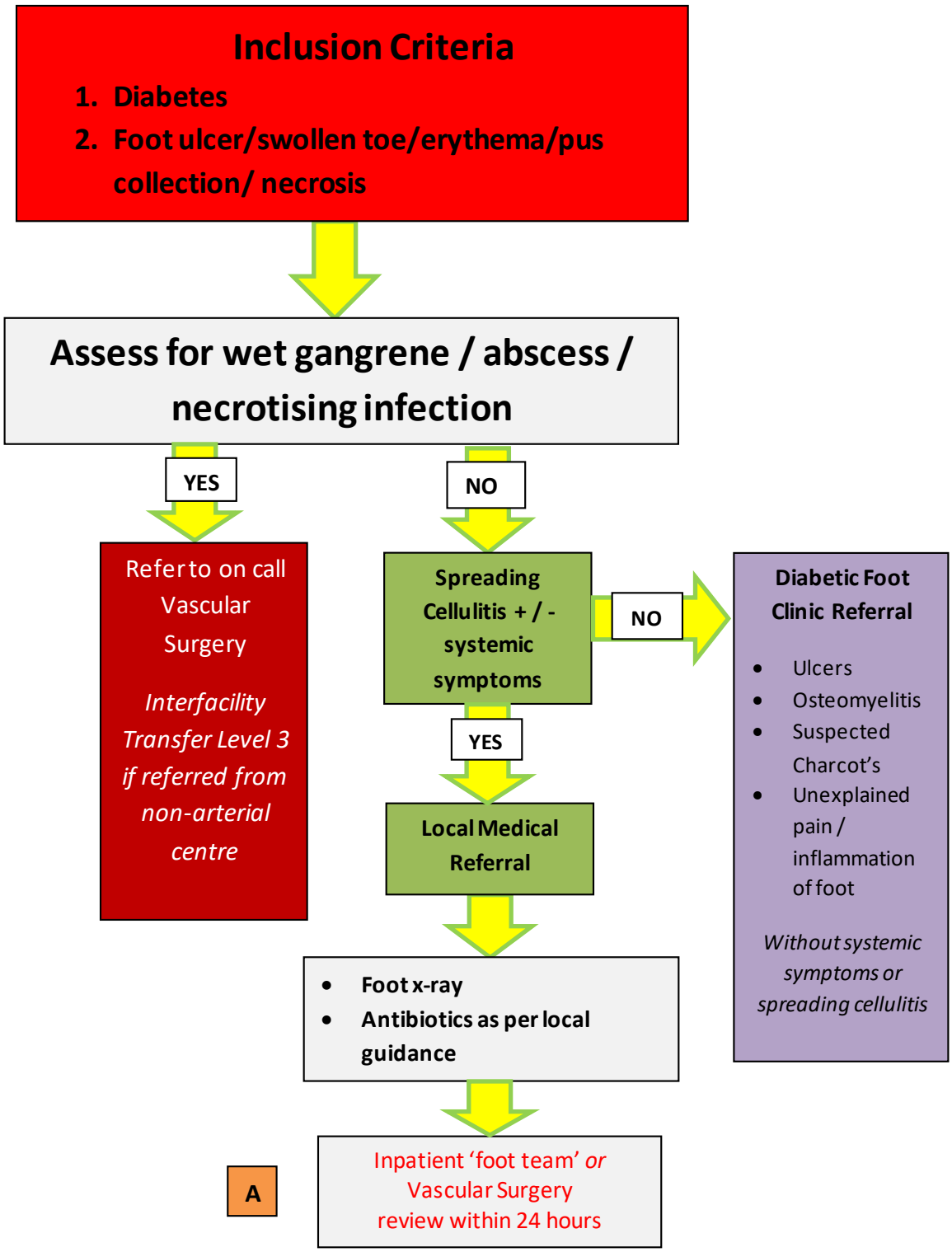
Carotid Endarterectomy (CEA) – Symptoms to Surgery 7 days

Guidance: NICE CG128, IPG389, ESVS (2017)



Emergency Diabetic Feet



A. In some circumstances, it may be appropriate for patients to be reviewed in the local Urgent Vascular Assessment Clinic (UVAC) within 24 hours. Assessment at this stage should include perfusion measurement and WIfI severity scoring

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Critical Limb Ischaemia

Guidance: NICE CG147, TASC-II, ESVS CTLI

Definition

1. Ischaemic Pain at rest ***or…***
2. Ulceration of Feet (without Diabetes) ***or…***
3. Gangrene

and…

1. Absence of Sepsis requiring antibiotics/debridement ***and…***
2. Duration of symptoms greater than 2 weeks

Refer to
'Urgent Vascular Assessment Clinic'
via local UVAC pathway

At UVAC:

- Confirm presence of critical limb ischaemia (History, Exam, ABPI)
- Commence Best Medical Therapy
- NVR Blood panel (FBC, U&E, Albumin, Glucose, Lipids)
- Consider admission if unstable ischaemia
- Urgent arterial imaging (within 7 days)
- Referral to MDT and add to virtual ward
- Schedule urgent intervention or surgery (within 14 days)

Notes:

1. Ischaemic Rest pain is typically felt in toes and feet after elevation (eg in bed) and relieved by placing feet in a dependent position (eg hanging leg out of bed or standing/walking)
2. Separate pathways exist for Intermittent Claudication, Acute Limb Ischaemia and Diabetes related foot problems.
3. In the presence of local or systemic infection refer to on-call inpatient service
4. Questions or doubts should be directed to the on-call vascular registrar or consultant at the nearest vascular arterial centre.

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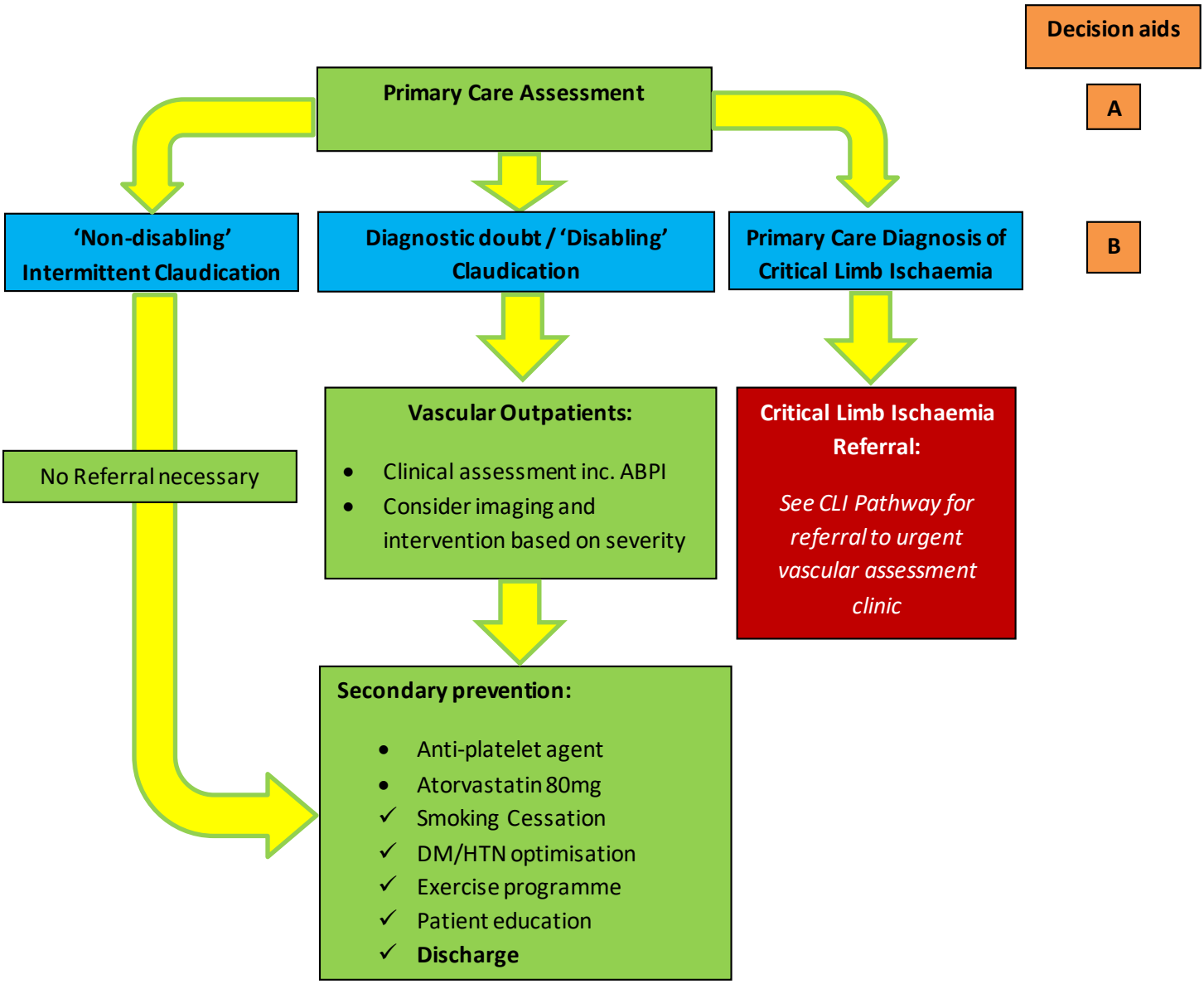
Management of Intermittent Claudication (IC) (nice.org.uk/guidance/cg147)



A. <u>Primary Care Assessment should include:</u>

- **Severity of symptoms, Cardiovascular risk factors / Pre-existing cardiovascular disease**
- **Absence of lower limb pulses**
- **ABPI**

B. <u>Diagnosis:</u>

- **Intermittent claudication is described as reproducible, exercise related pain in muscles, typically cramp/ache which disappears within 10 minutes of standing / rest**
- **Critical Limb Ischaemia is described as pain at rest in foot or ulcers/gangrene**

Patients referred with disabling symptoms should have

1. **Symptoms which significantly impact on ADLs, (eg walking distance < 50 metres, threatened employment) *****AND***** ceased smoking and already be on secondary prevention**

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Incidental (Asymptomatic) AAA

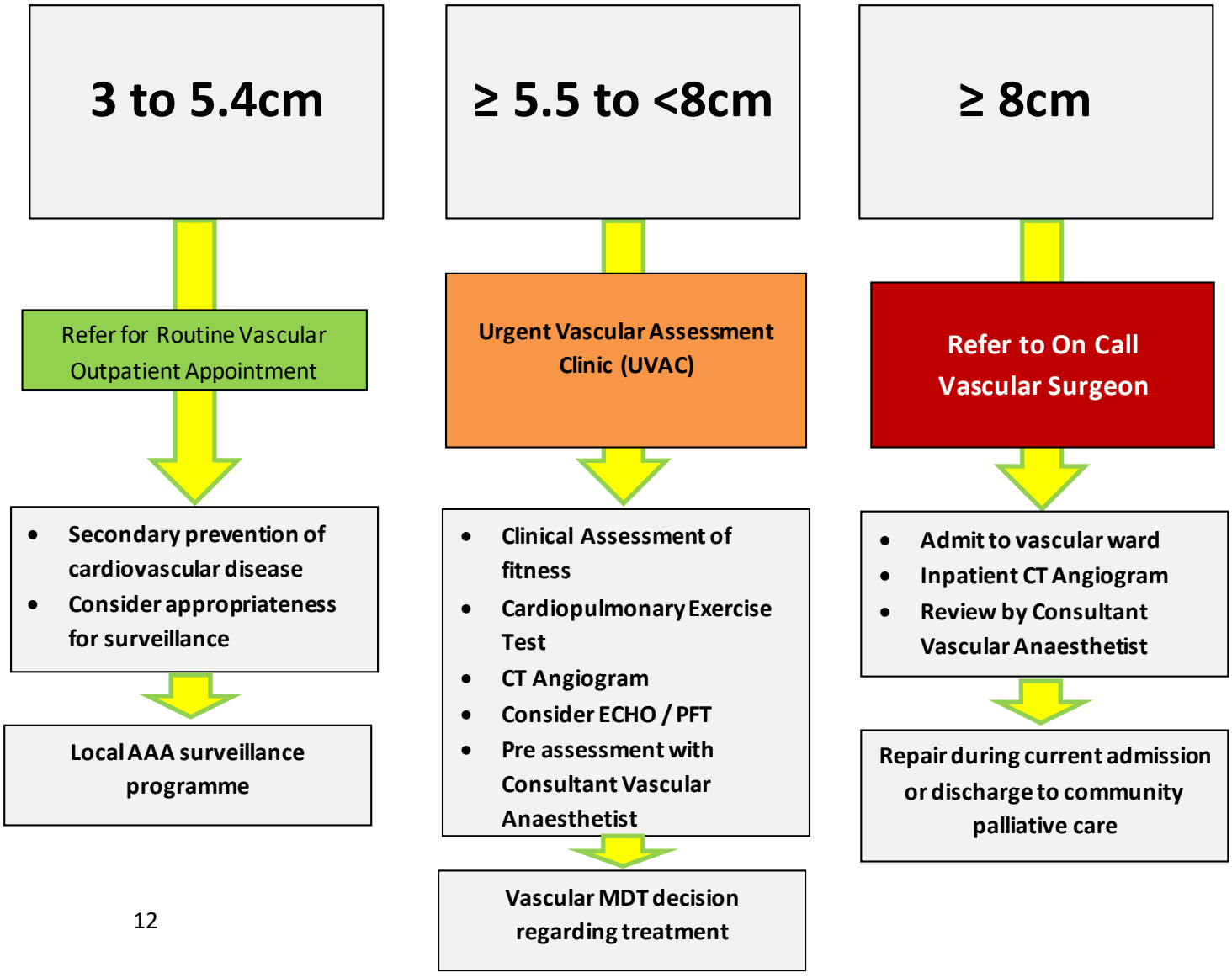
Investigation and Management of Unruptured AAA

Guidance: ESVS Management of Abdominal Aorto-iliac Aneurysms

Patients who have:

1. Abdo Pain
2. Back Pain
3. Collapse

Should be treated according to Symptomatic/Ruptured AAA Pathway



Formation of Vascular Access for Haemodialysis

Clinical decision for haemodialysis [A]

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Referral to vascular access CNS

- Bilateral Upper Limb Duplex (venous and arterial)
- Explanation of risks / benefits and aims of procedure.

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Vascular Access MDT Review

- Native AV Fistula as first line, followed by graft, then tunnelled line
- Arterial and venous diameter suitability for AV fistula
- Non-dominant arm, followed by dominant arm, then lower limbs
- Wrist Radiocephalic, forearm radiocephalic, brachiocephalic, brachiobasilic

↓

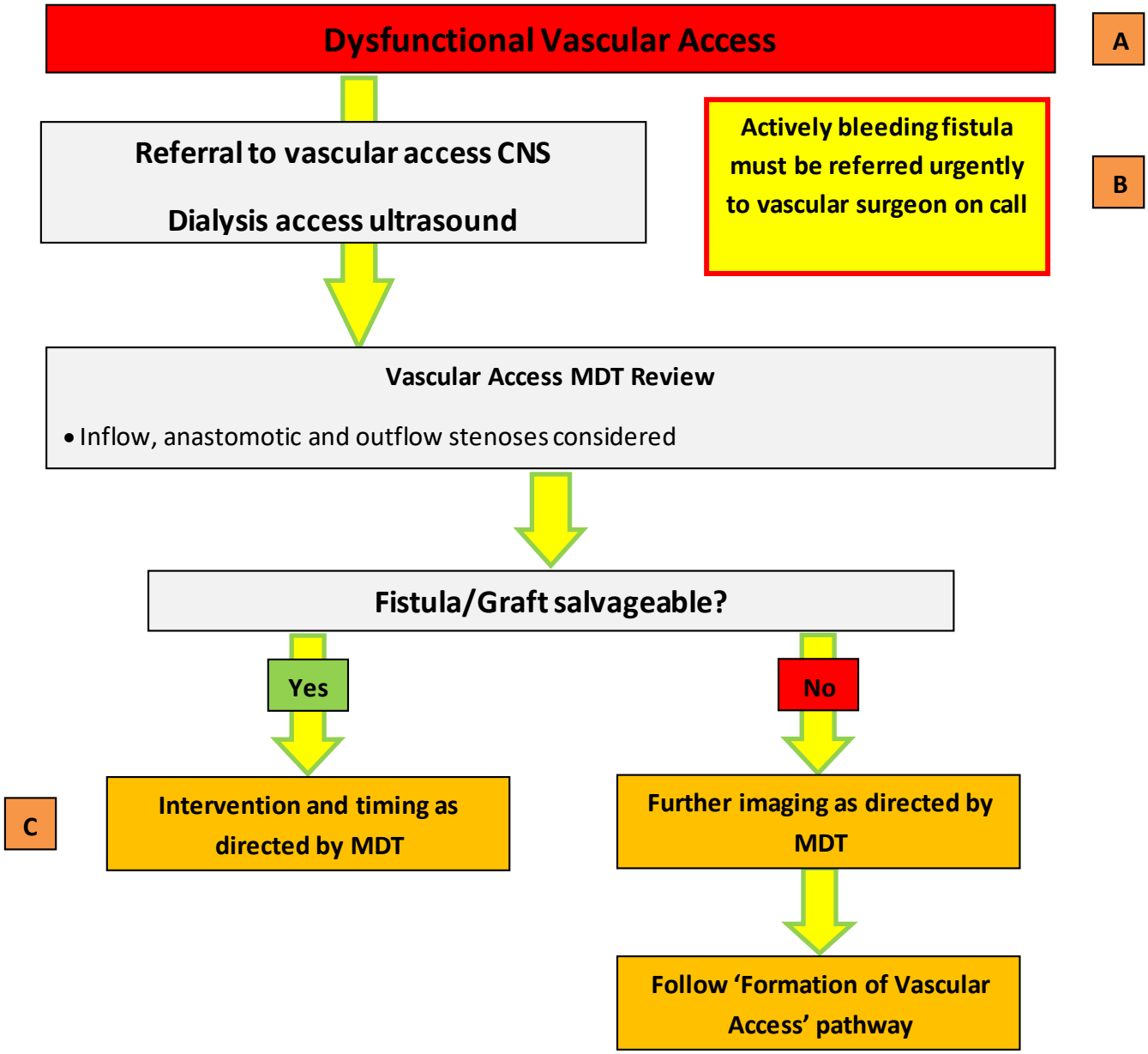
Urgent booking request for surgery at patient's local hospital if suitable for day surgery

- **Regional Block preferable 'first line' anaesthetic**
- **Patients requiring overnight stay should have surgery in arterial centre**

Notes

A. **The decision to commence haemodialysis is undertaken by the renal team in charge of the patient's care. Patients should receive appropriate education and psychological support about haemodialysis. Consideration should be given to transplant, peritoneal dialysis and palliative care prior to referral.**

Dysfunctional Vascular Access for Haemodialysis



Notes

A. **Causes may include poor flow rate, clotting of lines, prolonged bleeding, steal (pain on dialysis)**

B. **If patients cannot be safely discharged from dialysis unit or graft has occluded, admit to renal bed base and contact on call vascular surgeon**

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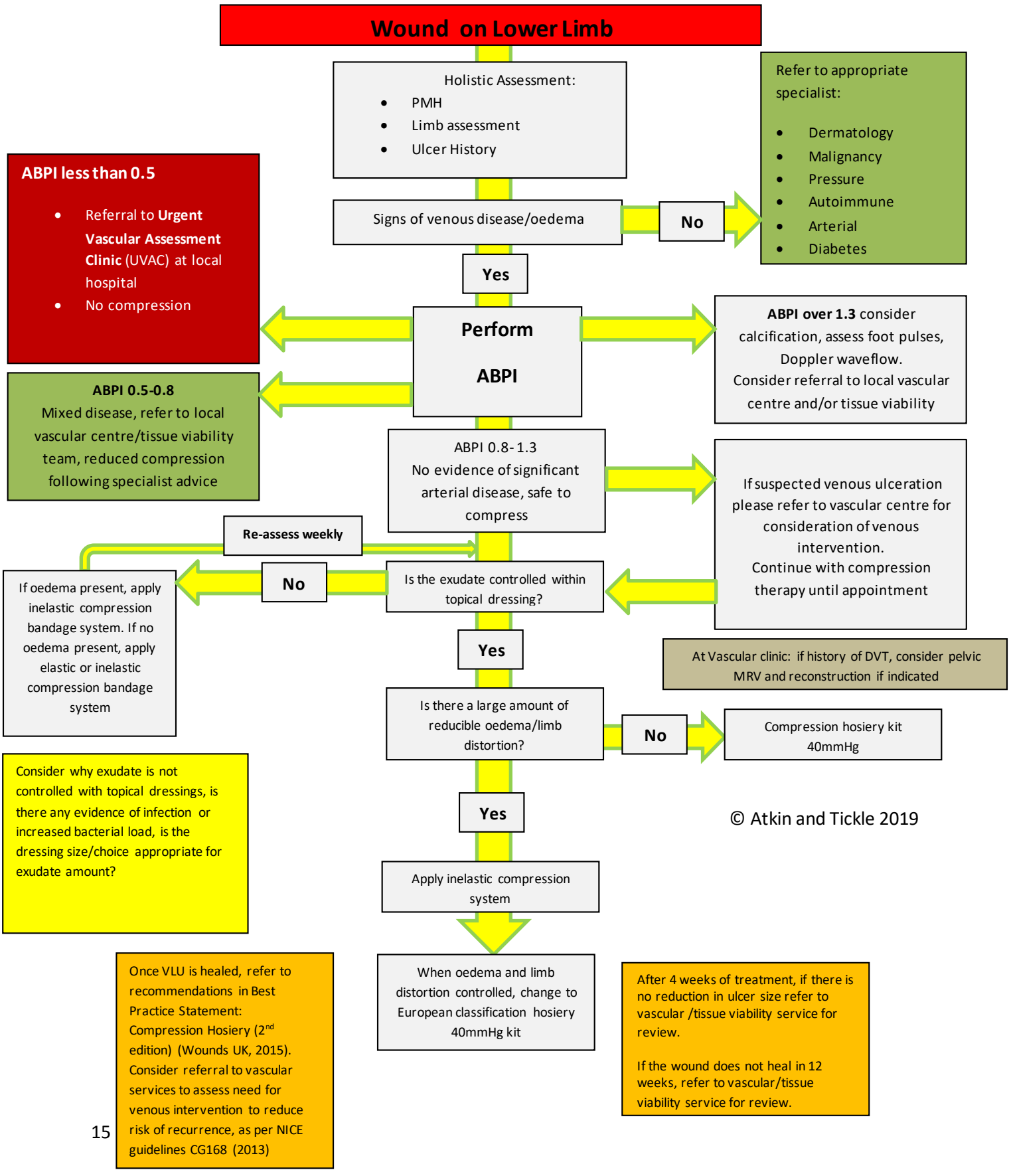
Lower limb wound treatment pathway



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Management of Symptomatic Varicose Veins
NICE CG 168

Symptomatic Varicose Veins — A

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Non-urgent outpatient referral to local vascular surgery service

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Clinical Review (One-stop clinic)
- History, examination (including arterial assessment / ABPI)
- Venous duplex scan (deep and superficial systems) to confirm venous reflux
- Application for CCG approval of funding (if required)

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Femoropopliteal Deep venous occlusive disease?

Yes →
- Compression Hosiery
- Anticoagulation if new diagnosis of DVT

No ↓

Pelvic/suprainguinal disease?

Yes → Discussion with vascular radiology regarding pelvic imaging and intervention

No ↓

Superficial venous intervention
1. EVLT / RFA if anatomically suitable +/- MSA or sclerotherapy (GA or LA)
2. Surgical ligation (+ GSV strip for SFJ) if not suitable for endovenous treatment
3. Compression hosiery if unfit or patient preference
4. Patient initiated follow-up if required

Notes

A. **Symptomatic Varicose Veins**
- **Aching / swelling after prolonged standing/ end of the day**
- **Itching (venous eczema)**
- **Skin staining / scarring (lipodermatosclerosis)**
- **Ulcers**

ABPI<0.8 is a relative contraindication to compression. Consider balance of risks.

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Urgent Vascular Assessment Clinic (UVAC)

Referral Guidance and Process

Referral

1. Check referral complies with UVAC Referral Guide
2. If in doubt regarding appropriateness of referral to UVAC, contact local Vascular Nurse Specialist (VNS) or Reg/Consultant on Call
3. Referrer completes proforma, attaches photo and refers via eReferral System
4. VNS Triage referral
5. Admin team books into clinic slot guided by VNS Triage
6. Admin team informs patient
7. If transport is needed follow local policy

Assessment Clinic

VNS/ACP assessment establishing diagnosis, urgency, severity and imaging/treatment plan

Same day imaging (where ever possible) if not possible same day to arrange urgent imaging within 48 hours

Review

VNS Advanced Clinical Practitioner (ACP)

- Imaging reviewed
- Diagnosis confirmed
- Establish treatment plan
- Escalate if concerns
- List for intervention
- Communicate plans to patient
- Arranges follow up
- Arranges MDT discussion
- Admit to virtual ward if appropriate

VNS

- Imaging reviewed
- Diagnosis confirmed
- Arrange urgent face to face or remote review by reg/surgeon
- Communicate plans to patient
- Arranges follow up
- Arranges MDT discussion
- Admit to virtual ward if appropriate

Immediate admission via SAU/on call vascular consultant

Planned urgent admission

Out patient management

Discharge

REFERRAL GUIDANCE

Inclusion Criteria:

- **Critical Limb ischaemia**
- **Infected Foot or Leg Ulcer where admission is being considered (photo evidence)**
- **Leg Ulcer with ABPI <0.5**
- **Asymptomatic AAA 5.5cm-7.9cm**

Exclusion Criteria:

Referrer to oncall vascular reg/consultant if:

- **Acute Limb Ischaemia**
- **Foot sepsis requiring drainage**
- **Patient is on end of life care**
- **New AAA greater than 8cm**
- **Tender AAA greater than 5.5cm**

Refer patient immediate to A&E if:

- **Patient acutely unwell or acute sepsis**
- **Suspected ruptured AAA**
- **Active bleeding**

Other conditions:

- Suspected DVT – refer to medical team
- TIA/CVA – refer to ED/TIA clinic as per local protocol
- Incidental finding of AAA less than 5.5cm routine OPA

APPENDIX

Ambulance Transfers – DO NOT REQUEST 999

Follow National Framework for Health Care Professionals Ambulance Responses and Inter-Facility Transfers (NHSE/I, 2019)

Management of Symptomatic AAA, Management of Rupture AAA

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Alert Arterial Centre (BRI/LGI)

IFT Level 2 – Tel: 03003300276

Management of Acute Limb Ischaemia & Isolated Vascular Trauma

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Alert Arterial Centre (BRI/LGI)

IFT Level 2 – Tel: 03003300276

Emergency Diabetic Feet

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Alert Arterial Centre (BRI/LGI)

IFT Level 3 – Tel: 03003300276

Reference link: https://www.yas.nhs.uk/our-services/health-care-professionals-area/

Terms of Reference

2019/2020

Context

The six acute hospitals in West Yorkshire and Harrogate are part of the West Yorkshire Association of Acute Trusts (WYAAT). WYAAT is the acute hospitals collaboration within the West Yorkshire and Harrogate Health and Care Partnership, one of the largest integrated care systems in England. The Partnership's ambition is for everyone to have the best possible health and wellbeing, by bringing together the wide range of skills and expertise across West Yorkshire and Harrogate we are working differently, innovating and driving forward change to deliver the highest quality care.

Through WYAAT, five Trusts (ANHSFT, BTHT, CHFT, LTHT, MYHT) have agreed a programme to create a single shared vascular service to provide safe, effective, patient focused, outstanding care across West Yorkshire in the form of WYVaS. This dynamic and ambitious move will make us one of the largest vascular services in the country covering 2.4m people

In the near future the single service will provide acute and high risk/complex intervention at two Arterial Centres in West Yorkshire whilst providing clinics, elective day case/low risk and diagnostics across all sites under WYVaS. One of the Arterial Centres is at Leeds, supporting the Major Trauma Centre. Following a process, supported by clinicians representing all the above trusts and the WYAAT Committee in Common (made up of the Chairs and Chief Executives of all WYAAT trusts), Bradford has been recommended to NHS England as the second arterial centre. We are now commencing this transformation process and are currently in a period of public consultation expected to end in early 2020.

Neeraj Bhasin, Clinical Director, WYVaS

1. Constitution

The Clinical Work Group will lead and oversee the development and implementation of the clinical element of the West Yorkshire Vascular Service (WYVaS). The triumvirate will report CWG progress towards implementation to the WYVaS Programme Board

2. Purpose

- To establish best evidence based clinical practice and equity of access for patients through the development of a single shared West Yorkshire Vascular Service, bringing together the existing vascular services across the five trusts.

- The CWG will support the West Yorkshire Vascular Service by designing and proposing working methods, expected benefits to patients of a high-quality vascular service, independent of location of care within the collaborative.

- The purpose of the CWG is to establish a cohesive, collaborative, multi-professional forum, bringing together expert clinical representation from all five trusts and external stakeholders.

- The CWG will ensure the WYVaS work towards the requirements of the NHSE vascular service specification.

- The CWG with incorporate GIRFT recommendations. The Getting It Right First Time (GIRFT) Programme is a national programme sponsored by NHS Improvement which engages frontline clinicians working in acute care with their own data to accelerate the adoption of evidence-based practice through peer to peer discussion and review.

3. Objectives

What is the Clinical Working Group responsible for?

- A core philosophy is to streamline/align clinical practices and pathways across the West Yorkshire Vascular Service. This requires a commitment towards single pathways, protocols and documentation for many areas of our work. The clinical experts are best positioned to understand the details of these aspects and develop, agree and own such pathways and protocols.

- The CWG will have three working groups, each will be chaired by a lead, agreed by the WYVaS triumvirate and the individual groups.

- The working groups:
    - Clinical Working Model e.g. Consultant of the week model, one stop/virtual clinics/admission avoidance clinics
    - Repatriation - internal and external, arterial and non-arterial centres, virtual ward
    - Standardising Clinical Pathways

- Each working group is responsible for ensuring adequate multi-professional representation.

- To design a clinical service that complies with NHS England's service specification.

4. Reporting structure and Governance

- The WYVaS Triumvirate is responsible for ensuring the group remains on track and will facilitate the meetings.

- The WYVaS Triumvirate (Clincal Director, General Manager, Head of Nursing) will present outcomes from the CWG to the WYVaS board.

- Membership is open to all grades of staff who are employed at a West Yorkshire Vascular Service trust. Typically, members may be invited by the working groups clinician lead or current members.

- The WYVaS Clinical Director, along with the Head of Nursing and General Manger, are responsible for the running of meetings, delegation of tasks and delivery of outcome documents to the WYVaS Programme Board.

- The WYVaS Triumvirate reports to both the WYAAT Programme Director and the West Yorkshire Vascular Programme Board.

5. Clinical Working Group Chair

Clinical Director of WYVaS

6. Membership

Membership will include representation from:

- WYVaS Clinical Director (Chair)
- WYVaS General Manager
- WYVaS Head of Nursing
- Vascular Surgeons
- Interventional Radiologists
- Vascular Specialist Nurses
- Vascular Ward Managers
- Interventional Radiology Team
- Therapists
- Primary Care
- Yorkshire Ambulance Service
- GIRFT implementation team

This list is non exhaustive, invites can be extended as the working groups develop.

7. Agenda/ Minutes

- The agenda will be circulated the week before the meeting and will include an update from the WYVaS CD, Group Leads, and confirmation of next meeting.

- Minutes will be summarised and circulated within 2 weeks of the meeting to those that have attended.

- The CWG meeting minutes will not be circulated outside the groups due to the potentially sensitive information been discussed.

8. Quoracy

The groups will be quorate if there are a minimum of 3 members of each group.

9. Frequency of meetings

Six weeks rolling programme on Monday afternoons.

Location of meetings will be rotated across the 5 trusts to ensure members have equal opportunity and access to attend.

10. Administration

Administration support to the CWG will be provided by the WYAAT/WYVaS PMO.

11. Review of Terms of Reference

Terms of Reference will be reviewed annually.

12. Governance Structure