Current problems and hurdles to deliver QIF

- Financial
    - Staffing
    - Imaging/machines
- Time
    - Staffing/clinical – 7 day working?!?
- Resources
    - Staffing, including AHPs (with admin support)
    - Imaging/machines (non-invasive), especially out of hours
- Capacity
    - Beds in Arterial centre (AC) for urgent admissions and transfer to and from Non-Arterial Centre (NAC) locations
    - Clinics
    - Theatres & angio suites
        - Both in AC and NAC
    - Anaesthetic support
- Networks/geography
    - AC/NAC locations – can be large distances for patient travel and transfers
    - Variation in service delivery between AC and NAC
    - Appropriate non-vascular consultant assessment in NAC of vascular patients
    - Referral pathways – network triage and quality of referrals
    - Education of GPs and primary care to help with appropriate and timely referral
    - Points of access within network
- Resistance to change/buy in
    - Perception that this creates extra work
    - Prioritising urgent over elective cases
    - Time to implement QIF
    - Data collection

How can we improve pathways and outcomes for patients with CLI?

- Community
    - Foot clinics
    - Education of GPs, community podiatrists, district nurses and patients to avoid delayed presentations of CLI
- One stop / rapid access CLI clinics, which would involve clinical review, imaging (Duplex/CTA), anaesthetic assessment and preoperative investigations if necessary (e.g. ECHO)
- Clearly defined pathways of care
    - With agreed dataset to capture required information in order to triage patients
    - Good transfer and repatriation arrangements between AC and NAC
    - Equitable access to vascular services for patient presenting to AC or NAC
    - Protocols for assessment in NAC, input from Podiatry, AHPs, etc.
    - Consultant led early referral vetting
    - Open door policy regarding who can refer patients in

    - Centralised referral system, already adopted by some centres with good results, with daily triage of referrals by Consultant and decision-making about booking in urgent or routine clinic slots
    - Strong network admin support, for data collection, management of HOT clinics and management of referred patients from NAC
    - Involvement of Care of Elderly Physicians, that can optimise patients preoperatively, expedite discharge and avoid re-admissions
    - Smart-working and review of contracts, in order to maximise use of personnel and resources, such as clinical areas in NAC.
- Increase capacity
    - Theatres & angio suites, especially for urgent and emergent cases
    - Hybrid suites
    - HDU
    - Ward beds (Ring-fencing beds and stepdown/rehab wards would facilitate patient turnover)
    - Treating patients in NAC if facilities available and unused. However, concerns were raised regarding the extent of procedures safely performed in NAC with limited resources and the individuals performing them. Consultant job plans with equal clinical responsibilities between AC and NAC were suggested as a way to strengthen the presence of vascular specialists in the NAC.
- Define successful outcomes for CLI patients
    - Revascularisation and/or amputation
    - Timeframes along the pathway of care
    - The importance of administrative support was underlined. It was suggested that, by reducing the inpatient length of stay, the teams will be able to demonstrate cost-effectiveness, and therefore build a business case for the increased resources required for the success of the project.

Next Steps for NVR

The main metrics for the NVR to monitor in relation to the QIF are around delays to revascularisation for patients with CLI. The NVR started collecting referral date in January 2019, and already collects admission date, admission mode, presenting problem and fontaine score (to identify CLI patients) and procedure date.

Decide if new data items can be captured on the NVR to assist with monitoring QIF:

- Date of first symptoms
- Date of first imaging
    - Either make non-mandatory or include option for not known if performed at another centre
- Can we record whether a patient was transferred or not.