CALDERDALE COUNCIL

WEST YORKSHIRE AND NORTH YORKSHIRE
JOINT HEALTH OVERVIEW SCRUTINY COMMITTEE (VASCULAR SERVICES)

FRIDAY, 17TH JANUARY 2020

PRESENT: Councillor Paul Godwin, Bradford Council
Councillor Robert Hargreaves, Bradford Council
Councillor Colin Hutchinson, Calderdale Council (Joint Chair)
Councillor Graham Latty, Leeds Council
Councillor Betty Rhodes, Wakefield Council
Councillor Liz Smaje, Kirklees Council (Joint Chair)

IN ATTENDANCE: Mike Lodge (Senior Scrutiny Officer, Calderdale Council)
Richard Dunne (Principal Governance & Democratic Engagement Officer, Kirklees Council)
Lee Squire (Head of Communications. NHS England/NHS Improvement)
Karen Stone (Medical Director, Mid-Yorkshire Trust)
David Black (Medical Director Commissioning, NHS England/NHS Improvement - North East and Yorkshire)
Matthew Groom (Regional Director, Specialist Commissioning, NHS England)
Neeraj Bhasin (Vascular Surgeon and Clinical Director, West Yorkshire)
John Stowes (Clinical Lead for Renal Services, Bradford Teaching Hospitals Trust)
Cornelle Parker (Deputy Medical Director, Calderdale and Huddersfield Foundation Trust)
Nikhil Bhuskuti (Clinical Director, Radiology Calderdale and Huddersfield Foundation Trust)
Sarah Ramsden (General Manager Radiology, Calderdale and Huddersfield Foundation Trust)
Sree Tumula (Clinical Director, Women's Services, Calderdale and Huddersfield Foundation Trust)
Jonathan Cowley (Clinical Director, Genecology and Specialist Surgery, Calderdale Huddersfield and Foundation Trust)
Amanda Pine (Emergency Medicine Consultant, Calderdale and Huddersfield Foundation Trust)
Catherine Riley (Assistant Director Strategic Planning, Calderdale and Huddersfield Foundation Trust)

APOLOGIES: Councillor Stephen Baines MBE, Calderdale Council
Councillor Jim Clark, North Yorkshire County Council
Councillor Helen Hayden, Leeds Council
Councillor Andy Solloway, North Yorkshire County Council
Councillor Lynne Whitehouse, Wakefield Council

1 Apologies for Absence

Apologies were received from Councillors Baines MBE, Clark, Hayden, Solloway and Whitehouse.

2 Members Interests

There were none to declare.

3 Admission of the Public

All items were taken in public session.

4 Election of Chair

RESOLVED that Councillor Hutchinson be elected as Chair for this meeting.

5 Terms of Reference and working arrangements - To receive and agree the Terms of Reference and to clarify the committee's working arrangements

The Chair asked Members of the Scrutiny Committee if there were any amendments or issues to be raised regarding the Terms of Reference and/or working arrangements as circulated prior to the meeting.

RESOLVED that the Terms of Reference, including clarification of the Committee's working arrangements be approved for the purpose of this meeting and any subsequent meetings.

5 Deputations from the Public

There were no deputations made at the meeting.

6 Proposed changes to specialised commissioned vascular services across West Yorkshire

Matthew Groom, the Interim Regional Director of Specialised Commissioning and Health and Justice submitted a written report regarding the proposed changes to specialised commissioned Vascular Services across West Yorkshire.

Representatives from North East and Yorkshire Region Specialised Commissioning Team, NHS England presented the proposals at the meeting which included an outline of the current service provision, the proposed changes, key drivers for change (including details of the national specification), standards for specialised vascular care, and expected patient flows.

In discussing the issues, the Committee would have an opportunity to consider the impact of the proposals on other clinical services, including identifying the key clinical interdependencies with other services and the effect on the continuing provision of these services. There were some areas such as the workforce challenges and assessing the sustainability of the workforce (including staffing levels in interventional radiology, vascular services and other key interdependent services), which would be considered by Members. The regional work being carried out to resource such positions was also to be noted.

Officers provided an overview of the NHS England (NHSE) perspective and clinical need for change in these services and what the impacts would be on CHFT and other organisations. The public consultation had been live but was due to close today; following this, an in-depth analysis would be completed in February, and reported to a future meeting of this Committee. Previously the services had been based on high cost and low volume in NHS Services and it was anticipated that these changes would help to address some of the identified issues. Vascular Services were specialised services and the NHSE specification was focused on reaching better outcomes for patients, ensuring they were cared for in high volume centres. There were some areas where this was more prevalent for example: major trauma cases were treated in Leeds, which had found a 19% reduction in mortality of majorly injured patients in the time this had been in place. Cancer and cardiac cases were limited to larger centres, not just in West Yorkshire areas, but this was already happening

in Mid-Yorkshire and the Leeds area. Officers advised that they were proud of the outcomes from the Vascular Services in all three centres in West Yorkshire, but these are not all felt to be sustainable. Currently the offer in West Yorkshire had been alternated, for example: one week these services were delivered at Huddersfield Royal Infirmary (HRI) and another week at Bradford Royal Infirmary (BRI). In implementing the proposed changes, the urgent care access would be provided at BRI and then patients would be discharged and either sent home or transferred to their local hospital. All of the centres would provide outpatient services. Ultimately this would mean that 1,300 procedures would be handled locally, along with those patients who do not require surgery.

Councillor Hutchinson endorsed the work that had been undertaken by the team and the quality of the outcomes the teams were currently delivering. The main driver of the case for change was the lack of appropriately skilled workforce, both locally and nationally, and this was something the Committee wished to explore further. The proposals had been written from the perspective of the Vascular Service, but no service operates in isolation and the report from the Yorkshire and the Humber Clinical Senate emphasized that the potential knock-on impact on other services needed to be considered, including Accident and Emergency, Hyperacute Stroke Services, Urology, Obstetrics and General Surgery. The proposals did not mention this and the Committee wished to explore this further.

A previous reconfiguration in 2014 had led to Pinderfields Hospital ceasing to be an Arterial Centre, so evidence was sought as to what impact this had had on the range of work carried out by other specialties. In response, the Committee was told that it had not affected the Urology Service and that most of the cancer, obstetrics and general surgery services had not suffered detriment. Any serious incidents would be reviewed ~~direction~~, however there had been only one case and this was due to how a patient was when they arrived at hospital, not as a cause of the changes to services.

Councillor Hutchinson commented that the Service Specifications underpinning the proposals (Appendix A and B) were much clearer in their description of the continuing provision of Vascular Surgeon input to the non-arterial sites than the description of the Interventional Radiology service that the non-arterial sites might expect. Officers responded that the intention was for a team of Interventional Radiologists to support the entire network of hospitals across West Yorkshire. They believed that this would give greater resilience and allow the team to respond to peaks and troughs of demand.

Councillor Hutchinson asked whether there would be the capacity in the Arterial Centres to accommodate Non-vascular patients requiring Interventional Radiology or Vascular Surgery in an emergency. Officers advised that this already was the case at non-arterial sites, such as CRH. Most patients could be stabilised overnight and any day time complications would be handled on site, in specific areas, however it was accepted that a plan was needed that worked all the time.

Councillor Smaje commented that if the NHSE was providing a network, some clinical services may be at risk where there were no solutions in place, which raised concerns about what was being proposed. There were concerns that other services may follow and move elsewhere, which would then impact on all hospitals in the West Yorkshire and Harrogate area. In response, Officers advised that IR had a shortfall across the country, as it was so specialised there were many different areas of interest. Every hospital required access to this service so the networks arrangement or ‘on rota’ procedure was ‘the norm’. CRH and HRI were difficult to cover all of the time due to the shortage in supply of IR’s; however links with BRI would supply more support to vascular patients. Officers would need to look at how this was networked to Acute Trusts around West Yorkshire, but it had to be achieved. This proposal was something different.

Councillor Smaje queried whether there would be a ‘domino effect’ if not resolved. In response, Officers

advised that for Vascular and non-Vascular Services CHFT covered both out of hours and when on-call, but this was possibly a different model to Mid-Yorkshire and Leeds. If the proposals put forward did occur, there would not be any access to this service, meaning those patients unwell out of hours, e.g. a kidney obstruction or severe bleeding during gall bladder removal, would have to transfer to another site If there were no beds at another site, this would also be a concern and something which would need to be addressed at that time. This had been flagged as a risk, something which would be looked into further following consultation. In terms of concerns for patients who had gastroenterology/endoscopy needs, of which it was not common for these issues to occur in these cases, patients would have to transfer to BRI. There was a small number of cases where interventions and patient transfer from BRI and HRI/CRH took place, but they did occur. There were no solutions at present and this would require colleague involvement from all Trusts in West Yorkshire to resolve this. It was a risk that NHSE were aware of and as clinicians, there would be a need to get agreements in place as to what these arrangements looked like.

Councillor Hutchinson asked how these risks were managed currently. For example, were non-vascular patients who developed vascular complications unexpectedly managed during daytime, and other times through a specialist on-site or through an ad-hoc arrangement. Members had heard there was an extremely small supply of specialists and understood that cover was extremely difficult. How can the Committee be assured that a clear and safe system was in place to deal with these emergency situations. Officers advised that to give a perspective on numbers, there had been less than 5 occasions in the last 20 years of patients with the types of gastroenterology/bleeding concerns referred to and although these were low numbers, they were still patients. There was lots of learning from neighbouring Trusts and experiences from other areas who had been through the process already, (to better understand the national strategy) and how to deal with the specific issues.

Councillor Smaje referred Members back to the ad-hoc arrangements which were in place. It was unclear as to why there was not already work on a network in these proposals and how could this work moving forward? For example, specialists from BRI to move to CRH and HRI rather than the patient moving across. Why had this not been looked at and what were the impacts on other Trusts, (e.g. If BRI was full, would Leeds be a second option and what was the capacity here, etc.)?

Officers advised that in terms of the non-vascular ‘knock on’ effects, this was not a core part of this consultation; there was work ongoing on this but it was not something which had been brought into this report or consultation. Work was already being done as part of this remit, e.g. BRI to CRH, although the main rota would be based in BRI, these were extraordinarily rare circumstances where these would happen. Officers advised that general IR was a specialty and at least half of the Trusts in England did not have his facility, as well as issues in accessing this. The Trust were aware of the problem and that comprehensive Vascular Services were required, however the workforce capacity was not available to meet a 24 hour requirement. The new proposal would give a much greater chance of recruitment and retention of the expertise needed. In terms of the non-Vascular Service, there was a need to manage general interventions outside of this service; Officers gave Mid-Yorkshire as an example, where the Trust was working with the CCG, ensuring less ad-hoc arrangements and a more robust service.

Officers advised that post-consultation and once a decision had been made, appropriate and necessary practicalities of reconfiguration arrangements would be determined. Arrangements would include the optimization of patient’s safety. Officers accepted the points made regarding access to specialist services, however general IR was not vascular IR and needed to be considered in a separate process.

Councillor Smaje commented on the clear dependency on specialists being available and where they were located due to dependencies. Why had this not already been looked at, and/or why was it not in scope? In terms of the Clinical Senate Report (2017), it was questioned whether the direction of travel can be supported

by the trainee numbers currently in place. What was being done in this region to train enough IR's and Vascular Surgeons? Even with the proposed reconfiguration, the number of Interventional Radiologists based at BRI would still be below the national standard. There appeared to be insufficient training places for the staff required and this had been the case for a number of years. Were we 'getting a grip' of this locally? In response, Officers advised that this was a new specialty and training figures overall were low in the region but it was about bringing people in. There were 5 throughout the whole of Yorkshire, they had been trained and work was ongoing to retain them. In liaising with these specialists, NHSE had heard about the reconfiguration; there were issues around being 'on call' as well as elective services, e.g. still in clinic and operating. It was anticipated that providing a wider rota, with a more attractive work/life balance and better career prospects, this would assist in attracting and retaining new and existing professionals. Many of the existing specialists wanted access to the high intensive work within the arterial centres, but no longer wanted to do the 24/7 work. This would allow for more work in a planned and protected environment, with a broader working pattern and rota. Officers provided an example of how this was working in Leeds Hospitals and the networking opportunities providing more provision for patients.

Members discussed the training of specialists. Officers advised that because there was a shortage of Radiologists (of any kind) across the UK, there was uncertainty of how these services would be staffed in the future; this had resulted in impacts on the service for recruiting and retaining staff. It was hoped that once there was a clear, long-term model of delivery of the service, the appointments or recruitment would follow.

Councillor Hutchinson asked if there had been an increase in trainee numbers for Radiology, including Interventional Radiology, in West Yorkshire. In response, Officers advised it had been marginal. Councillor Hutchinson asked that Officers should make this a priority at local level.

Councillor Smaje queried how the new process would work in terms of the larger centres. There were around 800 patients per year, who would currently be treated at HRI who would receive the service at BRI, with a small number choosing to go to Leeds. In Kirklees, there were two Trusts and patients could choose to go to either. Had the patient flow been modelled for work capacity at both ~~and~~ Leeds and Bradford, and if so, what adjustments had been made? In response, Officers advised that in the modelling stages there had been an options appraisal which looked at a years' worth of patients. There were 800 at HRI and all of the patient postcodes were mapped to the next closest hospital; in doing this, the pathway was considered where all patient diagnostics were done locally. It was anticipated that the vast majority of patients (around 750 patients or more) would stay at CHFT/BRI group. Some patients to the edge of the geographical area would go to Leeds, and some in the west may go to Pennine Acute Hospitals Trust., etc.

Members discussed repatriation of patients from the Arterial Sites and the concern expressed by the Yorkshire and the Humber Clinical Senate (2017) that "It is not evident, currently, that specialized commissioners are supporting their proposals with discussion with the CCGs to ensure effective planning of the whole patient pathway". There were standardized pathways across West Yorkshire, so the contact and quality of care should be the same across the board. There would be some patients who needed repatriation and general patients who had rehabilitation or complex patient needs, rather than surgical needs. In the process of designing this service, there had been assistance from Vascular, Therapy, Nursing and Clinical Services. Work would be ongoing with Occupational Therapists, Physiotherapists and work extending across the social care boundaries. The proposal ensured that patients did not have to be in their Council locality for the ongoing care to be arranged with the local services. There needed to be safe and effective handover in terms of assessment and this would be multi-disciplinary.

Councillor Godwin raised concerns regarding training as an issue; there was not one single area of medicine in which, most staff would only want to work at the bigger hospitals such as Leeds for experience and professional support. Despite these issues, the same models were being developed to deliver the same service and this was a problem. In response, Officers advised that there had also been more extended roles

developed such as Advanced Care Practitioners working at GP Level, extending nursing provision, etc. This was being looked at across the Board. Members discussed training of professionals in detail.

Councillor Godwin commented on the sustainability of services which depended on the patient moving rather than the professionals. People paid their taxes across West Yorkshire, only to receive a good service if they had an 'LS' postcode. Much of the Vascular Service discussed today seemed to be about patients moving and meeting the needs of doctors rather than ~~its~~ patients, including fulfilling the lifestyle aspirations of doctors in the recruitment and retention of staff. There was a level of expectation of services for patients, for example, what happens if a patient is elderly or could not travel. There needed to be consideration to meeting the needs of patients rather than the needs of the NHS. In response, Officers advised that there was always a 'trade off' agreement which was evidence-based in cases such as these; for example, mortality rates in larger centres were often less than in smaller ones and the outcomes were often better. There needed to be a greater sense of care and services needed to be as accessible as possible; people needed to travel if they wanted the best care. Some patients would need to go to high volume centres where the outcomes were good, and this was predominantly at a larger service. However, where possible, the service would aim to provide locally delivered services. In terms of the comments relating to retention and changing the recruitment strategy for staff - The outcomes for the whole of West Yorkshire were universally above the national average for all indexes, and it was unfair to clinicians delivering outstanding outcomes in the service to not want a better work/life balance and changes in their working day. Some clinicians were on-call for 72 hours or 7 days and this was too long a length of time to operate on; there were other jobs which had restrictions on people's hours, but this was not the case for clinicians and in order to run an optimal service, there needed to be a balance between appropriate hours and working times as well as an efficient service.

Councillor Godwin suggested that the were potentially a number of people of who were not fit for surgery due to travel and this would impact on the service; it stated in the documents provided that 20% of patients would meet their 45 minute target, etc. Did the organisations measure the number of people having to undertake a second procedure due to the impacts of not being able to travel? In response, Officers advised that there had been an audit for over two years undertaken on all transfers and there had been no adverse events for those patients that had had to travel. If an issue did occur, the patient would remain in the hospital and transfer to the appropriate service. Consultation with the Yorkshire Ambulance Service (YAS) had also been undertaken and they specified that if there was one dedicated centre they could pick up from and know where to send patients too, this would assist in transportation and service for patients.

Councillor Smaje asked whether the changes in the proposals would impact on Accident and Emergency (A&E). In response, Officers advised that currently, 50% of the time arterial emergencies, such as abdominal aortic aneurysms were taken to HRI and 50% of the time to BRI, depending on which was designated the Arterial Site. The changes would provide more clarity for hospitals, for example: knowing there was one arterial site would reduce confusion for doctors in terms of referrals and making things better in terms of patient care.

Councillor Hutchinson asked whether the proposals would jeopardise the future delivery of hyper-acute stroke services at CHFT. Officers replied that the key was the speed of assessment~~s~~ and rapid access to treatment. This sometimes required access to specialist Neurological Interventional Radiology, which is not available at all Hyperacute Stroke Centres, and would require patients to be transferred to a centre (such as LGI), where this service is available. That is the case currently.

Councillor Rhodes advised that the discussions had been of great interest, and as a representative for Wakefield, where a lot of services for patients were delivered in Leeds, there were a number of questions asked which had not been answered or considered in the handling approach. One of the questions focused on consultation; at what point would the impacts be made? Capacity at Leeds could not always take the numbers on board when issues were centralised, (e.g. from Wakefield). What did this mean in terms of capacity,

numbers, training, lack of staff etc.

Secondly, in terms of obstetrics – up to press there were no concerns and the majority of the time the situation was okay, but what would the impact be on the minority? In terms of Urology and Obstetrics, there were clear concerns of potential damaging impacts. If the consultation was ongoing, were there issues that had been mentioned but not added to the consultation, and would it not be too late in looking at them afterwards?

In terms of consultants being required to travel, had there been consultation with them about where they were willing to travel to, rather than patients travelling etc.

There were some issues about the 'step down' procedure as well, in terms of repatriation; how much of this had been scoped in consultation which had gone out? There needed to be some thought given to the kind of quality patients wanted and reassurance to patients that a system was in place from the outset, not that it would be developed in time. How could WYAAT involvement be blended and bonded together? There could only be so many professionals going from place to place, or was this outside the reconfiguration scope?

There needed to be a lot more patient and public understanding of what was being proposed and how this would be responded to. Would there be any input from NHSE into the issues the Senate had raised concerns about? Where was the information and was this going to be shared with the Committee?

In response Officers advised that where obstetrics were concerned this was relatively low volume. The numbers had been so small over a large span of time and ~~the~~ other interventions were in place to manage this. There were preferred options and due to the low volume / small impacts, this had not been included within this consultation. There had only been one case in ten years which had been referred to in the ongoing discussions of this meeting. There would be an independent report including the views of the public and Committee which would be published as part of the recommendations and would be brought to the next meeting for consideration.

For repatriation, in was dependent on each individual's circumstances and the arrangements to be made within their own locality, which would need to be able to provide the required services speedily. Councillor Rhodes queried whether the consultation document had been prepared in a language the public could understand In response, Officers advised they had worked with a small consultation group, some were patients and some clinicians, and the final version received positive feedback especially from patients. All of the information was published on the NHSE website. There had been a mix of questions at consultation events around diagnostics, care, patient access, etc.

Who would be responsible for the reply regarding the Senate concerns and how were the CCG being worked with to resolve some of these issues? In response, Officers advised that they had been clear in the recommendations in selecting the sites, there was lots around implementation which would have to come after two sites had been agreed in order to build on that work. An independent advisory body would take the work forward and NHSE would be taking the advice seriously and working with partners to continue progress.

For obstetrics urology and general surgery there would be an opportunity to reply to any concerns in the initial draft report where people believed issues could be remedied. NHSE had to listen to what the Senate had to say in the report, take account of any recommendations or comments made, but there was no requirement to go back and forth in seeking the Senate's further views. It was NHSE job to get it right. Councillor Rhodes commented on a recent example in Wakefield where the CCG had responded to the Senate's report. Within this report there were three areas noted regarding sufficient provision and understanding the need of the patient; were NHSE not going to respond to this? In response, Officers advised that due to the volume and very small impact on the number of patients, they did not deem this as necessary.

Councillor Hutchinson asked how officers would gauge the attractiveness of jobs in CRH and HRI if there was

no longer a Vascular Service? In response, Officers advised that they had been fortunate to recruit lots of urologists, (an area which had previously been lacking), within general surgery the West Yorkshire region was well-respected and there were no problems in recruitment. In terms of the concerns for Vascular Services there were more requirements for training and recruitment due to the specialised nature of the work. Could WYAAT help to alleviate some concerns? In response, Officers advised that the Trust was a member of WYAAT, which had been designed to put all of the Trusts under one umbrella to work together. There were a number of forums to work together through, e.g. vascular, Medical Directors forums, etc. where these issues would be looked at and clinicians would be brought together in terms of how the Trusts would work in the future. The culture of working together made those things easier in taking new proposals forward.

There had been an unexpected event in August where the IR rota was not covered for a period; it was through the network that vascular and non-vascular work ~~that~~ was covered across Mid-Yorkshire, Bradford and CHFT. Due to the short notice of this event, there had been a few issues experienced in terms of communications, however a solution had been arrived at to any problems where this might have been the case in the future. This was an example of how regional working could be achieved. If issues became more regular than shorter fix, there would not be a problem of learning from this.

Councillor Smaje commented that the Scrutiny Committee were responsible for looking at the issues and dependencies on these proposals. If there were issues where services were stretched, why weren't they already working on a solution to the problem through WYAAT? For example, if there was a problem in a current situation, WYAAT should have a solution or be working on one to deal with issues automatically when they came in. Was there a workstream in place already? If not, there should already be a workstream in place in case there are problems in the current system. In response, Officers advised WYAAT were already doing this. Where vascular was concerned, this had been picked up through general radiology as well as other specialties. The summer issue was ad-hoc due to a consultant leaving the region and the impacts had been felt operationally, but the chief operators and Medical Directors of the Trusts collaborated, through WYAAT, to enable the working together. The programmes or workstreams referred to were in place.

Had patients needing to go to hospitals, where there were other services involved, been mapped out to the requirements of other Trusts? (e.g. had bed numbers been considered, or in some cases where diabetic patients required Vascular Services was there a projection of the impact on general medical services in the Arterial Centre, of managing their diabetes, hypertension etc. NHSE were aware of the bed numbers and the activity numbers, equivalent to population sizes. Similar exercises had taken place in Bristol and Brighton and using this data, NHSE had arrived at a suitable number of beds for the population West and North Yorkshire. In terms of consultations for diabetes, assessments and care would be undertaken in local hospitals and working practices would be changed, for example, for minor procedures, these could be done on a 'day surgery' list to maintain local care and the ongoing presence of vascular specialists on-site. The future model would be better, as patients in Halifax had to travel to the HRI Vascular Ward currently.

Would other co-dependent services be reviewed across all Trusts? In response, Officers advised that from a Renal Services perspective there were currently 6 units in the area, but recognising one centre for all patients in the region would ensure an improved quality of care and multi-disciplinary teams that were fit for purpose for the local population, and ensuring this was maintained for patients. Renal Services had looked at this independently. The capacity model for population was based on additional patients in future and considered feedback from patients.

Councillor Hutchinson sought confirmation that this would allow for increased capacity if it was required, e.g. if located in Bradford, was the service confident the capacity could be met? In response Officers advised that yes it could. The service and WYAAT had looked in detail at this and undertaken a retrospective audit of acute facility and rate of usage, e.g. slots for dialysis, etc. and ascertained that it had the required capacity.

Councillor Hargreaves queried how the service had ended up split between Calderdale, Huddersfield and Bradford originally. If it had all been done before and the service was split, there had obviously been evidence presented that was robust. How robust was this evidence and how long a term was it? In response, Officers advised that vascular surgery was a relatively new specialty. Previously it formed one of the core competencies of many General Surgeons and was carried out at all three hospitals. There was no public discussion of creating the co-dependency of two Trusts then due to such difficulties in determining where the ideal centre would be, so this is where the alternation between the two Trust came from. In terms of the 'deep dive' of evidence, this was the first time this had been done.

In 2004 all out of hours emergency cases were transferred to Leeds for surgery. At the time, Leeds had 4 specialists and the caseload was too high. There were more trainees in hospitals and work was planned if being done in the day-time, so that emergency cases could be taken at night, however there were not enough staff in each hospital to take the work or maintain a sustainable rota. This was about joining hands to do the work as the requirements had changed over the last 10 years and would likely change again, over the next 10 years. It was about putting patients' safety first and to design the service that was needed now.

Councillor Hutchinson pointed out that vascular complications could arise unpredictably during many non-vascular operations and all of the equipment and instruments to deal with such complications needed to be accessible in every hospital, and the theatre staff be competent to use them. Officers replied that surgeons should be trained and capable of managing such complications in an emergency situation. The number of Vascular Surgeons and Interventional Radiologists within the proposed network would enable them to attend any patient who was too ill to be moved. Good communications are essential.

Councillor Latty advised that the most important concern for patients was the standard of care. There were certain requirements for surgery to be undertaken to meet standards. Firstly, did we have in excess of numbers to meet the standard and secondly, would ~~it~~ these proposals have a beneficial effect on the ability to meet those standards? In response, Officers advised that neither Bradford, Calderdale or Huddersfield met the recommended activity figures independently; it was about exposure to sufficient complex interventions. If the numbers were brought together, they exceed the numbers required, as per service specification.

Councillor Latty queried if there were not a sufficient number of people coming through or wanting to put in the time that was available now, was this a developing problem which may be exacerbated? In response, Officers advised that training was bound by the organisation it was attached too; so training was occurring within each organisation, however the new system would allow tailored training, e.g. a clinician may have a dedicated list in another hospital to train on different cases and expose them to different circumstances they may not witness in their host hospital. Members discussed recruitment opportunities again.

Councillor Smaje commented on Leeds appearing to support the complex surgeries and asked whether this would be a replica for Calderdale, Huddersfield and Bradford. In response, Officers advised that it was in the plan not just to restrict what was happening in specific sites, and that the changes should be seen as not limiting what was already in place. An example was provided where surgeons would spend 1 day per week in a 'set' hospital and 4 days per week across all sites undertaking procedures, admin tasks, etc. in order to support the overall network and working to move onto the rest of West Yorkshire.

Councillor Smaje asked about the retention of radiologists in Mid-Yorkshire and whether the existing CRH and HRI offer would continue. Officers advised that the arterial work remained unchanged in Leeds. If one of the Vascular Surgeons was engaged in elective surgery and a vascular emergency occurred, they would have sufficient additional staff to be able to respond. Out of hours, if non-arterial emergencies required vascular support, there would be a conversation between clinicians (through the existing network) regarding the safety of the transfer of a patient, or the surgeon attending the site.

All vascular emergencies would go to BRI, as they currently did in Mid-Yorkshire (to Leeds). All electives would be mirrored as it was. CHFT were to develop a non-vascular rota and there were still competencies to be built in (as this was an issue across the board, and would remain an issue wherever it was moved to), but there was ongoing work in the region to resolve this.

In terms of the service specification appendices, there were some differences of days/hours in the description of the duties of Consultant Vascular Surgeons between Appendix A and B. For clarity, would the number of sites or dual-sites outlined, aim to provide a surgeon who could respond to daytime emergencies on-site 5 days per week? In response, Officers advised that the Vascular Nurse Specialists were a key part of this. At least one Specialist Nurse would be present in each arterial centre. Councillor Hutchinson queried whether this was the current position or this was something that was to be built upon. Officers advised this was something that had started; recruitment could be done externally but it was about 'growing our own' staff; however it worked across the Board, e.g. some CHFT staff had been recruited from the Bristol hospitals. There was a strong and influential provision across West Yorkshire and organisations were willing to take on the new initiatives, e.g. seeing patients locally or for specific issues.

Appendix B appeared to be vague in terms of the commitment to provide Interventional Radiology services at the non-arterial sites. It would be expected that Interventional Radiologists (IR) would pick up the work during working hours, and other capacity and activity discussed would support this. Officers advised that the diagnostic component of Radiology work was crucial and the service could not function without it. The Service Specification was a nationally-produced document and, when it was due for review, these criticisms would be fed back to NHSE.

Councillor Smaje requested clarity on the process going forward. Would the consultation be reviewed by the Scrutiny Committee next time and would the recommendations/comments of this Board be separate to the consultation, or pulled together as one? What were the deadlines for which this needed to be done? The Senior Scrutiny Officer for Calderdale Council advised that the next meeting would focus on the outcomes of the consultation and a further discussion would be had on this. Members would probably wish to meet after the meeting to discuss any final comments they may have which would be fed back to NSE by 28th February 2020 and the outcome would be anticipated in March.

RESOLVED that the views and findings of the public consultation undertaken by NHS England be brought to the meeting of this Scrutiny Committee on 24th February 2020 for consideration.

6 Next Steps

The next meeting would provide an opportunity for the Consultation Feedback Report from NHS England (NHSE) to be received, and to further consider details of the outcomes from the consultation, and details of NHSE's recommended option for the delivery of specialised Vascular Services across West Yorkshire.

RESOLVED that the next meeting of the West Yorkshire and North Yorkshire Joint Health Overview Scrutiny Committee would meet on 24th February 2020, 10:30 hours in the Council Chamber at Huddersfield Town Hall.

(The meeting closed at 13:00 hours).