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Leeds CITY COUNCIL

WEST YORKSHIRE
JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Meeting to be held in Halifax Town Hall, Crossley Street, Halifax HX1 1UJ on Monday, 11th February, 2019 at 10.30 am

(Pre-meeting for all Committee Members at 10.00 am)

MEMBERSHIP

Councillors

Councillor N Riaz	-	Bradford Council
Councillor V Greenwood	-	Bradford Council
Councillor C Hutchinson	-	Calderdale Council
Councillor S Baines	-	Calderdale Council
Councillor J Hughes	-	Kirklees Council
Councillor E Smaje	-	Kirklees Council
Councillor B Flynn	-	Leeds Council
Councillor H Hayden (Chair)	-	Leeds Council
Councillor Y Crewe	-	Wakefield Council
Councillor B Rhodes	-	Wakefield Council

Co-opted Members

Councillor J Clark – North Yorkshire County Council
Councillor A Solloway – North Yorkshire County Council

Please note: Certain or all items on this agenda may be recorded

Principal Scrutiny Adviser:
Steven Courtney
Tel: (0113) 37 88666

A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded). (*In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the Chief Democratic Services Officer at least 24 hours before the meeting.)	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC** 1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report. 2 To consider whether or not to accept the officers recommendation in respect of the above information. 3 If so, to formally pass the following resolution:- **RESOLVED –** That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows: **No exempt items have been identified on this agenda.**	

Item No	Ward/Equal Opportunities	Item Not Open		Page No
3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 of the Members' Code of Conduct.	
5			**APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTES** To receive any apologies for absence and notification of substitutes.	
6			**PUBLIC STATEMENTS** At the discretion of the Chair, a period of up to 10 minutes may be allocated at each ordinary meeting for members of the public to make representations on matters within the terms of reference of the Joint Committee. No member of the public shall speak for more than **three minutes**, except by permission of the Chair. Due to the number and/or nature of comments it may not be possible to provide responses immediately at the meeting. If this is the case, the Joint Committee will indicate how the issue(s) raised will be progressed. If the Joint Committee runs out of time, comments may be submitted in writing at the meeting or by email (contact details on agenda front sheet).	
7			**MINUTES - 5 DECEMBER 2018** To confirm as a correct record, the minutes of the meeting held on 5th December 2018.	1 - 8

Item No	Ward/Equal Opportunities	Item Not Open		Page No
8			**WEST YORKSHIRE AND HARROGATE HEALTH AND CARE PARTNERSHIP: URGENT AND EMERGENCY CARE PROGRAMME** To consider a report from Leeds City Council's Head of Governance and Scrutiny Support introducing a report from the West Yorkshire and Harrogate Health and Care Partnership that provides an outline of the activity taking place across the Partnership relating to the urgent and emergency care programme.	9 - 16
9			**WEST YORKSHIRE AND HARROGATE HEALTH AND CARE PARTNERSHIP: MENTAL HEALTH PROGRAMME** To consider a report from Leeds City Council's Head of Governance and Scrutiny Support introducing a report from the West Yorkshire and Harrogate Health and Care Partnership that provides an outline of the activity taking place across the Partnership relating to the mental health programme.	17 - 18
10			**PROPOSED CHANGES TO SPECIALIST VASCULAR SERVICES FOR ADULTS IN WEST YORKSHIRE** To consider a report from Leeds City Council's Head of Governance and Scrutiny Support that introduces details provided by NHS England Specialised Services Commissioners relating to proposed changes to specialist vascular services for adults in West Yorkshire.	19 - 66
11			**WORK PROGRAMME** To consider a report from Leeds City Council's Head of Governance and Scrutiny Support on the development of the West Yorkshire Joint Health Overview and Scrutiny Committee's work programme.	67 - 84

Item No	Ward/Equal Opportunities	Item Not Open		Page No
12			**DATE AND TIME OF NEXT MEETING** To note the date and time of the next meeting as Monday 8th April 2019 at 10.30 am. (with a pre-meeting for Committee Members from 10.00 am). This meeting will be held in County Hall, Wakefield. **THIRD PARTY RECORDING** Recording of this meeting is allowed to enable those not present to see or hear the proceedings either as they take place (or later) and to enable the reporting of those proceedings. A copy of the recording protocol is available from the contacts named on the front of this agenda. Use of Recordings by Third Parties– code of practice a) Any published recording should be accompanied by a statement of when and where the recording was made, the context of the discussion that took place, and a clear identification of the main speakers and their role or title. b) Those making recordings must not edit the recording in a way that could lead to misinterpretation or misrepresentation of the proceedings or comments made by attendees. In particular there should be no internal editing of published extracts; recordings may start at any point and end at any point but the material between those points must be complete.	

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WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

WEDNESDAY, 5TH DECEMBER, 2018

PRESENT: Councillor H Hayden in the Chair

Councillors S Baines, Y Crewe, B Flynn, V Greenwood, C Hutchinson, B Rhodes, N Riaz and L Smaje

CO-OPTED MEMBERS Councillors J Clark and A Solloway

26 Welcome and Introductions

The Chair welcomed all present to the meeting and brief introductions were made. The Chair also thanked representatives of Bradford Metropolitan District Council for hosting this meeting in Bradford City Hall.

27 Appeals Against Refusal of Inspection of Documents

There were no appeals against the refusal of inspection of documents.

28 Exempt Information - Possible Exclusion of the Press and Public

The agenda contained no exempt information.

29 Late Items

There were no late items of business, however the Committee was in receipt of a supplementary pack containing the work programme (Minute 36 refers) and a copy of the "A Healthy Place to Live, A Great Place to Work" document was tabled at the meeting in support of discussions on the West Yorkshire and Harrogate Health and Care Partnership: Workforce Strategy (Minute No. 35 refers).

30 Declaration of Disclosable Pecuniary Interests

No declarations of disclosable pecuniary interests were made, however Councillor Baines MBE wished it to be recorded that he had a non-pecuniary interest in Agenda Item 8 'West Yorkshire and Harrogate Health and Care Partnership: Acute Care Collaboration and the West Yorkshire Association of Acute Trusts" as a member of the Board, Calderdale & Huddersfield NHS Trust. (minute 34 refers)

31 Apologies for Absence and Notification of Substitutes

No apologies for absence were received.

32 Public Statements

No public statements were made at the meeting.

33 Minutes of the previous meeting

In respect of minute 22, an amendment was requested to include the request that Kirklees Health and Adult Social Care Scrutiny Panel receive an update on patient flows.

RESOLVED – That, subject to the amendment outlined above, the minutes of the previous meeting held 8th October 2018 be agreed as a correct record.

34 West Yorkshire and Harrogate Health and Care Partnership: Acute Care Collaboration and the West Yorkshire Association of Acute Trusts

The Joint Committee received a report of Leeds City Council's Head of Governance and Scrutiny Support introducing an update report from West Yorkshire and Harrogate Health and Care Partnership on acute care collaboration and the West Yorkshire Association of Acute Trusts (WYAAT). The report detailed the WYAAT collaborative forum and a summary of each of the 12 current programme areas that contribute to the acute care collaboration priority.

The following were in attendance:
Matt Graham, WYAAT Programme Director
Ian Holmes - Director, West Yorkshire & Harrogate Health & Care Partnership.

Matt Graham, WYAAT Programme Director, presented the report and highlighted the following:

- The focus of WYATT was collaboration and standardisation of provision to improve and sustain care services throughout the 6 member Trusts.
- WYAAT provided a forum for partners to discuss the 12 programmes of work which were fully aligned with West Yorkshire Health and Care Partnership.
- Decisions on service provision remain vested with the partner Trusts.

Joint Committee discussions focussed on the following:

- How the WYATT programme outcomes were monitored, measured and reported. Members emphasised the importance of public accountability. Using pharmacy as an example, the response was noted that each programme had a clear set of metrics to evaluate benefits – such as financial benefits, stock control and freeing-up pharmacist's time to conduct clinical work. Additionally, WYAAT was developing a website where programmes and outcomes would be available in 2019.
- Whilst acknowledging the assurance that WYAAT itself was not a decision making body – all decisions remain with the partner Trust's Boards and clinicians, Members also noted the influence that discussions at WYAAT level could have on future service provision and the decisions that were made when considering a business plan for each programme of work.
- Noting that the detail of the 12 programmes was not yet available; it was agreed that the current position in terms of progress against anticipated outcomes for each of the programmes would be provided directly to Members of the Joint Committee.
- The need to identify a timeframe for the delivery of each of the 12 programmes.

- The need to provide the Joint Committee with case studies of how WYAAT's work benefits both patients and the NHS and to inform the Joint Committee when a programme delivery aim had been achieved.
- The links between WYAAT partners and primary care providers.

Specific matters were identified for further consideration –

- Clarity on the aim of "optimising estates" within the Elective Surgery work stream was requested.
- How the Workforce transformation has been consulted on and is being implemented and managed.
- How risks are identified and managed, particularly in respect of the Procurement programme; and WYAATs role/influence should the expected benefits of any programme area not be fully achieved.
- The role of mutual accountability between the representatives of the 6 Trusts.
- The costs associated with the establishment of WYAAT and any financial benefits brought through closer collaboration.
- Service provision within the more rural areas covered by the Partnership and how this was reflected within the work of WYAAT.

In conclusion, the Chair acknowledged the reassurance provided that the work of WYAAT linked through to the West Yorkshire and Harrogate Health and Care Partnership (the Partnership) and primary care providers. The Chair reiterated the importance of the role of the Joint Committee in monitoring the success of that partnership – and therefore the work of WYAAT. The Chair also reiterated the need for app partners within the Partnership to have regard to patient flow through health and care services and the needs of patients to access the right services across the individual Trusts and the wider Partnership areas.

On behalf of the Joint Committee the Chair thanked representatives for their attendance, presentation and contribution to the discussion.

RESOLVED -

a) To note the West Yorkshire Association of Acute Trusts' aims and principles of collaboration;
b) To note the West Yorkshire Association of Acute Trusts' role within the West Yorkshire and Harrogate Health and Care Partnership; and,
c) To note the 12 programmes within the identified acute care collaboration priority (Hospitals Working Together portfolio).
d) To note the contents of the discussions which identified any specific scrutiny actions and/or future activity associated with the details presented.
e) To note the intention for the relevant officer to provide the current position in terms of progress against anticipated outcomes for each of the 12 WYAAT programme areas to Members of the Joint Committee.

35 West Yorkshire and Harrogate Health and Care Partnership: Workforce Priority

The Joint Committee received a report of Leeds City Council's Head of Governance and Scrutiny Support presenting a report on workforce challenges from the West Yorkshire and Harrogate Health and Care Partnership Local Workforce Action Board (LWAB). The report provided a description of the LWAB and the plans in place to mitigate workforce challenges and risk.

A copy of the document "A Healthy Place to Live, a Great Place to Work" was tabled at the meeting.

The following were in attendance and contributed to the discussion:

- Chris Mannion, Associate Director - Workforce Transformation, West Yorkshire & Harrogate Local Workforce Action Board.
- Kate Holliday, Workforce Transformation Lead, Health Education England.
- Ian Holmes - Director, West Yorkshire & Harrogate Health & Care Partnership

A number of points were highlighted by way of introducing the item, including:

- The team worked closely with the Clinical Priority Programme and the 6 areas within the West Yorkshire and Harrogate Health and Care Partnership to identify workforce challenges.
- LWAB received £500k funding from Health Education England annually and Appendix 2 of the submitted report presented a breakdown of how that funding was spent along with examples of the work streams.
- The need to ensure the right staff with the right training were available at the right place and time was a key objective. To achieve this, LWAB had established several training packages to support staff through change and individual work streams such as the creation of the post of Operating Support Officer to provide support to patients through recovery and beyond.
- The importance of unpaid and/or working carers was recognised – a 'working carer's passport' had been developed, to encourage working carers to identify themselves and advise their managers of the challenges they face outside of the workplace. It was noted that 11% of NHS staff were recorded as being working carers

The Joint Committee discussed a range of workforce challenges, including the following areas:

Mental Health service areas where it was reported that 2000 staff had left the field. The Joint Committee noted the response that Health Directors had been asked to assess and report any service gaps in the system to LWAB. LWAB had developed better progression and clear pathways throughout mental health services to encourage staff retention.

Clinical Care settings where there were different staff requirements between teaching and non-teaching Trusts. It was reported that a 'Streamlining Programme' offering mandatory and statutory training packages on subjects and issues experienced at every hospital had been established so staff can

develop transferrable skills and work within both teaching and non-teaching Trust settings, thus removing some of the barriers to work progression. Employers did acknowledge the value of staff investment and progression which brought benefits to the service provided and continuity of care.
It was also reported that work was being undertaken with Universities and social care providers to encourage and support nursing staff with a programme of training and work placements.

Social Care and Home Care Services; although the direction of travel was for people to take responsibility for their own health at home, there was a shortage of home support for people with complex medical needs in the form of District Nurses and Health Visitors and a comment was noted that the presented work streams did not address this.

Discussion on the new technology available to support home care provision identified that some patients did not have internet access or reliable Wi-Fi connection and could not make use of the offer.

Additionally, events had been devised to promote careers in the health and care sector. For GP recruitment; a programme of repatriation had been developed as many more GPs were registered than practiced. It was noted that a "Return to Practice" booklet had been produced and would be provided to Members of the Joint Committee.

The Joint Committee identified the following matters for further discussion:

- The ambitious nature of the work streams.
- The NHS Ten Year Plan and the likely impact/implications for the workforce
- The impact of Brexit on the number of EU nationals working within the health and care sector, and the analysis undertaken by Health Education England.
- The impact of the lack of staff on service provision including the reported numbers of staff absent through sickness.
- Measures used to discourage the use of agency staff.

On behalf the Joint Committee, the Chair thanked representatives for their attendance, presentation and contribution to the discussion.

RESOLVED –

a) To note the contents of the submitted report and appendices.
b) To note the discussions on the details presented in the report
c) To progress the matters for further discussion identified at the meeting.

36 Work Programme

The Joint Committee received a report from Leeds City Council's Head of Governance and Scrutiny Support on the continuing development of the Joint Committee's future work programme.

The Principal Scrutiny Adviser highlighted proposals to adopt a consistent approach for future reports submitted for consideration by the Joint Committee; that being to reference the role of enablers and collaborative forums and consider the Partnership aims and criteria in each matter presented.

The Joint Committee considered the proposed future work programme and discussed the following matters:

- The volume of work within the Partnership's 9 programme areas and the capacity of the Joint Committee to address each area.
- Workforce issues and whether consideration of the detail of this issue would be best placed within a working group of the Joint Committee.
- The need for presenting officers to provide Members with feedback on the queries/concerns raised but unanswered at meetings.

RESOLVED –

a) That the proposed work programme and comments made at the meeting be noted.
b) That the proposals for a consistent approach to reporting, as detailed in paragraphs 3:6 to 3:9 of the submitted report, be agreed.
c) That officers continue to develop the Joint Committee's work programme, based on comments made at the meeting.
d) That a revised work programme be presented for discussion and agreement at a future meeting of the Joint Committee.

37 Date, Time and Venue of Future Meetings

RESOLVED - To note the following arrangements:
Monday 11th February 10.30 am until 12.30 pm - Halifax
Monday 8th April 2019 10.30 am until 12.30 pm – Wakefield

(Both with a pre-meeting for Committee Members at 10.00 am)

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Report author: Steven Courtney
Tel: (0113) 378 8666

Report of Head of Governance and Scrutiny Support

Report to West Yorkshire Joint Health Overview and Scrutiny Committee

Date: 11 February 2019

Subject: West Yorkshire and Harrogate Health and Care Partnership: Urgent and Emergency Care Programme

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Purpose

1. The purpose of this report is to introduce a report from the West Yorkshire and Harrogate Health and Care Partnership (the Partnership) that provides an outline of the activity taking place across the Partnership relating to the identified urgent and emergency care priority / programme

Summary of main issues

2. A report from the Partnership is attached and in broad terms covers the following areas in relation to the overall urgent and emergency care programme:

   - The scope, objectives and progress made to date;
   - The relationship between the West Yorkshire and Harrogate programme and the work led at place level; and,
   - Risks to delivery;

3. Appropriate NHS representatives have been invited to the meeting to discuss the details provided and address questions from Members of the JHOSC.

4. In considering the details provided in relation to any of the West Yorkshire and Harrogate Health and Care Partnership priority programmes, the JHOSC previously agreed it would seek to consider the details provided in the context of the high level aims and criteria for working jointly across the Partnership, namely:

   - To achieve a critical mass beyond local population level to achieve the best outcomes;

- To share best practice and reduce variation; and
- To achieve better outcomes for people overall by tackling 'wicked issues' (i.e., complex, intractable problems).

Recommendations

5. That the West Yorkshire Joint Health Overview and Scrutiny Committee considers the details provided and agrees any specific scrutiny actions and/or future activity.

Background documents[1]

6. None.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Appendix 1

West Yorkshire Joint Health and Overview Scrutiny Committee
Urgent and Emergency Care Programme

Introduction

The purpose of this paper is to provide the West Yorkshire JHOSC with a briefing on the activity taking place through the West Yorkshire & Harrogate Urgent and Emergency Care Programme. This includes a description of the Programme Board and the five A&E Delivery Boards' roles.

1. Urgent and Emergency Care Programme

The UEC Programme is run through a network of commissioners and providers of urgent and emergency care services across West Yorkshire and Harrogate (the UEC Programme Board). This also includes the Ambulance Trust (for NHS 111 and 999); GP Out of Hours service, from all five A&E Delivery Boards and NHS England/NHS Improvement. A small team is based within the WY&H Partnership to facilitate delivery. The Programme Board, through member organisations, provides support to A&E Delivery Boards where they identify requirements beyond the local footprint; and where there is advantage in delivering uniformity in the provision of a standard of care across all our places.

The programme currently leads on:

- 100% of the population to have access to an integrated urgent care Clinical Assessment Service by March 2019
- Working with CCGs, the GP Out of Hours Service and NHS 111 to increase the number of patients receiving advice.
- Bookable face to face appointments in Primary Care services through 111 where needed
- A WY&H campaign – 'looking out for your neighbours'
- Identifying and sharing good practice across A&E delivery boards

A "Commissioners only" meeting also takes place monthly to discuss any plans for procurement of WY&H wide UEC services.

2. A&E Delivery Boards

a) NHS England and NHS Improvement hold CCGs and Acute Trust providers to account for the delivery of NHS Constitutional standards around achieving the 4 hour A&E Standard and reductions in Delayed Transfers of Care. Commissioners and Providers across each hospital footprint have formed A&E Delivery Boards which are made up of local urgent and emergency care commissioners and providers alongside NHS England (Bradford & Craven covering 2 hospital trusts; Calderdale and Greater Huddersfield; Harrogate and Rural Districts; Leeds; and Mid-Yorkshire)

b) Local A&E Delivery Boards oversee responsibility for:

- Leading A&E recovery;
- Developing plans for winter resilience and ensuring effective system wide surge and escalation processes exist;
- Supporting whole-system planning (including with local authorities) and ownership of the discharge process;
- Design and delivery of local urgent and emergency care transformation

c) The five A&E Delivery Boards as members of the Programme Board maintain responsibility for the operational leadership and coordination of local services, coming together with partners in the West Yorkshire & Harrogate Urgent and Emergency Care Programme Board in order to ensure coordination of the overall NHS urgent and emergency care strategy across the Programme Board area and the wider bordering regional areas.

3. Key areas of work within the WY&H UEC programme

a) 100% of the population to have access to an integrated urgent care Clinical Assessment Service by March 2019

Central to an Integrated Urgent Care service which simplifies access for patients and increases confidence in services is the 'Clinical Assessment Service (Clinical Hub)'. It offers patients access to a wide range of clinicians, both experienced generalists and specialists.

In July 2015, West Yorkshire was one of eight Urgent and Emergency Care (UEC) Vanguards selected by NHS England as part of its New Care Models Programme. The WYUEC Vanguard was a multi-faceted programme in response to challenges faced by the UEC system. In West Yorkshire we used the Vanguard programme to establish the Clinical Assessment Service within NHS111. Over the past year we have worked with our partners in Humber, Coast & Vale and South Yorkshire & Bassetlaw to jointly re-procure the Integrated Urgent Care “Clinical Assessment Service”. The programme’s role was to ensure that the future specification enabled connectivity to sources of local clinical advice across West Yorkshire and Harrogate. This was built into the specification which was re-procured in 2018 we are now in mobilisation phase for the new service to commence in April 2019, with YAS providing the NHS111 telephony services, call handling and core Clinical Advice Service. We are on track to deliver.

b) Working with CCGs, the GP Out of Hours Service and NHS 111 to increase the number of patients receiving advice.

When a person phones NHS111 and it is identified by the call handler that they would benefit from speaking to a clinician on the phone, there is a requirement from NHS England that by March 2019 50%+ of calls receive clinical assessment (either from the 111 service itself or through locally commissioned services).

The programme has also used transformation monies from NHS England to fund a number of initiatives to improve the levels of clinical advice. This includes:

- Investment in our West Yorkshire GP Out of Hours Service to redesign patient flows and protocols. The West Yorkshire GP Out of Hours Service is run by Local Care Direct and is commissioned by Greater Huddersfield CCG on behalf of all the West Yorkshire CCGs. The management of this contract is out of scope of the Programme Board but commissioners from across all the CCGs are involved in on-going service developments. One example of the work is increasing number of clinicians who triage patients waiting for home visits to reassess their appropriateness for a home visit or referral elsewhere within the Out of Hours service. This began as a pilot in December 2018.

- Investment within the NHS 111 service to increase the number of patients who initially are recommended to attend A&E and ensure a clinician has a direct conversation with the patient to assess if this is the right place for them to go. We have invested with NHS 111 to see an extra 725 patients a week clinically validated over the winter period.

We are estimating that by the end of March 2019 47% of patients who could benefit from clinical advice receive this, either through NHS 111 or other locally commissioned services (against a national target of 50%+). This target is to continue within the **NHS Long Term Plan**.

c) Bookable face to face appointments in Primary Care services through 111 where needed

Two years ago West Yorkshire and Harrogate Health and Care Partnership were involved in a pilot to implement direct booking in to primary care from NHS 111. The pilot has now evolved in to a WY&H project to enable all extended access hubs, out of hours services; urgent treatment centres and some GP practices and is now part of a national drive to increase the availability of direct booking into appointment slots.

The principle behind direct booking is that patients are directly booked in to appointments by call handlers at NHS 111, into the most appropriate service that the 'directory of services' returns, based on the patient's symptoms and where the directory of services prioritises that patient needs to 'speak to' or 'contact' primary care.

The UEC Programme has also included any locally identified GP practices as part of the ongoing project, so as many sites as possible will be available for direct booking, enhancing the patient journey and experience. This has now been included in the **NHS Long Term Plan** published in January 2019, saying that as from 2019, NHS 111 will start direct booking into GP practices across the country. At the week commencing 31st January 2019 there were 43 live GP practices from a total of 233 that can currently be technically enabled (18%), across the region taking direct bookings from NHS 111. There are further GP practices booked in for configuration in the coming weeks so the live numbers should increase steadily.

There have been some complex technical issues that have affected the enablement of extended access services and have also affected GP practices with branch sites. 60% of extended access sites and 31% of GP practices. Currently there is no resolution for this technical issue and we escalated this to NHS England and NHS Digital in autumn 2018 as it requires a national solution to software issues.

Direct booking in to GP out of hours services is live across West Yorkshire and Harrogate. West Yorkshire and Harrogate are currently at 23% against the national target of 30% of patients direct booked in to appointments from NHS 111. This figure should rise steadily in line with the increasing numbers of services being enabled for direct booking, but is hampered by the number of sites which cannot be enabled.

d) A WY&H campaign – 'looking out for our neighbours'

This campaign is supported and funded by West Yorkshire and Harrogate Urgent and Emergency Care Programme Board and covers Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield. The total budget is £60,000. There is no cost to partners and supporters.

We know that not only hospitals and doctors keep people well; a person's life choices are also important. We need to see a change in people's behaviours, built on trust and empowerment, where the benefits of self-care, early help and preventing ill health can flourish. The success of this relies on our employees and communities more than any other stakeholder groups. If we can re-engage communities in looking out for their neighbours by providing local tips for micro wellbeing and social care interventions at a neighbourhood level, then we have

the potential to positively impact on the high and increasing demand on health and care services.

The main drivers of our campaign are:

To encourage communities to look out for vulnerable people thus reducing demand on health and care services through early help and preventing ill health.

To prevent loneliness in the community and its associated health issues that lead to strains on health and care services.

Our partners and supporters

Communication and engagement leads across WY&H are supportive of the campaign. This includes hospitals working together (West Yorkshire and Harrogate Association of Acute Trusts) Council and CCG heads of communications; Healthwatch (x6), carers and VCS programme leads. Many other partners and supporters are on board including Yorkshire Ambulance Services, housing organisations; Jo Cox Loneliness Programme. Chairs of Health and Wellbeing Boards have been updated.

What next?

We are collating a list of resident campaign champions and supporters to help with campaign delivery at a local level. We are working with local engagement leads to identify people / organisations before the campaign goes live. This will help to ensure we make the most of all our networks.

We aim to create an overarching campaign brand born out of our insight findings. We are testing the campaign materials with four communities. From 28 February until 6 March we will undertake further conversations and testing of the materials before refining the resources ready for wider roll out week beginning 15 March.

A further update will be provided in the coming months, including details on how we will continue the campaign in summer if the pilot is a success. There is already interest in phase two, for example working jointly on the Great Get Together and children and young people's loneliness.

We will conduct and evaluation of the campaign in May/June. We will measure opinions against the baseline insight and we will set out to find the difference (if any) the intervention has made in each area drawing upon case studies and anecdotes from the public. The University of Leeds will analyse the interviews so we can provide a more robust report on the impact of the campaign.

e) Identifying and sharing good practice across A&E delivery boards

The UEC programme board is used as a forum for local areas to share good practice and encourage areas to adopt any good practice emerging. For example, we recently shared the work at Bradford Teaching Hospitals NHS Foundation

Trust, who have developed a standardised service intervention with families called the 'Ambulatory Care Experience (ACE).' ACE aims to provide an alternative to a hospital referral or admission for children and young people (CYP) who have become acutely unwell with common childhood illnesses and need a period of observation after initial assessment for up to three days. ACE provides care out of hospital - in a CYP's own home. Consultant Paediatricians take clinical responsibility for these CYP from the point of referral from primary care, ED and the Children's Assessment Unit in a 'virtual ward'. The cost of a hospital admission is ten times the cost of a community nurse home visit.

To the end of April 2018, 107 referrals were made on the first pathway - the 'wheezy child' and saved 105 bed days. York University are providing an independent service evaluation. The ACE programme was subsequently discussed at the West Yorkshire & Harrogate Clinical Forum in January 2019 with support to further develop the good practice across West Yorkshire and links have now been made to the Maternity services programme.

The project was recently crowned winner of the Health Service Journal (HSJ) Improvement in Emergency and Urgent Care Award.

4. Key risks to the UEC Programme

- 50%+ clinical assessment/advice remains challenging to deliver. Mitigating actions include working NHS 111 and GP Out of Hours to identify where this can be further increased
- National IT issues impede rollout of Direct Booking. Mitigating actions include working with CCGs to ensure extended access services are profiled on the Directory of Services so mobilisation can be expedited as soon as the IT issues are resolved.

5. The NHS Long Term Plan

Over the coming months we will be working with our local Places to identify where the programme can help deliver the asks around urgent and emergency care. The Long Term Plan seeks to further expand and reform urgent and emergency care services to ensure patients get the care they need fast and relieve pressure on A&E departments. Further development of the Clinical Assessment Service and Direct Booking into Primary Care will be two of the key areas for us to work collaboratively and at scale.

January 2019

Report author: Steven Courtney
Tel: (0113) 378 8666

Report of Head of Governance and Scrutiny Support

Report to West Yorkshire Joint Health Overview and Scrutiny Committee

Date: 11 February 2019

Subject: West Yorkshire and Harrogate Health and Care Partnership: Mental Health Programme

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Purpose

1. The purpose of this report is to introduce a report from the West Yorkshire and Harrogate Health and Care Partnership (the Partnership) that provides an outline of the activity taking place across the Partnership relating to the identified mental health priority / programme

Summary of main issues

2. A report from the Partnership is to follow, which is anticipated to cover the following areas in relation to the overall Mental Health programme:

   - The scope, objectives and progress made to date;
   - Risks to delivery;
   - The role of the Committee in Common – including how it works and makes decisions;
   - The relationship between the West Yorkshire and Harrogate programme and the work led at place level.
   - Issues associated with Autism services, as an area where the JHOSC has previously expressed specific interest.

3. Appropriate NHS representatives have been invited to the meeting to discuss the details provided and address questions from Members of the JHOSC.

4. In considering the details provided in relation to any of the West Yorkshire and Harrogate Health and Care Partnership priority programmes, the JHOSC previously agreed it would seek to consider the details provided in the context of the high level aims and criteria for working jointly across the Partnership, namely:

    - To achieve a critical mass beyond local population level to achieve the best outcomes;
    - To share best practice and reduce variation; and
    - To achieve better outcomes for people overall by tackling 'wicked issues' (i.e., complex, intractable problems).

Recommendations

5. That the West Yorkshire Joint Health Overview and Scrutiny Committee considers the details provided and agrees any specific scrutiny actions and/or future activity.

Background documents[1]

6. None.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: (0113) 378 8666

Report of Head of Governance and Scrutiny Support

Report to West Yorkshire Joint Health Overview and Scrutiny Committee

Date: 11 February 2019

Subject: Proposed changes to specialist vascular services for adults in West Yorkshire

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Purpose

1. The purpose of this report is to introduce a report from the NHS England Specialised Services Commissioners that provides an details relating proposed changes to specialist vascular services for adults in West Yorkshire.

Summary of main issues

2. A report from NHS England is attached and in broad terms covers the following areas in relation to the overall proposed changes to specialist vascular services for adults in West Yorkshire:

   - A summary of the proposed changes;
   - An outline of why changes are needed;
   - An assessment of the impact on patients; and,
   - Planned patient and public engagement.

3. The attached report also sets out details of the national service specification requirements for specialist vascular services, which also states that vascular services should be organised in integrated vascular networks that should consist of “arterial centres”, which provide arterial surgery and complex interventions, and other hospitals that provide outpatient clinics, diagnostics, day-case surgery and interventions, review of in-patient referrals and rehabilitation. The aim of such networks is to ensure patients have direct local access to the vascular service and travel to the arterial centre for specific complex interventions only.

4. Key requirements for vascular networks and arterial centres are specified in the national service specification, and include:

   - The catchment population;
   - The consultant workforce;
   - The type and number of specific procedures.

   Specific details on these matters are set out in the attached report; along with an assessment of compliance against these standards across West Yorkshire.

5. In 2016, NHS England commissioned the Yorkshire and Humber Clinical Senate (a body providing free, fully independent and impartial clinical advice on any proposals for service change that have significant implications for patients and the public) to review vascular services across Yorkshire and the Humber, including West Yorkshire. The Clinical Senate published its report in January 2017 (which is also appended to this report) and recommended the following for West Yorkshire:

   - Due to population numbers and workforce concerns there should only be two arterial centres in West Yorkshire (WY),
   - One centre should be at Leeds General Infirmary (LGI) co-located with the Major Trauma Centre (MTC)
   - One should be at either Bradford Teaching Hospitals NHS Foundation Trust or Calderdale and Huddersfield NHS Foundation Trust.
   - Co-location of vascular and renal services should be an important consideration in the decision about the arterial centre location

6. Further details are provided in the attached report and appropriate NHS representatives have been invited to the meeting to discuss the proposals and address questions from Members of the JHOSC.

   Joint Scrutiny arrangements

7. It should also be noted that following informal consideration of the proposals set out in the attached report, NHS England wrote to the Chair of the North Yorkshire and each of the five West Yorkshire Health Overview and Scrutiny Committees advising that the proposals represented a substantial service change that impacts on several local authority areas; and requesting a Joint Health Overview and Scrutiny Committee as the most appropriate way to consider the proposals – as detailed in Section 30 of the Public Health, Health and Wellbeing Boards and Health Scrutiny Regulations (2013).

Recommendations

8. That the West Yorkshire Joint Health Overview and Scrutiny Committee considers the proposals set out in the attached report and agrees any specific scrutiny actions and/or future activity.

Background documents[1]

9. None.

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Briefing on proposed changes in West Yorkshire to specialist vascular services for adults:

Reconfiguration of emergency and complex planned surgery and interventional radiology services provided in arterial centres

The following briefing provides an overview of the proposed reconfiguration of Specialist Vascular Services for adults in West Yorkshire by NHS England and sets out the proposed approach to future public engagement and consultation.

The West Yorkshire Joint Overview and Scrutiny Committee (WY JHOSC) is requested to:

a. agree the proposed approach to public engagement and consultation;

b. advise on any changes or additions to the proposed approach to public engagement and consultation the committee suggests.

Summary of Changes

What change is proposed?

The change proposed refers to the number of arterial centres required to provide complex vascular care across West Yorkshire and in particular those currently delivered by Calderdale and Huddersfield NHS Foundation Trust (CHFT) and Bradford Teaching Hospitals NHS Foundation Trust (BTHT). The vascular services provided by Leeds Teaching Hospitals NHS Trust (LTHT) will remain the same.

The proposal relates to complex vascular inpatient care only (this involves major interventions to restore blood supply to arteries to prevent death and severe disability). It will mean there are no dedicated vascular beds at CHFT, where currently these are located at Huddersfield Royal Infirmary (HRI). Instead these beds will be located onsite at Bradford Royal Infirmary (BRI) alongside the existing vascular beds.

Why it is needed?

Services are currently not compliant with the NHS England national service specifications for specialised vascular care. Catchment populations are too small leading to insufficient procedures being delivered to maintain skills and competencies. There are also significant workforce challenges in this system – currently BTHT and CHFT provide a joint alternating weekly on call rota where only one of the two arterial centres is on call at any one time. This is considered sub-optimal and unacceptable as a long term solution.

What is scale of impact for patients?

The change will affect approximately 800 patients per year who would currently have their surgery and related inpatient stays in Huddersfield and in future will receive it in Bradford. This change represents 7 % of the total vascular activity across West Yorkshire with all other activity currently provided in Huddersfield, including day case (minor) surgery, diagnostics and outpatient clinics, remaining at HRI.

What engagement is planned?

A full engagement and formal consultation process across West Yorkshire has been planned over three phases, from January 2019 until July 2019 as detailed in the paper.

1. Introduction

This briefing covers the following areas:

- Definition of specialist vascular services
- National Service Specification requirements for specialist vascular services
- Description of the current service
- Options Appraisal for the future service, including the options considered, differentiating factors and the preferred option
- Impact of the preferred option
- Proposed approach to public engagement and consultation

2. Definition of Vascular Specialist Services

Specialised services support people with a range of rare and complex conditions. They often involve treatments provided to patients with rare cancers, genetic disorders or complex medical or surgical conditions. They deliver cutting-edge care and are a catalyst for innovation, supporting pioneering clinical practice in the NHS.

Specialised services are not available in every local hospital because they have to be delivered by specialist teams of doctors, nurses and other health professionals who have the necessary skills and experience. Unlike most healthcare, which is planned and arranged locally by Clinical Commissioning Groups (CCGs), specialised services are planned nationally and regionally by NHS England.

The chief aim of vascular services is to reconstruct, unblock or bypass arteries to restore blood flow to organs. These procedures reduce the risk of sudden death, prevent stroke and reduce the risk of amputation.

There are a number of risk factors that are known to contribute to the rising demand on vascular services both locally and nationally:

- vascular disease is a major cause of mortality in people with diabetes and there are an estimated 3m people with diabetes mellitus in England (NHS England schedule 2).
- 1 in every 4 adults and 1 in every 5 children in England is obese (NHS, conditions website). Obesity can cause serious health related problems which include; type 2 diabetes, heart disease, some cancers and stroke.
- in the long term diabetes can lead to complications of the veins and arteries which require vascular surgery, including in the worst cases major amputations.

NHS England commissions adult specialist vascular services, including all vascular surgery and vascular interventional radiology services, with the exception of the treatment of varicose veins. This includes services delivered in non-arterial centres and on an outreach basis as part of a provider network.

Specialist vascular services are commissioned by NHS England because:

- the number of individuals requiring the services is relatively small;
- the cost of providing the service is high because of the specialist interventions involved;
- the number of doctors and other expert staff trained to deliver the service is small; and
- the cost of treating some patients is high, placing a potential financial risk on individual CCGs.

3. National Service Specification Requirements

The NHS England Service Specification for specialist vascular services and the Vascular Society of Great Britain and Ireland's (VSGBI) "The Provision of Services for Patients with Vascular Disease 2018" both state that vascular services should be organised in integrated vascular networks. These networks should consist of "arterial centres" which provide arterial surgery and complex interventions, and other hospitals which provide outpatient clinics, diagnostics, daycase surgery and interventions, review of in-patient referrals and rehabilitation. This ensures that patients have direct local access to the vascular service and travel to the arterial centre is only for specific complex interventions.

The services provided in arterial centres and non-arterial centres are shown in the table below:

	Arterial Centre	**Non-Arterial Centre**
Emergency surgery & interventional radiology e.g. ruptured abdominal aortic aneurysms, emergency treatment of blocked blood vessels (ischaemia)	Yes	No
Planned inpatient surgery & interventional radiology e.g. planned surgery for abdominal aortic aneurysms, planned major limb amputations	Yes	No
Planned Day Case surgery & interventional radiology e.g. varicose veins, creating access to blood vessels for kidney dialysis patients	Yes	Yes
Diagnostic procedures	Yes	Yes
Outpatient Clinics	Yes	Yes
Advice to other specialties (e.g. inpatient referrals)	Yes	Yes
Emergency support to other specialties	Yes	Yes

The crucial differences between an arterial centre and a non-arterial centre are the seriousness of the conditions treated and the complexity and risk of the procedures undertaken. The arterial centre receives all vascular emergencies requiring vascular surgery or interventional radiology, along with all vascular inpatient planned (elective) care and it has dedicated vascular inpatient beds. A non-arterial centre provides everything other than very complex and emergency vascular care and has no dedicated vascular hospital beds.

The following key requirements for a vascular network and the arterial centres are specified in the national service specification:

a. **Catchment Population.**
The national service specification and the VSGBI both state that a minimum catchment population of 800,000 is considered necessary for an arterial centre. This is in order to generate sufficient volume of cases to maintain the skills and competence of the surgeons and interventional radiologists.

b. **Consultant Workforce.**
Inpatient arterial surgery and interventional radiology must be available 24/7 in the arterial centre through an on call rota covered by vascular surgeons and vascular interventional radiologists. To provide a resilient rota and an acceptable work-life balance for the consultants this requires a consultant team of a minimum of 6 surgeons and 6 interventional radiologists for each arterial centre.

c. **Procedures per year.**
To maintain the skills and competence of the surgeons and interventional radiologists, the national service specification indicates that each arterial centre should undertake:

   i. At least 60 abdominal aortic aneurysm (AAA) procedures (10 per surgeon); and

   ii. At least 50 carotid endarterectomy (CEA) procedures (a procedure to reduce the risk of strokes by removing fatty deposits which narrow the carotid artery and restrict blood flow to the head and neck).

The compliance of the current vascular services in West Yorkshire on these requirements is described in the next section.

4. Current Service

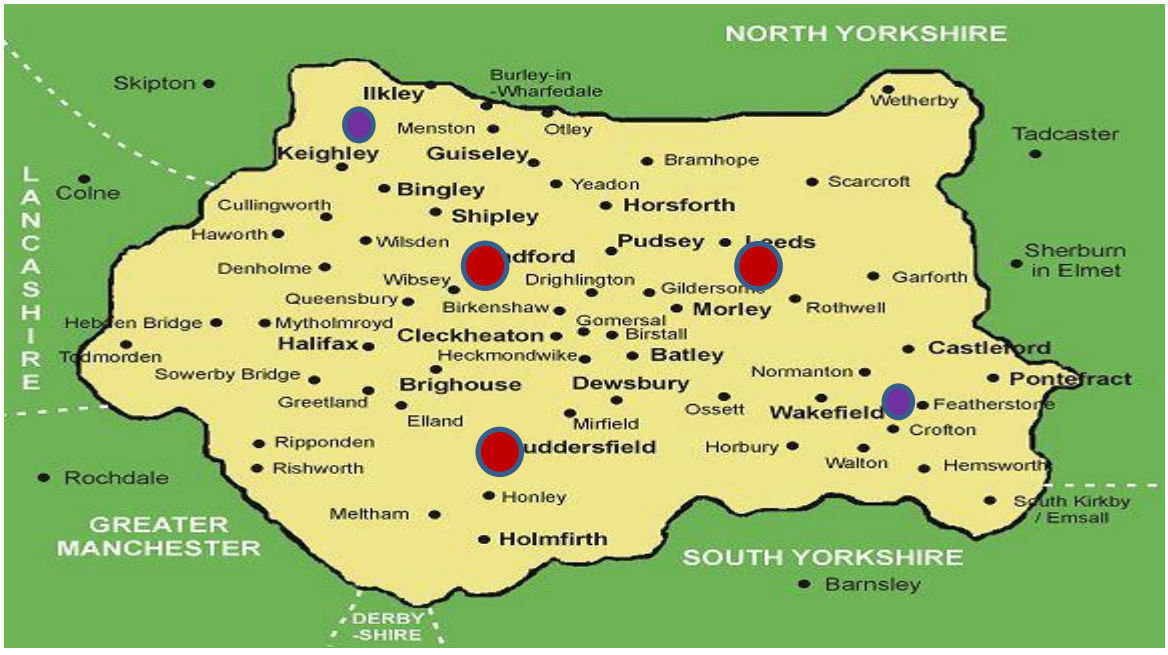
There are currently three arterial centres providing complex, inpatient vascular care in West Yorkshire:

- Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) - at Bradford Royal Infirmary (BRI)
- Calderdale and Huddersfield NHS Foundation Trust (CHFT) – at Huddersfield Royal Infirmary (HRI)
- Leeds Teaching Hospitals NHS Trust (LTHT) – at Leeds General Infirmary (LGI)

There are also two non-arterial centres providing other vascular services

- Mid Yorkshire Hospitals NHS Trust (MYHT), Pinderfields General Hospital. Working with the LGI arterial centre.
- Airedale NHS Foundation Trust (ANHSFT), Airedale General Hospital. Working with the BRI arterial centre.

The population of Harrogate and District is served by York Teaching Hospital NHS Foundation Trust at York District Hospital, which is the arterial centre supporting the population of North Yorkshire. Therefore, although Harrogate is part of the West Yorkshire and Harrogate Health and Care Partnership, vascular services for Harrogate are not part of, or affected by, this proposal. The map below shows the location of the current arterial centres and non-arterial centres across West Yorkshire:



KEY

Arterial Centre, providing complex vascular care **Non arterial centre, providing non-complex vascular care**

Outcomes for all three arterial centres in West Yorkshire are good. Risk adjusted mortality is either above or in line with the national expected levels, as shown by the data in the table below for four key surgical procedures which is taken from the National Vascular Registry Annual Report for 2017 (the most recent published). Further information can be found in the national vascular registry website at. https://www.vsqip.org.uk/surgeon-outcomes/

Procedure		BTHT	CHFT	LTHT
Aortic Aneurysm Repair (AAA) 2017	Number of Cases	37	30	78
	Risk Adjusted Survival	98.4%	100%	99.6%
	National Survival	98.7%	98.7%	98.7%
Carotid Endarterectomy 2015/17	Number of Cases	48	45	46
	Risk Adjusted Survival	98.4%	100%	95.8%
	National Survival	97.9%	97.9%	97.9%
Lower Limb Bypass 2015/17	Number of Cases	249	159	330
	Risk Adjusted Survival	97.5%	97.4%	97.5%
	National Survival	97.4%	97.4%	97.4%
Lower Limb Amputation 2015/17	Number of Cases	102	50	250
	Risk Adjusted Survival	97%	95%	93.2%
	National Survival	94.6%	94.6%	94.6%

The compliance of the current service against the requirements set out in section 4 above is described below:

a. Catchment Population.

Modelling of the catchment populations of the arterial centres in West Yorkshire (based on shortest travel times) undertaken for the West Yorkshire Association of Acute Trusts (WYAAT) by ORH, a specialist travel analysis consultancy, shows that while the LGI arterial centre significantly exceeds the minimum population of 800,000, neither BRI nor HRI do.

Arterial Centre	LTHT (LGI)	BTHFT (BRI)	CHFT (HRI)
Current Catchment Populations	1.2 million	630,000	498,000

b. Consultant Workforce.

The table below shows the current vascular consultant workforce in West Yorkshire:

	Minimum Requirement		LTHT (LGI) (including MYHT)	BTHFT (BRI) (including ANHSFT)	CHFT (HRI)
Vascular Surgeons	6	Funded	15	5	4
		In Post	15	5	4
Vascular Interventional Radiologists	6	Funded	11	3.5	4
		In Post	11	2.5	1 (1)

Note (1) The CHFT interventional radiology services is supported by locum consultants and consultants from LTHT

The vascular surgeon and interventional radiologist workforces in BRI and HRI do not meet the minimum requirement. Independently they are unable to maintain an adequate level of on call cover and so, for a number of years, the two arterial centres have worked together to share the out of hours on call rota.

Each arterial centre covers the out of hours on call for the west of West Yorkshire for alternate weeks, so that, at any one time, there is only one arterial centre able to accept emergency vascular patients out of hours. So every other week, emergency vascular patients from the CHFT catchment area are taken to BRI out of hours; and vice versa the other week. This arrangement is sub-optimal and no longer considered an acceptable long term solution.

Recruiting vascular consultants is a challenge nationally: there is insufficient medical expertise coming through the training programmes and demand for vascular care is rising. Recruitment of vascular interventional radiologists is particularly challenging with a large number of vacancies nationally.

There is significant risk to the sustainability of vascular interventional radiology in the west of West Yorkshire, particularly at CHFT. Large, well-resourced services which can offer opportunities for sub-specialisation, research, education etc are most able to attract, retain and, most importantly, train consultants.

c. Procedure Numbers.

i. AAA Procedures.

While LTHT exceeds the minimum number of 60 AAA procedures per arterial centre, neither BTHFT nor CHFT do. Combining their activity would exceed the minimum.

ii. CEA Procedures.
In 2017, none of the arterial centres met the minimum number of 50 CEA procedures per centre, although all three were close. Combining the CHFT and BTHFT activity would significantly exceed the minimum.

Therefore, while the LTHT arterial centre is sustainable and able to deliver specialist vascular services, neither the BTHFT nor CHFT services are independently sustainable or compliant**.**

5. Options Appraisal for the Future Service

The appraisal of future options has involved input from both the Yorkshire and Humber Clinical Senate and West Yorkshire Association of Acute Trusts (WYAAT):

a. Yorkshire & The Humber Clinical Senate Report.
In 2016, recognising the challenges in specialist vascular services across Yorkshire and The Humber, including in West Yorkshire, NHS England commissioned the Yorkshire & Humber Clinical Senate (a body providing free, fully independent and impartial clinical advice on any proposals for service change that have significant implications for patients and the public) to review vascular services.

The Senate published its report in January 2017 (the full report is at Appendix 1 and is available on the Senate website). For West Yorkshire, the report recommended the following:

- Due to population numbers and workforce concerns there should only be two arterial centres in West Yorkshire (WY),
- One centre should be at Leeds General Infirmary (LGI) co-located with the Major Trauma Centre (MTC)
- One should be at either Bradford Teaching Hospitals NHS Foundation Trust or Calderdale and Huddersfield NHS Foundation Trust.
- Co-location of vascular and renal services should be an important consideration in the decision about the arterial centre location

NHS England accepted the report and undertook to implement its recommendations to ensure that the services are sustainable into the future and compliant with the national service specification.

b. WYAAT Options Appraisal.
Following the Senate Report, WYAAT agreed with NHS England that it would undertake an options appraisal to make a recommendation on its preferred option for the location of the other centre, either CHFT or BTHFT. To determine its recommendation, WYAAT established a Programme Board and Clinical Working Group (CWG), and agreed a process and differentiation criteria.

The options considered were:

(i) Retain three arterial centres in West Yorkshire. This was not supported by the Senate report and was not considered feasible given the workforce concerns associated with BTHFT and CHFT so was discounted.

(ii) Preferred option of BTHFT as the other arterial centre in West Yorkshire.

(iii) Preferred option of CHFT as the other arterial centre in West Yorkshire.

The WYAAT Committee in Common (CIC, the Chairs and Chief Executives of all WYAAT trusts) considered the Options Appraisal on 24 April 2018. The analysis indicated that on most of the differentiation criteria, including financial, implementation timescale and travel and access, the differences between BTHFT and CHFT were not material. Only on clinical interdependencies was there a clear differentiation between the two options. Further information on the analysis of travel and access, and clinical interdependencies is provided below.

c. Travel and Access.

The Options Appraisal considered emergency ambulance and private car travel. Yorkshire Ambulance Service assessed the impact of the options on travel by emergency ambulance and WYAAT commissioned a specialist travel analysis consultancy, ORH, for private car travel.

Analysis of public transport travel was considered but ORH advised that it is very hard to produce useful analysis to inform recommendations for three reasons:

- It is very difficult to obtain complete and accurate data. There is no single database of public transport information in West Yorkshire. Data would have to be obtained from each public transport company providing services in the relevant area.

- Analysis of public transport journey times can quickly go out of date. Any change to the services or timetable can significantly affect the results (e.g. by making a previously possible connection impossible)

- Analysis of public transport journey times is very sensitive to the assumed time the journey is being made because services are not the same throughout the day. As with timetable changes, if the choice of start or finish times means a connection is just made or just missed a small change can make a big difference to the modelled journey time.

The impact of public transport journeys will be investigated through the public consultation process.

Yorkshire Ambulance Service considered the impact of closing either BRI or HRI as an arterial centre on emergency ambulance travel times and on their resource requirements to maintain performance and provide increased inter-hospital transfers. Due to the alternating system of weeks on-call and analysis of the number of inter-hospital transfers provided for vascular patients, they assessed there would be minimal impact on ambulance travel times or their resource requirements and so no material difference in the choice between the options.

For routine patient travel ORH considered the impact of the options on the overall population and a number of population groups identified by the vascular clinicians as at higher risk of vascular conditions. The key results of their analysis were:

- Closing the arterial centre at BRI produces a drop of 53,000 people within 45 minutes of an arterial centre in WY. Closing the centre at CRH results in 32,000 fewer people being within 45 minutes of an arterial centre in WY.
- The maximum expected journey time to an arterial centre increases from 58 minutes to 80 minutes when the centre at BRI is closed. There is no change in the maximum expected journey time when the centre at CRH closes.
- Closing the centre at BRI produces greater reductions in the population within 30, 45 and 60 minutes compared to when the centre at CRH is closed.
- For all the identified at risk-groups, the impact (both in terms of average travel time and in terms of population within 30 and 45 minutes of the closest arterial centre) is greater when BRI is closed than when CRH is closed.

The WYAAT Committee in Common concluded that although there were differences in travel times for the options, the differences were not material and so did not differentiate between the options.

d. Clinical Interdependencies.

The key differentiating factor was the interdependency between vascular and renal (kidney) services. There are close links between these services, especially for more complex inpatients, and the Yorkshire & The Humber Clinical Senate had highlighted that, ideally, they should be kept together.

BTHFT provides one of two inpatient renal units for West Yorkshire at BRI (the other is provided by LTHT), co-located with the BRI arterial centre, whereas CHFT does not provide an inpatient renal unit. Therefore option (ii), the preferred option of BTHFT as the other arterial centre in West Yorkshire, maintains co-location of vascular and renal services, while option (iii), the preferred option of CHFT as the other arterial centre in West Yorkshire, would split them with renal services provided by BTHFT at BRI and vascular services by CHFT.

e. WYAAT Committee in Common Recommendation.

Based on the analysis in the options appraisal, the Committee in Common unanimously agreed that WYAAT's recommendation to NHS England should be that its preferred option is (ii) BTHFT as the other arterial centre in West Yorkshire. Non-arterial vascular services, such as day case procedures, outpatients and diagnostics would continue to be provided at CHFT, with only complex, inpatient care moving to BRI.

The WYAAT Committee in Common also agreed that all vascular services in West Yorkshire should be delivered as a single service across the whole of West Yorkshire. A single service will bring together the expertise and resources from all five trusts. The opportunities for sub-specialisation, research and education, to work differently and experience a wider range of cases, will improve quality for patients, increase efficiency and make West Yorkshire a more attractive place to work.

6. Impact of the preferred option for the future service

The following describes the impact of delivering the preferred option on the services provided at CHFT, number of patients affected, and workforce sustainability:

a. Change in Services Provided at CHFT.

NHS England and WYAAT are committed to retaining services at CHFT and ensuring that future health care provision is in line with the needs of the resident population. The table below provides a breakdown of the different types of vascular services that are currently provided at hospitals in West Yorkshire. The table shows that the proposed reconfiguration of services would only impact those Huddersfield Royal Infirmary patients who require an emergency or planned procedure with an overnight stay in hospital.

Vascular services offered in West Yorkshire	**Airedale General Hospital**	**Bradford Royal Infirmary**	**Huddersfield Royal Infirmary**	**Leeds General Hospital**	**Pinderfields General Hospital**
Arterial Centre carries out Emergency surgery/ interventional radiology	No	Yes	Yes	Yes	No
Arterial Centre carries out Elective inpatient surgery	No	Yes	Yes	Yes	No
Non arterial centre carries out Elective day case surgery/ interventional radiology	Yes	Yes	Yes	Yes	Yes
Diagnostic procedures	Yes	Yes	Yes	Yes	Yes
Outpatients	Yes	Yes	Yes	Yes	Yes

Key

Highlights current vascular services that would not be provided in future proposals

The future pathway for vascular patients at CHFT, including some examples for specific conditions, is shown in Appendix 2

To expand on the table above, the following vascular services are currently provided at CHFT and, under this proposal, would continue to be provided:

- Abdominal Aortic Aneurysm Screening Programmes
- Diagnostic imaging including magnetic resonance imaging (MRI), computed tomography (CT), ultrasound and duplex angiography (an type of X-Ray to check blood vessels using dye injected into the blood)
- Therapeutic angiography and angioplasty (in selected low risk cases). Angioplasty is a procedure to unblock blood vessels.
- Day case surgery and interventional radiology such as: filter implantation; minor surgery for foot ulcers and diabetic foot; wound care; varicose vein surgery; non-complex vascular access surgery (for example for patients needing kidney dialysis); and central venous access line insertion and removal.
- Outpatient clinics

By providing elective day case surgery and outpatient clinics in the non-arterial centres, there will be vascular surgery and interventional radiology cover on site to support consultations and opinions on in-patients within other specialties. This will provide 'admission avoidance clinic' slots to reduce the number of patients transferred for an urgent, but not emergency, opinion. This cover will also ensure the service can respond to rare but significant events such as vessel injuries by other specialties in theatres, or vascular emergencies self-presenting to an emergency department.

b. Number of Patients Affected.

Based on recent patient data, it is estimated this proposed service change will affect approximately 800 patients per year (15 patients on average per week) who need complex, inpatient vascular care such as procedures to repair aortic aneurysms, improve lower limb circulation, major amputations, or to reduce the risk of strokes.

The majority of these patients, who currently have their specialised vascular surgery at CHFT (HRI), would in future, under this proposal, have their surgery at BRI. 800 patients is approximately 7% of all vascular related interventions and procedures in WY; the other 93% will continue to be delivered in the current locations, including CHFT, and will be unaffected by the reconfiguration.

The table below provides further detail on activity volumes as they currently are and how they are expected to be in the future. It highlights the split between complex (arterial) and non-complex (non-arterial) activity, and between emergency and planned (elective) care under the recommended proposal. The grey highlighted cells show how the activity changes between the current and recommended future proposal.

[1]	Current Activity					Future Activity				
	Arterial			Non-arterial	Current total	Arterial			Non-arterial	Future Total
	Emergency	Elective	Total			Emergency	Elective	Total		
BTHT	521	282	803	1072	1875	907	652	1559	1072	2631
CHFT	386	370	756	1352	2108	0	0	0	1352	1352
ANHSFT	0	0	0	311	311	0	0	0	311	311
LTHT	1486	970	2456	2149	4605	1486	970	2456	2149	4605
MYHT	0	0	0	2004	2004	0	0	0	2004	2004
Total	**2,393**	**1,622**	**4,015**	**6,888**	**10,903**	**2,393**	**1,622**	**4,015**	**6,888**	**10,903**

NB. HDFT is not shown in the table as Harrogate patients are treated at York District Hospital as the arterial centre for North Yorkshire and remain unaffected by this proposal.

c. Population Needs.

The Equality Impact Assessment has indicated that this proposal does not disadvantage any groups resident in West Yorkshire.

d. Workforce Sustainability.

Recruiting personnel with specialist vascular skill is a challenge nationally, there is insufficient medical expertise coming through the training programmes and demand for vascular care is rising. Recruitment of vascular interventional radiologists is particularly challenging with anecdotally there being over 200 vacancies nationally, making it important that services are well resourced and offer opportunities for sub-specialisation, research, education to attract and retain consultants.

Creating a more flexible and supported vascular workforce through a single West Yorkshire Vascular Service across all five trusts that currently provide vascular care in West Yorkshire will futureproof vascular services. This will ensure that they are better equipped and able to respond to the rising demands whilst meeting the needs of a population with a full range of vascular conditions.

Understanding the national shortage of personnel West Yorkshire vascular services have to be attractive as an employer, it is felt that moving to a single vascular service to cover the whole of West Yorkshire, with these two arterial centres, will help with recruitment and retention for the following reasons:

[1] Activity numbers have been provided by WYAAT

- It is reported through direct feedback that candidates are hesitant to apply for an interventional radiology position at BTHT or CHFT due to the uncertainty of where the second centre will be in the future. Candidates are hesitant about moving and settling family in a home and school without being fully informed about the situation. A definitive decision should allow certainty going forward.
- Due to a larger range of complex procedures and other opportunities (e.g. research) it appears candidates gravitate to the larger teaching hospitals. That is also due to, generally, a larger establishment of consultants and therefore, potentially less frequent on call. The single service should allow appointment of candidates to 'the service' where they can access the complex work and other opportunities, such as research, but then as opposed to doing high intensity complex work persistently, they can work in one of the non-arterial centres engaged in the more routine planned work. This should both satisfy career aspirations and provide some work-life balance.
- From a patient perspective and sustainability of services, moving to a more fluid working model between sites should ensure a more stable service. For example, if the consultant who routinely covers Airedale General Hospital is on holiday for 2 weeks a consultant from another site can continue the clinics and ward cover in their absence. Therefore, providing continuity in the service.

7. Engagement and Consultation

In line with the second review from the Clinical Senate, NHS England commissioned the School of Health and Related Research (ScHARR) to organise patient discussion group meetings at two locations in WY (Leeds and Huddersfield) to inform initial work on its vascular review in 2016.

Overall these events attracted participation from 41 vascular patients across Yorkshire and the Humber, with experience of a variety of vascular procedures. NHS England is now planning further engagement activities to build on this previous work and provide an opportunity to discuss the proposed changes in more detail and seek the views of patient groups.

Further events are expected to be held in the early part of 2019 in those locations affected by the proposed change.

Throughout this programme of work WYAAT has engaged with staff impacted and has harnessed the input of vascular clinicians via a clinical working group. WYAAT has appointed a clinical director to lead the WY vascular service and implementation of the proposed change. This individual will be instrumental in securing clinical input ahead of engagement activities. In addition the CCG Accountable Officers have received updates via the West Yorkshire Joint Committee of CCGs.

The draft timeline below shows high level communication and engagement activities proposed going forwards from January 2019. This will include focussed work in Bradford and Calderdale, as well as work across the broader Yorkshire and Humber population. This focuses on three phases of engagement and consultation activity:

- **Phase one** running to mid-February 2019 involving briefing health system partners, clinical leaders, health scrutiny leads, frontline clinical staff and other stakeholders on the recommended clinical model and seeking input to planned consultation and engagement activity.

- **Phase two** running from mid-February to late March 2019 when as part of a formal consultation there is a patient focussed approach to engagement across West Yorkshire to explain the recommended clinical model and seek wider views around experiences of vascular care to support and inform future improvements. The approach will involve a targeted communication to active vascular patients and those that have received vascular care in West Yorkshire within the last three years, with an invitation to return a survey or attend a 'listening event' to provide feedback and views ahead of implementing changes. *Please note any consultation activities will be paused in the period prior to local government elections on Thursday 2 May 2019.*

- **Phase three** running from May 2019 including continued formal consultation and community-focussed engagement in Bradford and Calderdale (delivered in partnership with community and patient advocacy leads) that provides information on the recommended clinical model to the wider population, including protected characteristic groups (hard to reach groups), with an opportunity to attend a 'listening event' to provide feedback and views ahead of implementing changes.

In view of the recommendations from the Yorkshire and Humber Clinical Senate Report and the West Yorkshire Association of Acute Trusts identifying that a preferred option is BTHFT as the other arterial centre in West Yorkshire, the purpose of the planned consultation and engagement activity will focus on the following areas:

i. Seeking an understanding from current and former vascular service users about how they prioritise or rank what is most important to them when accessing vascular services

ii. Understanding how current and former vascular patients travelled to access their vascular appointments, and any considerations that we should take into account about how people travel to access specialist vascular care Clarifying that patients and the public understand the proposed change and the need for the change

iii. Ensuring an opportunity for patients and the public to raise if there is anything else that should be taken into account at this stage

iv. Identifying if there is further interest from any survey respondents or listening event attendees to take part in further participation activity (i.e. a patient working group to work with clinical teams overseeing any transition phase)

Work will take place to analyse any engagement and consultation feedback to identify any key themes and trends, and this information will be used to inform the final clinical model. A further report will be presented to the J HOSC after closure of the consultation.

The table below provides an outline of timescales for the proposed engagement and consultation activity.

Activity	Jan	Feb	Mar	Apr	May	Jun	July onwards
Communications and engagement documentation working group establishment							
Clinically-led engagement with all frontline staff							
Meetings with JOSC Chairs as required							
Formal attendance at JOSC meetings as required							
Briefing to MPs							
Briefing to Healthwatch leads							
Formal attendance at OSC meetings as required							
Consultation patient mail out and invite to vascular 'listening events'							
Consultation patient experience survey offered to all vascular service patients							
Consultation vascular care 'listening events' in communities							
Decision by NHSE to be determined							
Implementation phase to be determined							

14. References and supporting information

1. Action on Vascular, Clinical Services Journal (2010)
https://www.clinicalservicesjournal.com/story/7048/action-urged-on-vascular-surgery

2. Life style, Vascular Society of Great Britain and Ireland
https://www.vascularsociety.org.uk/patients/vascular_health/lifestyle.aspx

3. Public Health Matters https://publichealthmatters.blog.gov.uk/2017/07/13/10-facts-that-sum-up-our-nations-health-in-2017/

4. Public Health England, https://fingertips.phe.org.uk/profile/wider-determinants/data#page/1/gid/1938133119/pat/6/par/E12000003/ati/101/are/E08000033/iid/90631/age/34/sex/4

5. Specialised Vascular Services (adults) NHS England service specification no 170004/S
https://www.england.nhs.uk/wp-content/uploads/2017/06/specialised-vascular-services-service-specification-adults.pdf

6. Vascular Society of Great Britain and Ireland,
https://www.vascularsociety.org.uk/

7. Vascular Surgery, Getting It Right First Time report 2018 (GIRFT)
http://gettingitrightfirsttime.co.uk/vascular-surgery-report/

8. NHS England Schedule 2, specialised Vascular Services (adults)
https://www.england.nhs.uk/wp-content/uploads/2017/06/specialised-vascular-services-service-specification-adults.pdf

9. National Health Service (NHS) conditions, https://www.nhs.uk/conditions/obesity/ (accessed 04/01/2019)

10. NHS Networks, https://www.networks.nhs.uk/nhs-networks/major-trauma-networks (accessed 04/01/2019)

11. Vascular Surgery Quality Improvement Programme,
https://www.vsqip.org.uk/surgeon-outcomes/

APPENDICES:

1. Yorkshire and Humber Clinical Senate Report on Vascular Services (enclosed as a separate document)
2. West Yorkshire Vascular Service Pathway (below)

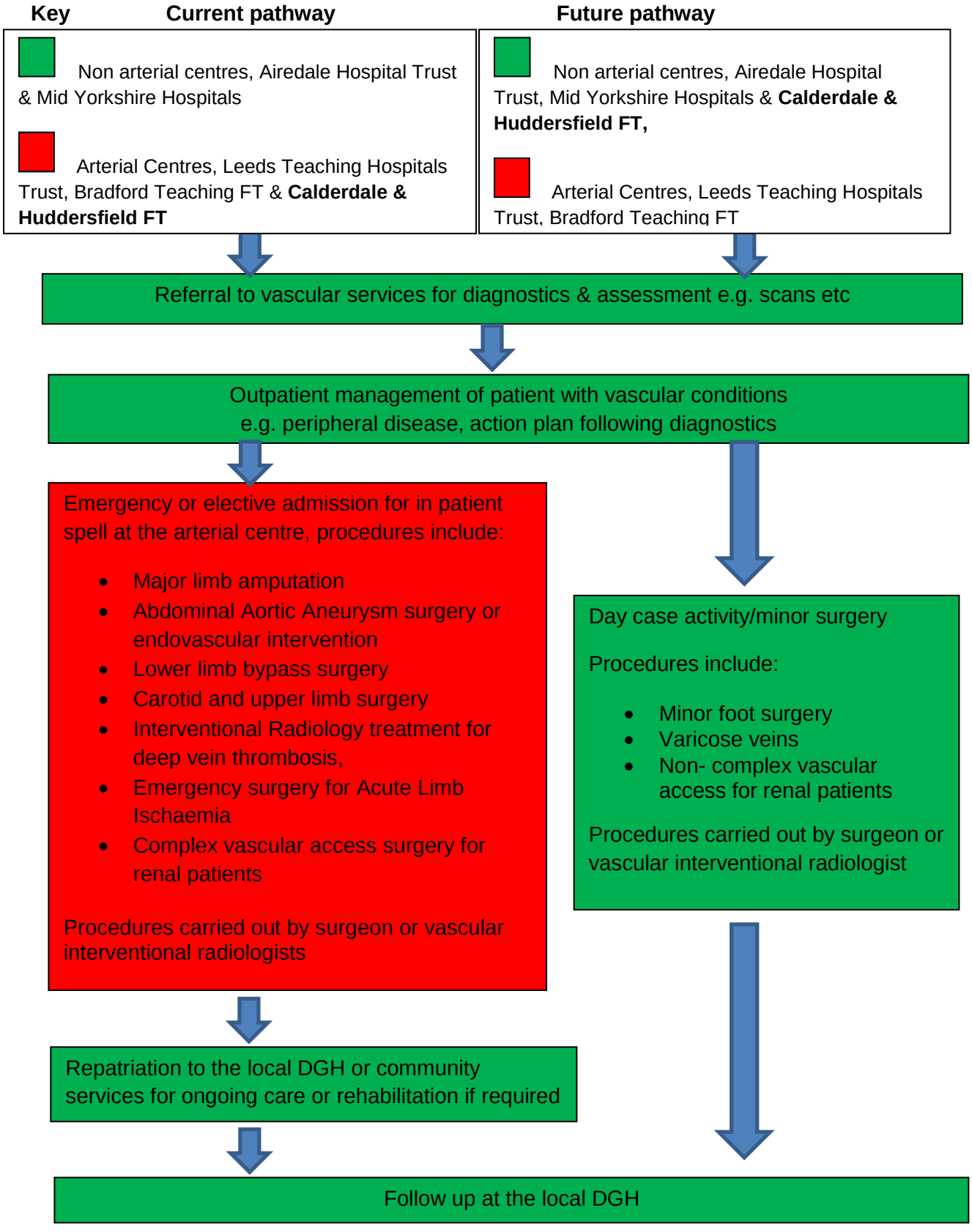
APPENDIX 1 – SENATE REPORT

Link here:
http://www.yhsenate.nhs.uk/modules/reports/protected/files/YH%20Senate%20Report%20-%20Vascular%20Services%20in%20YH%20Part%202%20-%20January%202017.pdf

and

Attached as a separate PDF document

APPENDIX 2 – WEST YORKSHIRE VASCULAR SERVICE PATHWAY



Example Pathways

Example 1

A patient from Halifax who develops very limiting pain in their leg (Intermittent Claudication) due to a blockage in the blood vessel (Peripheral Vascular Disease).

GP would refer to local non-arterial site through normal process
Patient seen in clinic at Calderdale Royal Hospital (CRH, Halifax)

Patient undergoes scan of vessels at CRH

Follow up clinic at CRH and decision for bypass surgery

Pre-assessment clinic to work up for surgery at CRH

Admission on the day of surgery to Bradford Royal Infirmary (BRI)

Post-operative recovery at BRI

If suitable after a few days the patient would be discharged back home directly from BRI

If the patient needed extended rehabilitation they would be repatriated to CRH

Post discharge clinic follow up at CRH

Example 2

A patient from Huddersfield or Halifax who is admitted to Calderdale Royal Hospital (CRH) under the Diabetic team having been referred for a toe infection.

The patient is seen at CRH by a vascular surgeon, following a clinic, and assessed there rather than being transferred to Bradford Royal Infirmary.

If a decision is made that the toe needs amputating the patient remains under the Diabetic team at CRH.

Toe amputation arranged and performed on a day-surgery list at CRH and the patient is returned to the diabetic ward.

Post-operative review on the diabetic ward by the vascular surgeons/specialist nurses/podiatry team.

Post discharge the patient would be followed up in the clinic most local to the patient

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Clinical Senate
Yorkshire and the Humber

"An independent source of strategic clinical advice for Yorkshire and the Humber"

Clinical Senate Review

for

Yorkshire and the Humber

Vascular Services

Part 2

January 2017

Clinical Senate Reviews are designed to ensure that proposals for large scale change and reconfiguration are sound and evidence-based, in the best interest of patients and will improve the quality, safety and sustainability of care.

Clinical Senates are independent non statutory advisory bodies hosted by NHS England. Implementation of the guidance is the responsibility of local commissioners, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of access. Nothing in the review should be interpreted in a way which would be inconsistent with compliance with those duties.

Yorkshire and the Humber Clinical Senate
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Date of Publication: December 2016

Version Control

Document Version	Date	Comments	Drafted by
Draft version 0.1	21 November 2016	Based on Working Group teleconferences, discussion with commissioners and Council discussion	J Poole
Draft version 0.2	28th November 2016	Amended following Council and Working Group comment	J Poole
Draft version 0.3	2 December	Amendment from the Chair	J Poole
Draft Version 0.4	16th January	Amended following comment from the commissioners and Council discussion	J Poole
Final Version 1.0	17th January	Formatting for the final version	J Poole
Final Version	24th January	Final minor comments from commissioners	J Poole

1. Chair's Foreword

1.1 The Yorkshire and the Humber Clinical Senate thanks commissioners for the invitation to work with them on their proposals for a service model for vascular services across Yorkshire and the Humber. This builds upon our report published in April 2016 which considered the earlier stages of this work. I would like to thank the expert clinicians who have worked with us in both stages of this review.

1.2 In our consideration of the question, we have continued to focus on providing impartial clinical advice on the long term sustainability of the services. I hope that this report provides a balanced clinical overview on the proposed configuration of the services and assists commissioners in moving forward to achieve the changes required.

2. Summary of Key Recommendations

2.1 The Senate supports the model of all elective and emergency arterial care being provided in an arterial centre linked to one or more non-arterial centres, as set out in the national service specification.

2.2 The Senate recommends that:

i. To comply with the national service specification standards and develop a long term sustainable vascular surgical service, the number of arterial centres within Yorkshire and the Humber needs to be reduced.

ii. Commissioners need to support their direction of travel with a clear set of criteria for how they have reached their recommendations on the location of the arterial centres. This criteria needs to be applied equally across the current arterial centres to demonstrate the transparency of decision making.

iii. Commissioners need to more clearly articulate the range of procedures to be undertaken in the arterial and non-arterial centres as stated within the national service specification.

iv. Commissioners undertake further work to understand the workforce implications of their direction of travel.

v. Commissioners revisit the population figures to ensure that their recommendations on arterial centre locations can be fully supported by population data and that this work also considers the residual flows of population across the boundaries of Yorkshire and the Humber within that work.

vi. Commissioners consider the recently published outcome data and address the issues raised by this data in their future proposals.

vii. Commissioners support their proposals with early discussions with the Clinical Commissioning Groups (CCGs) to ensure intermediate care and community services are in place to support the effective operation of the arterial centre.

viii. Commissioners consider their proposals within the context of the STPs and demonstrate the fit of their proposals with other re-organisations like urgent and emergency care and hyper acute stroke.

ix. Major Trauma Centres (MTCs) require an arterial centre to be located within the MTC. Arterial centres of themselves do not need to be located within a MTC.

x. Any performance issues within the vascular service located at a MTC needs to be addressed during the transition process.

xi. Commissioners address in the documentation the ability of the arterial centres in the reorganised service to make the investment required.

xii. Commissioners engage with a wider sample of patients and their families in the next stages of engagement.

2.3 The Senate is limited in its ability to comment on the proposed location of the arterial centres due primarily to the absence of the criteria of assessment and due to the need for commissioners to address the range of other factors discussed in this report in more detail. Based on the information provided:

i. **Within South Yorkshire.** The Senate agrees that the population figures as presented and the inability of both Trusts to meet all minimum activity requirements would support the change to one arterial centre within this geography. The Senate is unable to support the proposals outlined for a single vascular specialist service delivered across 2 arterial sites for a 3 year period. The direction of travel needs to be clearly presented as a single arterial centre.

ii. **Within West Yorkshire.** The Senate is supportive of the direction of travel of 2 arterial centres within this geography supported in a network arrangement with non-arterial centres.

iii. **Within Humber Coast and Vale.** The Senate is supportive of the decision to maintain 2 arterial centres on this geography.

3. Background

Clinical Area

3.1 Vascular disease relates to disorders of the arteries, veins and lymphatics. Conditions requiring specialised vascular care include: lower limb ischaemia, abdominal aortic aneurysm (AAA), stroke prevention (carotid artery intervention), venous access for haemodialysis, suprarenal and thoraco-abdominal aneurysms, thoracic aortic aneurysms; aortic dissections, mesenteric artery disease, Reno vascular disease, arterial/ graft infections, vascular trauma, upper limb vascular occlusions, vascular malformations and carotid body tumours.

3.2 Specialised vascular services are those commissioned by NHS England and include all vascular surgery and vascular interventional radiology services but exclude varicose veins and inferior vena cava filter insertion.

3.3 A minimum population of 800,000 is often considered the minimum population required for a centralised vascular service. This is based on the number of patients needed to provide a comprehensive emergency service, maintain competence among vascular specialists and nursing staff, the most efficient use of specialist equipment, staff and facilities and the improvement in patient outcome that is associated with increasing caseload.

3.4 All arterial surgery should be provided at a vascular centre meeting the following core standards[1]:

- Leg amputations should be undertaken in the arterial centres
- 24/7 in-patient arterial surgery and vascular interventional radiology services with an on call rota vascular medical team comprising of a minimum of 6 vascular surgeons and 6 vascular interventional radiologists

[1] A04/S/a 2013/14 NHS Standard Contract for Specialised Vascular Services (adults)

- Minimum of 10 AAA emergency and elective procedures per surgeon per year/ 60 per centre
- Minimum of 50 carotid endarterectomy procedures per centre per year.

3.5 The overall purpose of the vascular services project is to commission and implement the optimum model of service provision for vascular services across Yorkshire and the Humber, addressing any identified issues of inequality of access and within available resources, from providers who are able to meet the full NHS England service specification for vascular services.[1]

3.6 Commissioners consulted with the Senate early in 2016 to discuss their early thoughts with regard to the future service model considering the national service specification, draft vascular standards and a stocktake of the service developed by Public Health England.

3.7 Since our April 2016 report commissioners have concluded their visits with the provider Trusts, undertaken initial engagement with the public and developed a direction of travel for the clinical configuration of the services.

3.8 Vascular services are currently provided in the following trusts across Yorkshire and the Humber:

- Sheffield Teaching Hospitals NHS Foundation Trust (STHFT)
- Doncaster and Bassetlaw Hospitals NHS Foundation Trust (DBHFT)
- Leeds Teaching Hospitals NHS Trust (LTHT)
- Bradford Teaching Hospitals NHS Foundation Trust (BTHFT)
- Calderdale and Huddersfield NHS Foundation Trust (CHFT)
- York Teaching Hospital NHS Foundation Trust (YTHFT)
- Hull and East Yorkshire Hospitals NHS Trust. (HEYHT)

3.9 The direction of travel stated by commissioners is:

- **South Yorkshire and Bassetlaw** -a single vascular specialist service delivered across 2 arterial sites (at DBHFT and STHFT) with a single team led by joint governance and leadership. Complex arterial workload to be delivered at a single site within 3 years
- **West Yorkshire -** 2 specialist arterial centres for West Yorkshire.
- **Humber Coast and Vale** – no change. 2 specialist vascular services would continue at YTHFT and HEYHT

Role of the Senate

3.10 The Senate has been asked to identify any clinical risks, issues, opportunities or concerns on the work undertaken to date in this review or with the proposed direction of travel and to provide a clinical view on the future configuration of vascular services across the region.

3.11 The specific question the Senate has been asked to address is:

Considering the progress and work undertaken to date on this service review, the Senate is asked to consider the direction of travel for clinical configuration of services, supported by the NHS England Regional Leadership Group, addressing the following questions:

i. ***Based on the submission of evidence, is the Senate supportive of the proposed clinical direction of travel and proposed configuration of services to ensure sustainability of vascular services and deliver improved outcomes for the population of Yorkshire and the Humber?***
ii. ***Advise on any clinical concerns or adverse impacts relating to this proposed direction of travel***
iii. ***Provide clinical recommendations to mitigate any adverse clinical impacts and ensure the safe and sustainable transition of services to the proposed configuration.***

Process of the Review

3.12 The Working Group involved in the first part of the review in April 2016 all confirmed their willingness to engage in the second part of this review in early September. The Terms of Reference for this review were agreed on 31st October.

3.13 The Senate Working Group held a teleconference to aid their discussions on 8th November and commented also via email discussion. A discussion was arranged with the commissioners for the 15th November to provide opportunity to explore the issues in further detail. The Senate Council met on 17th November and discussed the vascular proposals in detail. A final teleconference was held with the Working Group on 21st November and the report was drafted following these discussions. The Senate Council ratified the draft by email following their Council discussion. The final draft was provided to the commissioners for comment on the 30th November 2016.

4. Evidence Base

4.1 This is an area rich in detailed guidance, underpinned by strong evidence. In considering its recommendations, the Senate has drawn upon the recommendations and the published evidence. The evidence is referenced in the April 2016 Senate report.[2]

[2] Yorkshire and the Humber Clinical Senate - Published advice and recommendations

5. Recommendations

Based on the submission of evidence, is the Senate supportive of the proposed clinical direction of travel and proposed configuration of services to ensure sustainability of vascular services and deliver improved outcomes for the population of Yorkshire and the Humber?

5.1 The Senate is supportive of the model of all elective and emergency arterial care being provided in an arterial centre linked to neighbouring hospitals which would provide non arterial vascular care and with outpatient assessment, diagnostics and vascular consultations undertaken in these and other local hospitals. This is the model clearly set out in the national service specification.[1]

5.2 The range of procedures and services to be provided at the arterial centres and non-arterial centres are also clearly set out within the specification and the Senate recommends that commissioners develop their model of service on this basis and more clearly articulate this in their documentation. Some non-vascular interventional radiology procedures like nephrostomies, gastro-intestinal bleeds and obstetric bleeding complications may move to the arterial centre and the ability of the non-arterial site to maintain a range of interventional radiology supported services needs to be considered by commissioners.

5.3 In order to comply with the national service specification standards and develop a long term sustainable vascular surgical service, the Senate is supportive of the reduction in the number of arterial centres within Yorkshire and the Humber. The evidence provided by commissioners supports this conclusion.

5.4 The Senate advises however that commissioners need to support their direction of travel with a clear set of criteria for how they will reach their recommendations on the location of the arterial centres. The stocktake document prepared by commissioners discusses the service issues in terms of the ability of the current arterial centres to meet the arterial centre core standards, to meet the population minimum of 800,000, the geography the service supports, the outcomes of the service and the co-dependent services. These issues, however, are not translated into a clear set of criteria on which proposals are being made within the Regional Leadership Group (RLG) document. The Senate recommends that a clear set of criteria is agreed and applied equally across the current arterial centres before further progression of this work. This should also include the ability of the arterial site to maintain an emergency endovascular aneurysm repair (EVAR) service by appropriately trained staff. The criteria will ensure transparency of decision making and it will demonstrate the clear clinical narrative that supports the direction of travel. The ability to demonstrate equity in the decision making is key.

5.5 The Senate acknowledges the difficulties in obtaining the workforce data but recommends that commissioners undertake further work on this to understand in more detail:

- the current workforce of vascular surgeons and interventional radiologists
- the impact of the proposals on that workforce, we recommend that this includes an assessment by the clinicians about their willingness to move their practice to the new arterial hub,
- whether the direction of travel can be supported by the trainee numbers
- The wider workforce of vascular nurses, sonographers and allied medical specialties

5.6 The Senate recommends that commissioners revisit the population figures, particularly the differences between the self-declared populations and the Public Health England (PHE) figures to ensure confidence in the data and to ensure that their recommendations on arterial centre locations can be fully supported by population data. 800,000 is the minimum population required to support a long term sustainable arterial centre. The residual flows of population across the Yorkshire and the Humber boundaries between Lincolnshire, Nottinghamshire and Teesside need to be fully considered within this further work. Commissioners may also wish to draw upon the Office of National Statistics data on the predicted population increases.

5.7 Since the documentation has been prepared there has been further outcome data published.[3][4][5][6] The Senate recommends that commissioners need to fully consider this and address the issues raised by this data in their future proposals.

5.8 The Senate has considered the interdependency of the Major Trauma Centre with the arterial centre and recommends that a MTC needs to be co-located with an arterial centre; arterial centres of themselves do not need to be located within a MTC.[7] There are 3 MTCs within Yorkshire and the Humber and the Senate supports the direction of travel which maintains the arterial centres at these 3 sites.

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[3] Surgical outcomes of Trusts and individual operators: Data published 5th September 2016 https://www.vsqip.org.uk/**surgeon-outcomes**

[4] https://www.vsqip.org.uk/contents/uploads/2013/11/Outcomes-after-Elective-Repair-of-Infra-renal-Abdominal-Aortic-Aneurysm.pdf

[5] National Vascular Registry Annual Report 2015
https://www.vsqip.org.uk/content/uploads/**2015**/12/NVR-**2015**-Annual-**Report**.pdf

[6] Provision of Services for Patients with Vascular Disease 2015
https://www.**vascular**society.org.uk/_userfiles/pages/files/Resources/POVS%20**2015**%20Final%20version.pdf

[7] The Clinical Co-dependencies of acute hospital services, SEC Clinical Senate Dec 2014

5.9 Since we originally worked with commissioners on these proposals in early 2016 we have seen the development of Sustainability and Transformation Plans as the main vehicle for planning service change. The vascular proposals for Yorkshire and the Humber cover 3 STPs and there is little reference in the documentation from commissioners on the fit of their proposals with the wider STP planning. It is noted that the commissioner plans do maintain at least 1 arterial centre within each STP. From a planning perspective it could be argued that an ideal solution would be the location of 1 arterial centre within each STP footprint, co-located with the Major Trauma Centre, increasing this to 2 arterial centres if this is required to support the population.

5.10 The Senate recommends that the impact of the arterial centre proposals on other STP led re-organisations like urgent and emergency care and hyper acute stroke, for example, need to be considered in greater detail within the documentation provided. We accept that some STPs are further in their decision making than others but the integration of decision making on these services is not demonstrated in the documentation.

5.11 The Senate recommends that as part of the planning of the service model, commissioners need to consider the need for good intermediate care, community and social services to support the effective operation of the arterial centre. There needs to be as much planning into the discharge of patients from the arterial centre as the effective planning of services within the centre. It is not evident, currently, that specialised commissioners are supporting their proposals with discussion with the CCGs to ensure effective planning of the whole patient pathway. It is also noted that there is reduced funding in social care[8] which makes these early conversations even more essential.

5.12 The ability of the arterial centres in the reorganised service to make the investment required is also not considered within this documentation and the Senate recommends that this also needs consideration in this early planning stage.

5.13 In our earlier consideration of this service, commissioners confirmed that they would be engaging with the public and we are pleased that the commissioners have held patient and public engagement events between July and August. It is evident from the public engagement report supplied to the Senate that there is more work to do to help the public to fully grasp the issues. It was also noted that 2 of the trusts were unable to supply any patients for the engagement work, whereas another trust managed to engage with 17 patients. The breadth and depth of patient engagement is currently lacking and we support the need to engage a wider sample of patients and their families in the next stages of engagement. We also support the recommendations from the School of Health and Related Research (ScHARR) to

8 http://www.local.gov.uk/documents/10180/7632544/1+24+ASCF+state+of+the+nation+2016_WEB.pdf/e5943f2d-4dbd-41a8-b73e-da0c7209ec12

provide more detailed documentation for the public to help them to understand the issues.

5.14 In the absence of the criteria discussed and the recommended further work detailed above, the Senate has made the following observations:

South Yorkshire Proposals:

5.15 The Senate agrees that the population figures as presented, the inability of both Trusts to meet the minimum activity per surgeon and the inability of the Doncaster service to meet the minimum activity as a centre, would support the change to one arterial centre within this geography.

5.16 The Senate is unable to support the proposals outlined for a single vascular specialist service delivered across 2 arterial sites for a 3 year period as this model is not supported by the national service specification. Historically both of the Trusts have shown a lack of engagement in local discussions which has contributed to the current issues. The Senate understands the need to address the differences in clinical culture on both sites and supports commissioner intentions to maintain the best clinical practice for this service. The Senate considers it unhelpful however to state that the 2 arterial sites will continue for 3 years. Commissioners could make it clearer that the recommendation is for this to be a single arterial centre which we acknowledge will take time to achieve. The proposals for this geography need to be supported by the application of the decision making criteria and with the issues listed above addressed by commissioners.

5.17 When considering the services currently provided at the 2 centres, the data suggests that Doncaster has the more progressive clinical model and had the MTC been located at Doncaster the Senate would have supported this Trust as the location of the arterial centre. There are factors that need to be addressed as part of the direction of travel if Sheffield is to become the single arterial centre for this geography. These factors include a better understanding of the data which suggests that there have been fewer EVAR grafts performed in Sheffield than one would expect when compared to the total numbers of AAA patients and in addition we recommend development work to clarify the relationship between the interventional radiology and vascular services within that Trust. Supported team development may help to achieve this.

West Yorkshire Proposals:

5.18 It is noted that Leeds Teaching Hospitals Trust, the site of the major trauma centre, is unable to expand to become the single arterial centre for this population.

5.19 The Senate is supportive therefore of the direction of travel of 2 arterial centres within this geography as currently 2 of the 3 arterial centres are unable to meet the population minimum, the minimum activity for the centre and per surgeon.

5.20 Bradford Teaching Hospitals Foundation Trust and Calderdale & Huddersfield Foundation Trust currently operate as 1 service across 2 sites. This model is not supported by the national service specification and the Senate supports the proposal

that this arrangement changes to the model outlined within the service specification of an arterial centre supported in a network arrangement with a non-arterial centre. There is an excellent working example of this arrangement in the West Yorkshire geography between Leeds and Mid Yorkshire Trusts.

5.21 The Senate notes that Bradford Teaching Hospitals Foundation Trust is a renal centre and the presence of a renal centre does support this trust as the location of the arterial centre. Commissioners need to clearly articulate the decision making criteria to support the decision on the location of the second arterial centre in West Yorkshire and ensure that all factors have been considered in the decision. This will ensure confidence when demonstrating which current service can provide the most sustainable service in the long term.

Humber Coast and Vale Proposals:

5.22 The Senate supports the decision to maintain Hull, a major trauma centre, as an arterial centre and on the basis of the information provided the Senate also supports York as an arterial centre. Both Hull and York services meet the minimum activity for the centre and per surgeon and meet the population minimum in their self-declared population figures. It is also noted that there are geographically remote parts of Yorkshire that are supported by the York service. Our concerns about the population data are discussed in paragraph 5.6 and this needs to be addressed by commissioners. The proposals for this geography also need clear assessment against decision making criteria.

Advise on any clinical concerns or adverse impacts relating to this proposed direction of travel.

5.23 Our clinical concerns relating to this proposed direction of travel are articulated in our response to the first question but can be summarised as:

- The lack of clearly developed criteria, supported by the data, applied to all current arterial centres to provide a clear narrative on the decision making that has led to the proposed direction of travel
- The need to have a better understanding of the population, including cross boundary flows and the workforce implications
- The need to address the outcome data within the direction of travel
- The recommendation of a 1 centre 2 site approach in South Yorkshire for a 3 year period. Although we recognise the commissioner reasons for this, to allow for the differences in clinical culture on the 2 sites to be overcome, commissioners should be clearer that the service will operate as a single arterial centre
- The lack of consideration of the whole patient pathway including discharge into the community
- The lack of discussion on the fit of these proposals with other re-organisations
- The lack of discussion on the investment available to support the model in the arterial centres that will require expansion. This includes beds, potentially ICU and workforce

Provide clinical recommendations to mitigate any adverse clinical impacts and ensure the safe and sustainable transition of services to the proposed configuration.

5.24 The Senate is supportive of the need to reduce the number of arterial centres within the Yorkshire and Humber geography to ensure a long term sustainable and high quality service for our population. If commissioners are able to demonstrate within the documentation that the above points are considered and addressed this would mitigate the concerns expressed by the Senate.

6. Summary and Conclusions

6.1 The Senate supports the model of all elective and emergency arterial care being provided in an arterial centre linked to one or more non-arterial centres as set out in the national service specification. The Senate recommends that in order to comply with the national service specification standards and develop a long term sustainable vascular surgical service the number of arterial centres within Yorkshire and the Humber needs to be reduced.

6.2 The Senate advises however that commissioners need to support their direction of travel with a clear set of criteria for how they will reach their recommendations on the location of the arterial centres. This criteria needs to be applied equally across the current arterial centres to demonstrate the transparency of decision making.

6.3 The Senate also recommends that the direction of travel would be strengthened with commissioners better demonstrating their understanding of the workforce implications, population figures, recently published outcome data and the fit of proposals with other re-organisations.

6.4 Based on the information provided at this time, the Senate supports the direction of travel for a single arterial centre within South Yorkshire, 2 arterial centres within West Yorkshire and the maintenance of 2 arterial centres within Humber Coast and Vale.

APPENDICES

Appendix 1

LIST OF INDEPENDENT CLINICAL REVIEW PANEL MEMBERS

Council Members

Professor Chris Welsh, Senate Chair

Dr Sally Franks, GP, Dr Penn & Partners, Leeds

Dr Ben Wyatt, GP, Brig Royd Surgery, Ripponden

Rebecca Bentley, Nursing Professional Lead & Non-Medical Prescribing Lead, Bradford District Care Foundation Trust

Assembly Members

Peter Allen, Citizen Representative

Co-opted Members

Ruth Chipp, Vascular Nurse Specialist, City Hospitals, Sunderland

Dr Claire Cousins, Lead Consultant Interventional Radiologist, Cambridge University Hospitals Foundation Trust

Dr Stephen D'Souza, Consultant Interventional and Vascular Radiologist and IR Lead, Lancashire Teaching Hospitals NHS Trust

Dr Paul Eyers, Vascular Consultant, Taunton and Somerset Hospitals Foundation Trust

Dr Stephen Gilligan, Clinical Director Critical Care, Consultant in Anaesthesia & Intensive Care, East Lancashire Hospitals Foundation Trust

Mr Simon Hardy, Consultant Vascular Surgeon, East Lancashire Hospitals Foundation Trust

Andy Swinburn, Associate Director of Paramedicine, East Midlands Ambulance Service

Appendix 2

PANEL MEMBERS' DECLARATION OF INTERESTS

Name	Reason for Declaration	Proposed way of Managing Conflict
Dr Stephen D'Souza	Knows the IRs at Sheffield, Doncaster and Hull well.	You have informed the Senate that you have a professional friendship with the Interventional Radiologists in some of the Trusts and have been teaching staff affected by this review. You are also a member of the Independent Reconfiguration Panel. You do not have any direct or indirect pecuniary interest in this review or non-pecuniary personal benefit. We have agreed that we can manage the Conflict of Interest by your abiding by the Working Group's confidentiality agreement which requires you not to divulge or disclose any of the confidential information during the process of that review.
Mr Simon Hardy	I hold posts for Cumbria and Lancashire (AAA Screening Director, Vascular lead for the SCN) and I worked in a neighbouring Trust (East Lancs) to the area concerned	You have informed the Senate that you hold a post in a neighbouring Trust to this review. You do not have any direct or indirect pecuniary interest in this review or non-pecuniary personal benefit. Your conflict is therefore notes but we agree that you can participate in this work on behalf of the Senate.
Dr Stephen Gilligan	I currently work at a Vascular Centre in Lancashire bordering the Yorkshire and Humberside region. Potentially a reorganisation may affect patient flow across traditional boundaries. I once worked in a neighbouring Trust to the area concerned	You have informed the Senate that you hold a post in a neighbouring Trust to this review. You do not have any direct or indirect pecuniary interest in this review or non-pecuniary personal benefit. Your conflict is therefore notes but we agree that you can participate in this work on behalf of the Senate.
Andy Swinburn	The vascular proposals include services on the south of the Humber including North and North East Lincolnshire which also fall within the EMAS catchment.	You have informed the Senate of a potential conflict of interest in that you work for an organisation whose catchment includes services south of the Humber which may be affected by the vascular services review. You do not have any direct or indirect pecuniary interest in this review or non-pecuniary personal benefit. Your conflict of interest is therefore noted but as the conflict is limited to your role as an employee of East Midlands Ambulance Service NHS Trust we can agree that you can participate in this work on behalf of the Senate.
Chris Welsh	Non-executive director of a NHS Trust outside the Yorkshire and the Humber region.	

COUNCIL MEMBERS DECLARATION OF INTERESTS

There are several members of the Council who declared a conflict in this issue:

Sewa Singh, Medical Director, Doncaster & Bassetlaw Hospitals NHS Foundation Trust, Jon Hossain, Consultant Vascular Surgeon & Deputy Post Graduate Dean, Health Education England – Yorkshire and the Humber, Jon Ausobsky, Consultant General Surgeon, Bradford Teaching Hospitals NHS Foundation Trust, Mark Millins, Lead Paramedic for Clinical Development, Yorkshire Ambulance Service NHS Trust, Dr Pnt Laloë, Consultant Anaesthetist, Calderdale & Huddersfield NHS Foundation Trust. Their conflicts of interest were due to their employment in a position of authority at a provider Trust whose vascular services were under consideration as part of this review. The Chair restricted or excluded their participation in Council debate

Appendix 3

CLINICAL REVIEW

TERMS OF REFERENCE

TITLE:

YORKSHIRE AND THE HUMBER VASCULAR SERVICES REVIEW – part 2

Sponsoring Organisation: NHS England North Specialised Commissioning (Yorkshire and the Humber)

Terms of reference agreed by: Vicki Broadley, Senior Supplier Manager

Date: October 2016

1. CLINICAL REVIEW TEAM MEMBERS

Clinical Senate Review Chair: Chris Welsh, Yorkshire and the Humber Clinical Senate Chair

Citizen Representative: Peter Allen

Clinical Senate Review Team Members:

Name	Job Title
Chris Welsh	Senate Chair
Peter Allen	Patient Representative
Dr Claire Cousins	Lead Consultant Interventional Radiologist, Cambridge Univ. Hospitals FT
Mr Simon Hardy	Consultant Vascular Surgeon, East Lancashire Hospitals FT
Dr Paul Eyers	Vascular Consultant, Taunton & Somerset Hospitals FT
Dr Stephen D'Souza	Consultant Interventional and Vascular Radiologist and IR Lead, Lancashire Teaching Hospitals NHS Trust
Rebecca Bentley	Nursing Professional Lead & Non Medical Prescribing Lead, Bradford District Care FT
Dr Ben Wyatt	GP, Brig Royd Surgery, Ripponden
Dr Sally Franks	GP, Dr Penn & Partners, Leeds
Andy Swinburn	Associate Director of Paramedicine, East Midlands Ambulance Service
Ruth Chipp	Vascular Nurse Specialist, City Hospitals, Sunderland
Mr Stephen Gilligan	Clinical Director Critical Care, Consultant in Anaesthesia & Intensive Care

2. AIMS AND OBJECTIVES OF THE REVIEW

Question:

Considering the progress and work undertaken to date on this service review, the Senate is asked to consider the direction of travel for clinical configuration of services, supported by the NHS England Regional Leadership Group, addressing the following questions:

i. Based on the submission of evidence, is the Senate supportive of the proposed clinical direction of travel and proposed configuration of services to ensure sustainability of vascular services and deliver improved outcomes for the population of Yorkshire and the Humber?

ii. Advise on any clinical concerns or adverse impacts relating to this proposed direction of travel

iii. Provide clinical recommendations to mitigate any adverse clinical impacts and ensure the safe and sustainable transition of services to the proposed configuration.

Objectives of the clinical review (from the information provided by the commissioning sponsor):

- Identify any clinical risks, issues, opportunities or concerns on the work undertaken to date on this review
- Identify any clinical risks, issues, opportunities or concerns with the proposed direction of travel
- Provide a clinical view on the future configuration of vascular services across the region

Scope of the review:

To commission and implement the optimum model of service provision across Yorkshire and Humber that best meets the needs of patients, addressing any identified issues of inequality of access and within available resources, from providers who are able to meet the full NHS England service specification for vascular services.

3. TIMELINE AND KEY PROCESSES

Receive the Topic Request form: not applicable

Agree the Terms of Reference: 26th October 2016

Receive the evidence and distribute to review team: 30th October 2016

Working Group Teleconferences: 8th and 21st November 2016

Teleconference with commissioners: 15th November 2016

Draft report submitted to commissioners: 30th November 2016

Commissioner Comments Received: 14th December

Senate Council ratification; by email before end November 2016

Final report agreed: end December 2017

Publication of the report on the website: January 2017

4. REPORTING ARRANGEMENTS

The clinical review team will report to the Senate Council who will agree the report and be accountable for the advice contained in the final report. The report will be given to the sponsoring commissioner and a process for the handling of the report and the publication of the findings will be agreed.

5. EVIDENCE TO BE CONSIDERED

The review will consider the following key evidence:

- Y&H Vascular Stocktake 2015
- Y&H Vascular Senate Report April 2016
- Y&H Vascular Public and Patient Engagement Report September 2016
- Vascular Services Data Briefing October 2016
- Health Education England Y&H workforce briefing September & October 2016
- North of England Regional Leadership Group Service Review paper October 2016
- Correspondence from West Yorkshire & South Yorkshire provider trusts on the direction of travel will be shared with the senate following receipt (expected by 4 November 2016)

The review team will review the evidence within these documents and supplement their understanding with a clinical discussion.

6. REPORT

The draft Clinical Senate report will be made available to the sponsoring organisation for fact checking prior to publication. Comments/ correction must be received within 10 working days.

The report will not be amended if further evidence is submitted at a later date. Submission of later evidence will result in a second report being published by the Senate rather than the amendment of the original report.

The draft final report will require formal ratification by the Senate Council prior to publication.

7. COMMUNICATION AND MEDIA HANDLING

The final report will be disseminated to the commissioning sponsor, provider, NHS England (if this is an assurance report) and made available on the Senate website. Publication will be agreed with the commissioning sponsor.

8. RESOURCES

The Yorkshire and the Humber Clinical Senate will provide administrative support to the clinical review team, including setting up the meetings and other duties as appropriate.

The clinical review team will request any additional resources, including the commissioning of any further work, from the sponsoring organisation.

9. ACCOUNTABILITY AND GOVERNANCE

The clinical review team is part of the Yorkshire and the Humber Clinical Senate accountability and governance structure.

The Yorkshire and the Humber Clinical Senate is a non-statutory advisory body and will submit the report to the sponsoring organisation.

The sponsoring organisation remains accountable for decision making but the review report may wish to draw attention to any risks that the sponsoring organisation may wish to fully consider and address before progressing their proposals.

10. FUNCTIONS, RESPONSIBILITIES AND ROLES

The **sponsoring organisation** will

i. provide the clinical review panel with agreed evidence. Background information may include, among other things, relevant data and activity, internal and external reviews and audits, impact assessments, relevant workforce information and population projection, evidence of alignment with national, regional and local strategies and guidance. The sponsoring organisation will provide any other additional background information requested by the clinical review team.
ii. respond within the agreed timescale to the draft report on matter of factual inaccuracy.
iii. undertake not to attempt to unduly influence any members of the clinical review team during the review.
iv. submit the final report to NHS England for inclusion in its formal service change assurance process if applicable

Clinical Senate council and the **sponsoring organisation** will:

i. agree the terms of reference for the clinical review, including scope, timelines, methodology and reporting arrangements.

Clinical Senate council will:

i. appoint a clinical review team, this may be formed by members of the Senate, external experts, and / or others with relevant expertise. It will appoint a chair or lead member.
ii. endorse the terms of reference, timetable and methodology for the review
iii. consider the review recommendations and report (and may wish to make further recommendations)
iv. provide suitable support to the team and
v. submit the final report to the sponsoring organisation

Clinical review team will:

i. undertake its review in line the methodology agreed in the terms of reference
ii. follow the report template and provide the sponsoring organisation with a draft report to check for factual inaccuracies.
iii. submit the draft report to Clinical Senate council for comments and will consider any such comments and incorporate relevant amendments to the report. The team will subsequently submit final draft of the report to the Clinical Senate Council.
iv. keep accurate notes of meetings.

Clinical review team members will undertake to:

i. commit fully to the review and attend all briefings, meetings, interviews, and panels etc. that are part of the review (as defined in methodology).
ii. contribute fully to the process and review report
iii. ensure that the report accurately represents the consensus of opinion of the clinical review team
iv. comply with a confidentiality agreement and not discuss the scope of the review or the content of the draft or final report with anyone not immediately involved in it. Additionally they will declare, to the chair or lead member of the clinical review team and the Clinical Senate Manager, any conflict of interest prior to the start of the review and /or materialise during the review.

END

Appendix 4

BACKGROUND INFORMATION

The evidence provided for this review is listed below:

- Y&H Vascular Stocktake 2015
- Y&H Vascular Senate Report April 2016
- Y&H Vascular Public and Patient Engagement Report September 2016
- Vascular Services Data Briefing October 2016
- Health Education England Y&H workforce briefing September & October 2016
- North of England Regional Leadership Group Service Review paper October 2016
- Correspondence from South Yorkshire provider trusts on the direction of travel

Report author: Steven Courtney
Tel: 0113 37 88666

Report of Head of Governance and Scrutiny Support

Report to the West Yorkshire Joint Health Overview and Scrutiny Committee

Date: 11 February 2019

Subject: Work Programme

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. This report provides an opportunity for members of the West Yorkshire Joint Health Overview and Scrutiny Committee to consider and agree the priorities for developing its future work programme.

Recommendation

2. The West Yorkshire Joint Health Overview and Scrutiny Committee is asked to note the overall matters set out in this report and associated appendices and agree (or amend) the:
   (a) JHOSC's proposed future work programme, presented at Appendix 1.
   (b) Draft terms of reference and proposed work group arrangements associated with the proposed review of the West Yorkshire and Harrogate Health and Care Partnership Workforce Strategy, presented at Appendix 3.

1.0 Purpose

1.1 This report provides an opportunity for members of the West Yorkshire Joint Health Overview and Scrutiny Committee to consider and agree its priorities and future work programme.

1.2 This report also specifically presents for agreement, draft terms of reference and proposed work group arrangements associated with the proposed review of the West Yorkshire and Harrogate Health and Care Partnership Workforce Strategy.

2.0 Background information

The West Yorkshire Joint Health Overview and Scrutiny Committee (JHOSC)

2.1 The JHOSC was originally established in December 2015; drawing its membership from the five constituent West Yorkshire local authorities.

2.2 At its meeting in July 2018, the JHOSC requested that officers proceed to review the current arrangements and develop proposals for the future operation of the JHOSC. Appropriate officers from each of the six local authorities1 within the West Yorkshire and Harrogate Health and Care Partnership footprint continue to contribute to the development of future arrangements.

2.3 Until such time that any future arrangements are in place, work continues to support the current joint scrutiny arrangements and to develop the future work programme for the JHOSC.

Summary of previous work programme discussions

2.4 Since the formal establishment of the JHOSC, a number of issues / work streams have been considered by the Joint Committee, including:

- The Urgent and Emergency Care Vanguard
- Work of the West Yorkshire Association of Acute Trusts
- Cancer waiting times
- Autism assessments
- Stroke Services
- Access to dental service
- Specialised services

2.5 In noting that some of the above areas form part of the agreed priority areas and programmes of the West Yorkshire and Harrogate Health and Care Partnership (the Partnership); the JHOSC previously concluded its future work programme should be developed to reflect the nine clinically based programme / priority areas of the Partnership.

2.6 The JHOSC also agreed that in considering the Partnership's nine clinically based programme / priority areas, the JHOSC would seek to consider how the work meets and/or supports the following agreed aims and criteria for working jointly across the Partnership:

[1] This refers to the six top-tier authorities across West Yorkshire and Harrogate with specific Health scrutiny functions/ powers.

- To achieve a critical mass beyond local population level to achieve the best outcomes;
- To share best practice and reduce variation; and
- To achieve better outcomes for people overall by tackling 'wicked issues' (i.e., complex, intractable problems).

2.7 The Partnership priority areas and programmes also includes a number of areas described as 'enablers', alongside a number of collaborative forums. At its meeting in December 2018, the JHOSC agreed that future reports on the Partnership's nine clinically based programme / priority areas, should specifically seek to convey:

- How relevant 'enablers' are contributing / supporting the specific clinically based programme/ priority under consideration; and,
- The role, arrangements and contribution of any relevant collaborative forum.

2.8 At its meeting in December 2018, the JHOSC also agreed the following guiding principles for the ongoing development of its work programme.

Good Practice

- Avoid duplication by having a full appreciation of any existing forums already having oversight of, or monitoring a particular issue.
- Ensure any Scrutiny activity has clarity and focus of purpose; adding value within an agreed time frame.
- Avoid pure "information items" except where that information is being received as part of an identified policy/scrutiny review.
- Seek advice about available resources and relevant timings, taking into consideration the overall workload of the JHOSC and the Health Overview and Scrutiny Committees across the constituent authorities.
- Build in sufficient flexibility to enable the consideration of urgent matters that may arise during the year.
- Have due regard for the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, which provides for local NHS bodies to consult with the appropriate health scrutiny committee where they have under consideration any proposed substantial developments or variations in the provisions of the health service in the area(s) of a local authority; alongside the associated good practice regarding the early engagement of appropriate health scrutiny committees.

3.0 Main Issues

Developing the work programme

3.1 In considering additional items/ areas for inclusion on the work programme, the JHOSC previously agreed it would consider how such matters meet and/or support the agreed aims and criteria for working jointly across the Partnership, namely:

- To achieve a critical mass beyond local population level to achieve the best outcomes;
- To share best practice and reduce variation; and
- To achieve better outcomes for people overall by tackling 'wicked issues' (i.e., complex, intractable problems).

3.2 The JHOSC has previously recognised that in developing its work programme, it would remain necessary for the JHOSC to consider the scope of the agreed areas /

topics it wishes to consider, alongside the overall level of resource available to support its work.

3.3 A copy of a proposed work programme for JHOSC is attached at Appendix 1 for consideration and agreement. This reflects further discussions with the core team of the Partnership regarding the scheduling of programme areas.

NHS Long Term Plan

3.4 At its previous meeting in December 2018, Members identified the NHS Long Term Plan as a potential area for consideration. The NHS Long Term Plan was subsequently published on 7 January 2019 and soon after, members of the JHOSC received a letter from the Chief Executive Officer Lead for West Yorkshire and Harrogate Health and Care Partnership.

3.5 The letter provided a summary of the implications and an update on the next steps for the Partnership. A copy of the letter is attached at Appendix 2.

3.6 Work continues in order to make arrangements for the JHOSC to discuss the NHS Long Term Plan and the development of the Partnerships associated 5-Year Strategy.

Proposed review of the West Yorkshire and Harrogate Health and Care Partnership Workforce Strategy

3.7 At its meeting in December 2018, when considering the Partnership's Workforce Strategy (*A Healthy Place to Live, a Great Place to Work*) the JHOSC reflected on whether further and more detailed consideration of the strategy would be best placed within a working group.

3.8 There has been further consideration of this approach, including consideration of initial draft terms of reference and an informal discussion on 23 January 2019. The revised terms of reference and proposed work group arrangements are presented at Appendix 2 for the JHOSC's consideration.

4.0 Recommendations

4.1 The West Yorkshire Joint Health Overview and Scrutiny Committee is asked to note the overall matters set out in this report and associated appendices and agree (or amend) the:

(a) JHOSC's proposed future work programme, presented at Appendix 1.
(b) Draft terms of reference and proposed work group arrangements associated with the proposed review of the West Yorkshire and Harrogate Health and Care Partnership Workforce Strategy, presented at Appendix 3.

5.0 Background documents[2]

5.1 None

[2] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

APPENDIX 1

WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Work Schedule for 2018/19 Municipal Year (Draft)

July 2018	August 2018	October 2018
Meeting Agenda for 30/07/18 at 1.30 pm.	**No meeting scheduled**	**Meeting Agenda for 8/10/18 at 1.30 pm.**
<u>Governance Matters</u> • JHOSC Governance arrangements • Integrated Care System (ICS) Update • West Yorkshire and Harrogate Health and Care Partnership – Next Steps <u>Programme Matters (WY&H)</u> • Specialised Stroke Care Programme <u>Other Matters</u> • Access to Dentistry		<u>Governance Matters</u> • Draft Partnership Memorandum of Understanding <u>Programme Matters (WY&H)</u> • Specialised Stroke Care Programme <u>Other Matters</u> • Financial Challenges
Working Group / Development Session	**Working Group / Development Session**	**Working Group / Development Session**

Scrutiny Work Items Key:

PSR	Policy/Service Review	RT	Recommendation Tracking	DB	Development Briefings
PDS	Pre-decision Scrutiny	PM	Performance Monitoring	C	Consultation Response

WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Work Schedule for 2018/19 Municipal Year (Draft)

November 2018	December 2018	January 2019
No meeting scheduled	**Meeting Agenda for 5/12/18 2018 at 10:30am**	**No meeting scheduled**
	<u>Programme Matters (WY&H)</u> • Acute Care Collaboration <u>Programme Matters (Enabling)</u> • Workforce challenges	
Working Group / Development Session	**Working Group / Development Session**	**Working Group / Development Session**
		• 21 January 2019 – Informal briefing regarding Vascular Services proposals. • 23 January 2019 – Initial discussion regarding the proposed scrutiny review of WY&H Workforce Matters (Meeting 1)

Scrutiny Work Items Key:

PSR	Policy/Service Review	RT	Recommendation Tracking	DB	Development Briefings
PDS	Pre-decision Scrutiny	PM	Performance Monitoring	C	Consultation Response

WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Work Schedule for 2018/19 Municipal Year (Draft)

February 2019	March 2019	April 2019
11 February 2018 – 10:30am (Halifax)	**No meeting scheduled**	**8 April 2018 – 10:30am (Wakefield)**
<u>Programme Matters (National)</u> • Urgent and Emergency Care • Mental Health <u>Programme Matters (WY&H)</u> • None <u>Other Matters</u> • Specialised Services – Vascular Services Proposals		<u>Programme Matters (National)</u> • Cancer <u>Programme Matters (WY&H)</u> • None <u>Other Matters</u> • Access to Dentistry – update • Proposed scrutiny review of WY&H Workforce Matters – draft report and recommendations.
Working Group / Development Session	**Working Group / Development Session**	**Working Group / Development Session**
	• NHS Long Term Plan – date TBC. • Proposed scrutiny review of WY&H Workforce Matters (Meeting 2; evidence gathering) – date TBC • Proposed scrutiny review of WY&H Workforce Matters (Meeting 3; draft report) – date TBC	

Scrutiny Work Items Key:

PSR	Policy/Service Review	RT	Recommendation Tracking	DB	Development Briefings
PDS	Pre-decision Scrutiny	PM	Performance Monitoring	C	Consultation Response

WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Work Schedule for 2018/19 Municipal Year (Draft)

May 2019	June 2019	July 2019
No meeting scheduled	**Meeting date TBC**	**Meeting date TBC**
	Governance Matters • New Municipal Year arrangements Programme Matters (National) • Primary & Community Care Programme Matters (WY&H) • Standardisation of Commissioning Other Matters • TBC	Programme Matters (National) • Maternity Programme Matters (WY&H) • Specialised Stroke Care Programme – update Other Matters • Specialised Services Update
Working Group / Development Session	**Working Group / Development Session**	**Working Group / Development Session**

Scrutiny Work Items Key:

PSR	Policy/Service Review	RT	Recommendation Tracking	DB	Development Briefings
PDS	Pre-decision Scrutiny	PM	Performance Monitoring	C	Consultation Response

WEST YORKSHIRE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Work Schedule for 2018/19 Municipal Year (Draft)

August 2019	September 2019	October 2019	Unscheduled
No meeting scheduled	**Meeting date TBC**	**Meeting date TBC**	
	Programme Matters (National) • TBC Programme Matters (WY&H) • TBC Other Matters • TBC	Programme Matters (National) • TBC Programme Matters (WY&H) • TBC Other Matters • Specialised Services Update	Programme Matters (National) • None Programme Matters (WY&H) • Prevention at Scale – timing to be confirmed. • Acute Care Collaboration – timing and focus of general update to be confirmed. Other Matters . Partnership Risks – reporting principal and timings to be confirmed
Working Group / Development Session	**Working Group / Development Session**	**Working Group / Development Session**	

Scrutiny Work Items Key:

PSR	Policy/Service Review	RT	Recommendation Tracking	DB	Development Briefings
PDS	Pre-decision Scrutiny	PM	Performance Monitoring	C	Consultation Response

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West Yorkshire and Harrogate
Health and Care Partnership

To: Councillor Helen Hayden
Chair, Scrutiny Board (Adults and Health), Leeds City Council
Chair, West Yorkshire Joint Health Overview and Scrutiny Committee

Tuesday, 15 January 2019

Dear Cllr Hayden

Publication of the NHS Long Term Plan

The NHS Long Term Plan was published on Monday 7th January. I am writing to provide a summary of what this means for us and to update you on the next steps for the West Yorkshire and Harrogate Health and Care Partnership.

The NHS Long Term Plan

The NHS Long Term Plan sets the direction of travel for the NHS over the next ten years. It sets out some of the ways that we want to improve care for people over the next ten years; including making sure everyone gets the best start in life; reducing stillbirths and mother and child deaths during birth by 50%; taking further action on childhood obesity; increasing funding for children and young people's mental health; bringing down waiting times for autism assessments. It also includes the importance of delivering world-class care for major health problems; preventing 100,000 heart attacks, strokes and dementia cases; investing in spotting and treating lung conditions early to prevent 80,000 stays in hospital and delivering community-based physical and mental care for 370,000 people with severe mental illness a year by 2023/24.

It also sets out how we can overcome the challenges that the NHS faces, such as staff shortages and growing demand for services, by doing things differently and giving people more control over their own health and the care whilst preventing illness and tackling health inequalities.

You can view the plan here. A summary is also available here. Further information about the NHS Long Term Plan, including case studies can be found here.

The role of STPs and Integrated Care Systems

The NHS Long Term Plan gives formal backing to integrated care systems like West Yorkshire and Harrogate Health and Care Partnership. It gives a further boost to the priorities that we have been working on locally and the help we need to deliver reductions in health inequalities and unwarranted care variation. For example, the focus on mental health services, cancer, prevention, and primary care will build on our approach and the progress we have already made.

The recognition of workforce challenges is welcome and we are keen to understand how the full workforce plan will further support local efforts to secure a workforce for the future. This is perhaps our biggest single challenge. You can read the West Yorkshire and Harrogate Workforce Plan: 'A healthy place to live, a great place to work' here.

Alongside the NHS Long Term Plan we will need additional resources and support for social care and for local government. Without these we cannot deliver our ambitions. We therefore look forward to seeing the Government's Social Care Green Paper and the outcome of the spending review later this year.

A communication and engagement plan has been drafted to support this work. Following our principles of openness and transparency we will continue to publish information via our weekly leadership messages and on our website – and via local communication and engagement colleagues. Information is also available on the West Yorkshire and Harrogate website here.

What next?

There is an expectation that all STPs and ICSs will produce a 5 year strategy by the Autumn. We have begun the conversation with West Yorkshire and Harrogate health care leaders about how we lead the development of this strategy. The main messages are as follows:

- There is really good alignment between the long term plan and our regional ambitions, as we set out in our 'Next Steps to Better Health and Care for Everyone' document last February. We have a good platform to build from;
- The long term plan is a framework not a blueprint. There is flexibility for us to tailor our response to local needs and priorities;
- Our strategy will be our plan: It will articulate our collective ambitions for the people of West Yorkshire and Harrogate;
- We continue to focus on collaboration to improve outcomes locally – working better together at every level and putting the person at the centre of all we do.

Over the coming months, alongside our stakeholders, workforce and communities, we will work through what the NHS Long Term Plan means for us. It's important that we explain clearly what this means whilst setting out how the local plans, regional and national plans fit together – and most importantly what this means for people. An editorial board for the 5 year strategy will be set up soon which will co-ordinate the development of the strategy.

We believe that the West Yorkshire and Harrogate Health and Care Partnership provides the best chance in a generation to succeed. We are working together – councils, NHS organisations, voluntary and independent organisations and communities – in ways which recognise that in modern Britain it is multi-morbidity and the wider determinants of health that hold the key to our future. The quality of housing, education, environment, employment and lifestyle factors sit squarely alongside joined up health and care as priorities.

Our aim is to put people, not organisations, at the heart of everything we do so that we meet the diverse needs of our communities. Health services, local authorities, charities and community groups are equal partners working together more practically to improve the quality and outcomes of our health and care services.

I look forward to continuing to work with you on this important agenda and value the important role that the JHOSC plays in our partnership. I understand that Ian Holmes is working with Steven Courtney to arrange a session to discuss the long term plan.

Yours sincerely

Rob Webster, CEO Lead for West Yorkshire and Harrogate Health and Care Partnership / CEO South West Yorkshire Partnership NHS Foundation Trust

Cc: WY&H HCP Leadership Group
Tom Riordan, CEO for Leeds City Council
Anthony Cooke, Chief Officer for Health Partnerships, Leeds City Council

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West Yorkshire Joint Health Overview and Scrutiny Committee

Scrutiny Review of the West Yorkshire and Harrogate Health and Care Partnership Workforce Strategy

Terms of Reference for the Working Group

Introduction

The West Yorkshire Joint Health Overview and Scrutiny Committee (the JHOSC) has agreed to undertake a review of the West Yorkshire and Harrogate Health and Care Partnership Workforce Strategy and has agreed to appoint a working group to undertake this review.

Objectives

- To understand how the strategy addresses key areas of concern such as shortages in key staff groups such as GPs, medical and nursing specialists and paramedics.
- To understand how the workforce strategy contributes to the delivery of West Yorkshire and Harrogate Health and Care Partnership key priorities and other key priorities.
- To understand the contribution all partner agencies can make in delivering the strategy, including local authorities.
- To prepare a report for the West Yorkshire Joint Health Scrutiny Committee including any key findings and recommendations for the West Yorkshire Health and Care Partnership and key partner agencies.

Membership

The membership of the review group will comprise one Member from each of the six authorities represented on the JHOSC.

The following Members have been appointed to the working group.

Bradford	Councillor Vanda Greenwood
Calderdale	Councillor Colin Hutchinson
Kirklees	Councillor Liz Smaje
Leeds	Councillor Billy Flynn
North Yorkshire	Councillor Andy Solloway
Wakefield	Councillor Yvonne Crewe

If a Member is unable to attend a meeting, their authority may identify a substitute Member.

Who should give evidence to the Working Group?

- West Yorkshire and Harrogate Health and Care Partnership - Workforce Action Board (Chris Mannion – Associate Director - Workforce transformation, West Yorkshire & Harrogate Local Workforce Action Board and Kate Holliday – Workforce Transformation Lead, Health Education England)

- West Yorkshire and Harrogate Health and Care Partnership - leadership
- Yorkshire and Humber LMC Alliance
- Trades Unions - Unite, Unison, GMB
- Royal College of Nursing
- British Medical Association
- West Yorkshire Association of Acute Trusts
- Yorkshire Ambulance Service NHS Trust
- Mental Health Trusts
- GPs and Primary Care
- Community Health Services
- Queens Nursing Institute
- Therapist professional bodies, including the Chartered Society of Physiotherapists, the Royal College of Occupational Therapists, the British Orthoptic Society
- Local Authorities
- Institute of Health Visiting
- Health Education England
- NHS England
- Kings Fund

What resources do we need?

- Support will be provided by Mike Lodge, Senior Scrutiny Support Officer, Calderdale Council
- Assistance may be sought from Council HR departments
- There may be a need for some desktop research, including a literature search, examples of best practice from other areas.

Timetable

It is anticipated that the review will need at least three meetings to complete its work. If three meetings are not sufficient, the review group will prepare a report for the April 2019 meeting of the JHOSC and arrange a subsequent "scrutiny in a day" session to cover further areas, with a second report back to the JHOSC at a later date.

<u>Meeting 1 – January 2019</u>

To elect a chair
To agree Terms of Reference to be submitted to February JHOSC
To consider a critique of the Workforce Strategy
To agree a programme of work

The working party may choose to issue a call for evidence well before Meeting 2 to allow organisations and individuals to submit written evidence and to help the working party decide who it wished to invite to attend the meeting.

Meeting 2 – Early March 2019

Scrutiny "in a day" – to question key witnesses
To identify broad conclusions

The meeting will probably take a whole day, starting at 1000 and ending at 1630

Meeting 3 – late March 2019

To consider a draft report and recommendations that has been prepared by the Scrutiny Officer
To agree final report to be presented to the JHOSC at the April 2019 meeting

Meeting 2 will be open to the public to attend and observe.

The Terms of Reference will be submitted to the JHOSC for approval on 11 February 2019 when it meets.

A final report will be submitted to the JHOSC when it meets on 8 April 2019 when it meets.

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