Public Document Pack

Health and Wellbeing Scrutiny Committee

Agenda

Date:	**Wednesday, 5th October, 2011**
Time:	**10.00 am**
Venue:	**The Bridestone Suite, Congleton Town Hall, High Street, Congleton CW12 1BN**

The agenda is divided into 2 parts. Part 1 is taken in the presence of the public and press. Part 2 items will be considered in the absence of the public and press for the reasons indicated on the agenda and at the foot of each report.

PART 1 – MATTERS TO BE CONSIDERED WITH THE PUBLIC AND PRESS PRESENT

1. **Apologies for Absence**

2. **Declarations of Interest**

   To provide an opportunity for Members and Officers to declare any personal and/or prejudicial interests and for members to declare the existence of a party whip in relation to any item on the agenda.

3. **Minutes of Previous meeting** (Pages 1 - 6)

   To approve the minutes of the meeting held on 28 July 2011.

4. **Public Speaking Time/Open Session**

   A total period of 15 minutes is allocated for members of the public to make a statement(s) on any matter that falls within the remit of the Committee.

   Individual members of the public may speak for up to 5 minutes, but the Chairman will decide how the period of time allocated for public speaking will be apportioned, where there are a number of speakers.

   Note: in order for officers to undertake any background research, it would be helpful if members of the public notified the Scrutiny officer listed at the foot of the agenda at least one working day before the meeting with brief details of the matter to be covered.

For any apologies or requests for further information, or to give notice of a question to be asked by a member of the public

Contact: Denise French
Tel: 01270 686464
E-Mail: denise.french@cheshireeast.gov.uk

5. **Vascular Service Reconfiguration and Abdominal Aortic Aneurysm screening** (Pages 7 - 44)

Julia Curtis, Commissioning Manager (Planned Care), GP Commissiong (South and Vale Royal Consortia) and Dr Gurnani will present on proposals regarding Vascular Services

6. **The Cheshire and Wirral Councils Joint Scrutiny Committee** (Pages 45 - 50)

To receive the minutes of the meeting of the Cheshire and Wirral Councils Joint Scrutiny Committee held on 11 July

7. **Work Programme** (Pages 51 - 60)

To review the current Work Programme (attached).

8. **Forward Plan**

To consider extracts of the Forward Plan (if any) that fall within the remit of the Committee.

9. **Consultations from Cabinet**

To note any consultations referred to the Committee from Cabinet and to determine whether any further action is appropriate.

Agenda Item 3

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Health and Wellbeing Scrutiny Committee** held on Thursday, 28th July, 2011 at Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

Councillor G Baxendale (Chairman)
Councillor J Saunders (Vice Chairman)

Councillors S Gardiner, A Moran, P Raynes, J Saunders and J Wray

14 APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors G Boston, M Hardy, D Hough and A Martin.

15 ALSO PRESENT

Councillor M Grant, member of the Committee
Councillor G Merry, member of the Committee
Councillor D Flude, substitute for Councillor G Bolton
Councillor B Silvester, substitute for Councillor A Martin
Councillor R Domleo, Cabinet Member for Adult Services; Cabinet Member for Health and Wellbeing (interim)
Councillor J Clowes, Cabinet Support Member for Health and Wellbeing

16 OFFICERS PRESENT

G Kilminster, Head of Health and Wellbeing, Cheshire East Council
L Scally, Head of Strategic Commissioning and Safeguarding, Cheshire East Council
H Grimbaldeston, Director of Public Health, Central and Eastern Cheshire Primary Care Trust (CECPCT)
F Field, Director of Governance and Strategic Planning, CECPCT
D J French, Scrutiny Officer
J Hawker, Clinical Commissioning Group (East Cheshire)
S Whitehouse, Clinical Commissioning Group (South Cheshire)
L Nolan, East Cheshire NHS Trust

17 DECLARATIONS OF INTEREST

None

18 MINUTES OF PREVIOUS MEETING

RESOLVED: That the minutes of the meeting of the Committee held on 9 June be confirmed as a correct record.

19 PUBLIC SPEAKING TIME/OPEN SESSION

There were no members of the public present who wished to address the Committee.

20 **GP COMMISSIONING CONSORTIA**

The Chairman welcomed Simon Whitehouse and Jerry Hawker who were attending to talk about progress with establishing GP Commissioning Consortia in Cheshire East; it was explained that these bodies were now known as Clinical Commissioning Groups (CCG). In Cheshire there were 4 Groups to be known as West, Vale Royal, South and East. A map was circulated showing the boundaries of the Groups and the Local Authority boundaries. The majority of the population of Cheshire East would fall within the South or East Groups. Although the Health and Social Care Bill was currently going through parliament, work could still continue to manage the transition process from the Primary Care Trust to the CCGs.

Simon Whitehouse explained that the South Cheshire Clinical Commissioning Group (CCG) included 16 GP practices and covered Nantwich, Crewe, Alsager and Sandbach and surrounding areas. At the moment the focus was on maintaining services, developing financial arrangements, building relationships and ensuring good engagement practices were developed. As part of the engagement process, a Question Time event had been held with the Local Involvement Network (LINk) on 26 July.

Jerry Hawker outlined the position with the East Cheshire Clinical Commissioning Consortia which had 22 GP Practices and a population of around 202,000 people. To date, work had been carried out on building relationships with the main acute providers including East Cheshire Hospital Trust as well as providers in Manchester and Stockport and developing relationships with the local population; a meeting had been held with the LINk and a Patient Forum was under development. The Board included a Lay Member and a Nurse. One of the challenges for the Consortia was the ageing population and management of long term conditions.

During discussion of the item the following points were raised:

- The Commissioning Groups had now been running for almost a year and were based on the former practice based commissioning groups;
- Staffing issues were still to be resolved as the earliest the CCGs could become statutory bodies would be October 2012, although it was likely to be April 2013, therefore staff could not currently be directly employed;
- It was noted that the PCT had previously been overspent but had managed to reduce its debt and Members asked about the current position? In response, the Committee was advised that at Quarter 1 the PCT was forecasting a balanced position but nevertheless the local health economy was still in a challenging financial position overall. The Acute Trust and PCT were working closely together to manage financial pressures;
- In relation to Mental Health, it was noted that improvements had been made by the PCT compared with the position it had inherited in 2006. It was a challenge that there was no in-patient provision in the South Cheshire CCG area, however the Group would continue to work with

Cheshire and Wirral Partnership NHS foundation Trust (CWP), the provider of mental health services in the area;

- In relation to the transfer of community services to the East Cheshire Hospital Trust, it was reported that the transfer process had required some financial investment and, at this early stage, work was still underway to assess the success of the transfer for patient care and staff; monthly meetings were being held and it had led to closer working opportunities between the acute service and the community;
- In relation to benefits to patients and the public resulting from the CCGs, it was felt that good quality primary care already existed in Cheshire East so the CCGs would aim to continue this good provision. They would also look to increase integrated working opportunities and arrangements through the Local Independent Living Teams and with Children and Families Services and through working closely with other health partners, wherever possible;
- Arrangements to establish a Health and Wellbeing Board were underway and a summary of the findings from the recent Visioning Day would be available shortly. There would be a number of statutory members on the Board and the governance arrangements were being developed. The role of the Board would include supporting an effective Joint Strategic Needs Assessment that informed commissioning decisions, encouraging effective communications and engagement, and informing the Health and Wellbeing Strategy.

RESOLVED: That the update on the Commissioning Consortia Groups in Cheshire East be noted and Jerry Hawker and Simon Whitehouse thanked for their attendance.

21 MINOR INJURIES UNIT AT CONGLETON WAR MEMORIAL HOSPITAL

The Committee considered a report of East Cheshire NHS Trust on proposed changes to the provision of the Minor Injuries Unit at Congleton War Memorial Hospital.

The proposal related to an alteration to the opening times of the Unit; it was proposed that the opening hours be reduced and an Emergency Nurse Practitioner be employed each day to mainly treat minor injuries patients and a Health Care Assistant be employed, for half a day, to deal with most of the GP referral patients. This option would remove the risk related to lone working as a radiographer would work at the Unit during the morning.

The Unit's current opening hours were from 8.30 am until 8.30 pm but the number of patients attending with minor injuries was low and patients mainly attended between 10.00am – 4.00 pm. It was proposed that the weekday hours be amended to 10.00 am – 6.00pm and the weekend and Bank Holiday hours remain as 8.00 am – 8.30pm. Consultation had been carried out with the Ambulance Trust, local GP surgeries and the Local Involvement Network.

RESOLVED: That the proposed changes to the opening times of the Minor Injuries Unit, as set out in the report, be supported.

22 LOCAL INVOLVEMENT NETWORK (LINK) ANNUAL REPORT

Barrie Towse, Chair of the Cheshire East Local Involvement Network (LINk), presented the Annual Report.

The report outlined the structure and membership of the LINk and detailed the work carried out over the year, including:

- Enter and View – the LINk had a statutory right to Enter and View Health and Social Care facilities to ensure that they complied with essential standards set by the Care Quality Commission. A number of such visits had been undertaken including a number of unannounced visits, including to 2 Emergency Departments, 1 Elderly Care Ward (which had been unannounced) and to 2 Learning Disability facilities. The notice when undertaking visits was anything up to 15 days. It was sometimes helpful to give a short period of notice as this would enable the manager to make sure they were available;
- The Mental Health Sub Group had undertaken work with CWP, the provider trust, and been involved with a number of consultations on service changes;
- Hospital discharges and readmissions – the LINk had listened to patient experiences and sought views on the local radio. Discussions had been held with both Acute Trusts on discharges and readmissions, and the East Cheshire Hospital Trust had introduced Patient's Passport to try to identify those at risk of readmission;
- Communications – a Sub Group had been formed to look at improving communications and had commissioned an advertising campaign on the local radio as well as reviewing the website;
- Social Care – work in this area had included a one day conference at Crewe Alexandra Football Club on Demystifying Personalisation which had been attended by over 100 delegates; following the success of this event, 2 workshop events had been held in Knutsford and Congleton.

The LINk had developed constructive relationships with a number of partners through Joint Liaison Meetings which were seen as a successful initiative; these were monthly meetings with representation from a wide variety of organisations including the Primary Care Trust, GP Consortia, Council for Voluntary Services and Local Authority. The LINk attended the Overview and Scrutiny Committee meetings and representatives welcomed the opportunity to contribute.

Neil Garbett, the Support Team Leader, explained the role of the Support Team. The role had been refocused due to staff changes and close working arrangements had been developed with a number of organisations. Training had been held for members especially in relation to Enter and View. The LINk had also applied for Pathfinder Status and was waiting to hear the outcome. There was still uncertainty around future funding. Lucia Scally explained that there was uncertainty from central Government around the future funding of Healthwatch but some transitional funding had been made available from the Adult Social Care budget.

Members discussed the Annual report and made the following points:

- The LINk were to be congratulated on their work and their report which was an excellent in-house production;
- The hard work of the LINk members, who were all volunteers, was to be commended;

- It was suggested that a short introduction to the Report on the role and purpose of the LINk, including how people could get involved, would be useful;
- The LINk representatives were asked about their funding sources and explained that funding came from the Carers Federation towards staff costs and from the Local Authority for carrying out work;
- Fiona Field advised the committee that during a recent visit by the Care Quality Commission the Patient Passport had been commended as an "outstanding" piece of practice;
- It was noted that one very useful finding from the work carried out by Manchester Metropolitan University in relation to Safeguarding had been the need for organisations to keep contact details and websites up to date so that contacting the relevant person was straightforward;
- A suggested area for the LINk to look at in future was the liaison within a hospital for patients with both a mental and physical illness, such as a dementia patient who was admitted due to a broken bone.

RESOLVED: that the Annual Report of the LINk be received and the representatives of the LINK be thanked for their attendance.

23 **WORK PROGRAMME**

The Committee considered its Work Programme which had been reviewed and updated by the Chairman and Vice Chairman, together with the Scrutiny Officer.

The Committee was advised of the proposed timetable for setting the Work Programme, as agreed at the Scrutiny Chairman's Group. It was proposed that 1:1 meetings with Portfolio Holders take place between the Scrutiny Chairman and Vice Chairman and Portfolio Holder, this would enable the Portfolio Holder to highlight any future issues. It was then proposed that an informal meeting of the Committee take place to give detailed consideration to items raised at these 1:1 meetings, together with items on the existing Work Programme and any items raised by members.

This would then enable a Work Programme to be formulated for discussion with Corporate Management Team (CMT) and Cabinet around Autumn. The intention behind involving CMT and Cabinet in a two way process to formulate the majority of the work programme was to ensure that resources were made available to Overview and Scrutiny Committees from Service Heads to complete reviews and to enable the committees to focus on Corporate priorities.

An issue had also been referred from the Children and Families Scrutiny Committee in relation to health and Cared for Children; this had arisen during a Scrutiny Review on Fostering Services. Councillor Flude, who had chaired the Scrutiny Review, outlined the findings and why it was felt that some scrutiny work specifically on health and cared for children would be useful.

RESOLVED: that

(a) an informal meeting of the Committee be held on Thursday 8 September at 10.00 am to enable Members to give full consideration to the Committee's Work Programme, with support from all relevant officers; and

(b) a report on the main issues in relation to health and Cared for Children be submitted to the Scrutiny Chairmen's Group for initial consideration and agreement as to how to progress the issue.

24 **FORWARD PLAN**

The Committee considered extracts of the Forward Plan insofar as they related to its work. Following approval of the Scrutiny Committee remits at full Council on 21 July, there were two issues on the Plan that were now relevant to this Committee's work – "Future operation of Knutsford Cinema" and "Future operation of Crewe Lyceum Theatre". Both items had previously been considered by the Corporate Scrutiny Committee. The Committee received an update on the current position as follows:

- Knutsford Cinema – an advert was to be published the first week of August to invite bidders to run the cinema within the Civic Centre with a 6 week response period. Bids would be evaluated in September and a preferred option taken to full Cabinet in October or November;
- Crewe Theatre – soft market testing was being undertaken to establish likely levels of interest from commercial operators or community enterprises. This would be completed around the end of August and outcomes shared with the Portfolio Holder and the next steps agreed.

RESOLVED: that the update on Knutsford Cinema and Crewe Theatre be noted.

25 **CONSULTATIONS FROM CABINET**

There were no consultations from Cabinet.

The meeting commenced at 10.00 am and concluded at 11.40 am

Councillor G Baxendale (Chairman)

Cheshire and Merseyside Vascular Review

CONSULTATION DOCUMENT

Improvements to vascular services in Cheshire and Merseyside

Contents

"The current review of vascular services in Cheshire and Merseyside is a once in a generation opportunity to shape the provision of increasingly specialist vascular and endovascular care to our population. This can only be brought about by concentrating expertise into a small number of centres dealing with an increased volume of patients, which we know results in better outcomes for our patients."

John Brennan
Consultant vascular surgeon
Royal Liverpool Hospital

Introduction

This document describes some improvements that the NHS is planning to make to the way vascular services are provided in Cheshire and Merseyside, and asks you for your views on these changes.

We want to make sure that all of our vascular services give patients care of the highest possible quality. Although current services are good and offer safe treatment, we believe that to sustain high quality services into the future, things will have to change, which may involve the relocation of some services. This document sets out the planned changes, why they are necessary, what benefits they will bring and how they will be delivered.

There is a glossary on page 11.

What are vascular services?

Vascular services are for people with disorders of the arteries and veins. These include narrowing or widening of arteries, blocked vessels and varicose veins, but not diseases of the heart and vessels in the chest.

These disorders can reduce the amount of blood reaching the limbs or brain, or cause sudden blood loss if an over-stretched artery bursts. Vascular specialists also support other medical treatments, such as kidney dialysis and chemotherapy.

All of these diseases used to be treated by surgery only. More recently, specialists have been able to treat many vascular disorders by reaching the site of the problem via the inside of the blood vessels. This is known as interventional radiology, and is a much less invasive approach. Making these advanced techniques readily available to all patients is one of the goals of the review.

"There is good evidence to suggest that complex vascular procedures have better outcomes when performed in major centres with multidisciplinary teams working closely together. Major trauma and endovascular aneurysm repair are good examples of procedures where groups of interventional radiologists and vascular surgeons can obtain better results for patients. When patients realise the benefits of arterial centres, they will be willing to travel for their elective and emergency treatment. The high volume of work will result in more experience in dealing with vascular disease and produce dedicated specialist doctors to provide the service. Fewer, larger, better staffed high quality vascular arterial centres will enable patients to obtain better treatment for vascular disease."

Gian Abbott
Consultant interventional radiologist
Countess of Chester Hospital

At the moment, treatment for vascular conditions takes place at most district hospitals. The district hospitals in Cheshire and Merseyside which currently provide vascular services are Aintree Hospital, Arrowe Park Hospital, Countess of Chester Hospital, Halton Hospital, Leighton Hospital Crewe, Royal Liverpool Hospital, Southport Hospital, Warrington Hospital and Whiston Hospital.

Why are vascular services important?

Vascular services are an important part of the local NHS. People helped by vascular services include:

People with abdominal aortic aneurysms: This is a condition in which the main artery in the abdomen becomes stretched and prone to bursting. Timely detection and treatment of abdominal aortic aneurysms prevents later problems with rupture and bleeding, and can be life-saving. About 350 aortic aneurysm repairs are carried out annually on people from Cheshire and Merseyside.

People with strokes or transient ischaemic attacks (TIAs or mini-strokes): Sometimes, these problems with the blood supply to the brain occur because of a narrowing in a blood vessel in the neck called the carotid artery. This can be treated with an operation to improve the flow of blood and reduce the risk of future strokes. About 300 of these procedures are carried out annually on people from Cheshire and Merseyside.

People with poor blood supply to the feet and legs: Some people, particularly those who smoke or have diabetes, can develop narrowings in the blood supply to the legs and feet. This can cause pain on walking, ulceration and infection. Surgical or interventional radiological treatment can improve the blood supply, make walking easier and prevent the serious complications of inadequate blood supply. About 450 of these procedures are carried out annually on people from Cheshire and Merseyside.

All these operations take place in local hospitals in Cheshire and Merseyside. However, some people live nearer to a hospital in Manchester or Staffordshire and may have their operations there instead.

Why do we need to change how we provide vascular services?

> "With the increasing evidence base which links higher volumes to improved clinical outcomes, a reconfiguration of vascular services across the region is timely. We are very happy to be part of a process that will improve patient quality of care in the NHS."
>
> **Sameh Dimitri**
> **Consultant vascular surgeon**
> **Countess of Chester Hospital**

To provide the best possible care for our patients

Treating vascular disease very well is not easy. Research shows that the chances of survival and improved quality of life after treatment of arterial diseases are greatest when patients are treated by a highly trained specialist team working in a large centre to which many patients are referred.

The more operations carried out at a particular hospital, the more likely it is that treatment will be successful. Seeing more patients allows doctors and other staff to hone their skills and maintain them at the highest level, ensuring that patients get the care they need.

This means that we need to have a small number of hospitals carrying out higher numbers of operations, rather than lots of hospitals carrying out only a few operations each year.

To ensure specialist doctors are available at all times

In some smaller hospitals, there are not enough consultants to provide high quality twenty-four hour care for patients with vascular diseases. By concentrating specialists in fewer

hospitals and ensuring patients are taken to those hospitals promptly, we can ensure everyone gets the treatment they need, when they need it.

One particular issue is the availability of interventional radiology. Skilled consultants can use specialist techniques to save limbs and organs that might otherwise have to be removed. Changing the service so that round-the-clock interventional radiology rotas become possible will ensure that no-one misses out on these benefits because of where and when they become ill. The delay in accessing treatment will be more than outweighed by the better outcomes.

To meet the standards set by our doctors

Vascular specialists in the UK have set out how they think vascular services should be organised so that they can give their patients the best possible results. We have built on that work with specialists from Cheshire and Merseyside, developing our own clinical standards for our future services; these are in Appendix 1. We are determined to improve our local NHS so that these standards are met in full. We can only achieve this by changing where some treatments are provided.

To make sure that everyone has equal access to innovative procedures, such as keyhole techniques

At the moment, patients in the region are not all able to access the latest treatments and techniques. For example, a type of treatment for blood clots which are blocking important arteries is not at present available at all times in every hospital in Cheshire and Merseyside, because of the way in which interventional radiology services are arranged. We do not think that this is fair and want to make sure that all patients can benefit from innovations such as this.

To be ready for a new screening programme

The NHS is starting to screen older men for abdominal aortic aneurysms. Men who are discovered to have the condition need specialist treatment to reduce their risk of dying from their aneurysm. At present, local vascular services are not set up to undertake a screening programme that would meet the standards required by the NHS.

"The best outcomes from modern treatments for patients with vascular disease require the input of a multidisciplinary team working in an environment with high quality imaging equipment and with access to a wide range of expensive medical devices. It makes clinical and economic sense to concentrate the efforts of the health service on fewer centres to guarantee that all the facilities and personnel are available for our patients."

Richard McWilliams
Consultant interventional radiologist
Royal Liverpool Hospital

What changes are planned?

Vascular services are changing in a similar way throughout the country to secure these benefits for patients. In Cheshire and Merseyside, we are proposing that hospitals work in partnership to deliver vascular services, with complex and emergency operations carried out at a small number of specialist vascular centres and the remaining care continuing to be provided locally. The only services which will be relocated are surgery on the arteries and some more complex endovascular procedures. There will be no change in the location of outpatient clinics, initial investigations, surgery for venous disease, amputation, some angioplasties and follow-up, all of which will continue to be available at local hospitals, provided they meet quality standards. Emergency transfers will be completed quickly enough that the improved service outweighs any effect of a delay.

"We vascular surgeons know that hospital services for patients with blood vessel disease can be improved. This review will guarantee that patients with blood vessel disease in Cheshire and Merseyside will receive the best possible standard of hospital care, in a timely fashion."

Francesco Torella
Consultant vascular surgeon
Aintree Hospital

Pathways of elective care for vascular disorders

The flowchart on page 7 shows the pathway of care of patients who consult their GPs with vascular problems. It shows that only one of the six key steps in the pathway of care will change as a result of the proposed improvements to vascular services.

How many patients will be affected?

We cannot yet tell exactly how many patients will receive their specialist arterial treatment at a different hospital as a result of these changes. This is because the number depends on which hospitals become vascular centres. Our estimate is that about 550 patients a year will be affected in this way, having a longer journey time but with better results following treatment.

Present arrangements		Proposed future arrangements	
Step	**Setting**	**Step**	**Setting**
Patient sees GP	Local GP surgery	Patient sees GP	Local GP surgery
↓		↓	
GP refers to vascular specialist	Local GP surgery	GP refers to vascular specialist	Local GP surgery
↓		↓	
Outpatient consultation	Local hospital	Outpatient consultation	Local hospital
↓		↓	
Investigations	Local hospital	Investigations	Local hospital
↓		↓	
Arterial operation	Local hospital	Arterial operation	Vascular centre
↓		↓	
Follow-up	Local hospital	Follow-up	Local hospital

How many vascular centres will there be?

At this stage, we think about two vascular centres would be optimal. This will ensure that

- all patients are treated at hospitals that meet the minimum number of operations per year specified by local clinicians (Appendix 1) and where specialist surgeons and interventional radiologists are available all the time
- care will still continue if one hospital becomes temporarily unavailable, for example because of a fire or an outbreak of infection.

However, the purpose of the consultation is to check that these benefits are worth the change in accessibility, so the final outcome depends on what the consultation shows.

Which hospitals will be vascular centres?

We do not yet have all the information we need to say which hospitals might become vascular centres. We have proposed clinical standards for the vascular centres and other hospitals (Appendix 1), but there are other factors we will need to take into account when we decide upon the most suitable hospitals. These factors are set out on pages 8 and 9. We

want to wait until we have heard your opinions about these aspects of vascular services before we decide on how the vascular centres will be chosen.

What are the benefits of the changes?

The changes will mean that

- Patients have better outcomes from vascular procedures. They will be more likely to survive aortic aneurysm surgery and less likely to have a stroke after treatment of a narrowing in the carotid artery. We estimate that three to five lives a year could be saved if surgery was concentrated in fewer centres. In addition, fewer patients are expected to suffer avoidable complications of surgery, such as renal failure, stroke and damage to the blood supply to the spinal cord and legs.

> "The national strategy to consolidate major vascular surgery into fewer, larger centres is based on evidence that patients get better outcomes at larger centres."
>
> **Stephen Blair**
> **Consultant vascular surgeon**
> **Arrowe Park Hospital**

- The new clinical standards will ensure that designated vascular centres and other hospitals offer prompt access to high quality services, and will be monitored against those standards to make sure they continue to provide a consistently high service.
- Patients can have a wider range of treatments, because of the twenty-four hour availability of consultant interventional radiologists.
- Screening for abdominal aortic aneurysms can be successfully introduced. This will save about 150 lives per year in Cheshire and Merseyside, because people with a problem will be detected early and treated before there is a risk of life-threatening bleeding.

Are there any risks from the change?

The transition period will need careful management to ensure services continue to be delivered successfully, and that relationships are correctly set up between the vascular centres and other parts of the NHS. Non-medical staff, such as nurses and technicians, play a vital role in vascular services. We will need to ensure that they are able, if necessary, to transfer to new hospitals so that their skills are not lost to the local NHS.

How will vascular centres be selected?

We are proposing the following criteria, but would like your comments on whether they are the right ones:

1. *Compliance with clinical standards (Appendix 1)*

   Hospitals that would like to be vascular centres will need to show how they will satisfy the clinical standards.

2. *Maximum degree of co-location with inter-dependent clinical services*

   People who are in hospital because they have just had a stroke, people with kidney disease and people with major injuries benefit from rapid access to vascular services (Appendix 2). This is easiest if all the services such people need are available in one hospital, but we cannot achieve this for all services in every hospital for practical reasons. The clinical standards require a vascular centre to be able to provide a vascular specialist to other hospitals quickly.

3. *Close to where most people live, with good public transport links*

   If patients are to travel further for some parts of their treatment, we need to make the journey as straightforward as possible for them and their visitors.

4. *Lowest investment required to bring about the changes*

   We need to bring about the service reconfiguration at the lowest financial cost to the NHS.

"From a Southport and Ormskirk perspective I feel an important benefit of an arterial centre for our patients would be on-site 24 hour specialist care for our major vascular cases allowing prompt treatment of complications or issues arising from their condition without the need for transfer due to lack of a vascular specialist out of hours."

Frank Mason
Consultant vascular surgeon
Southport Hospital

The consultation process

The necessity for change is evident to all the Primary Care Trusts, hospitals and vascular specialists in Cheshire and Merseyside. They feel a clear responsibility to arrange services in as safe and effective a way as possible, and are therefore keen to carry out the reconfiguration.

Given the strength of scientific evidence and professional consensus, we are not consulting on whether to make the change. However, we need your views on how vascular centres should be chosen, and also on the balance between local access and high-quality specialist care.

The Project Board will review the results of the consultation, and publish a report on what it revealed. Hospitals wishing to be vascular centres will be invited to explain how they will fulfil the criteria and quality standards. The Project Board will then recommend which hospitals should become vascular centres, with local NHS commissioners making the final decisions.

There are a number of ways in which we are trying to make sure that we hear from as many of the people of Cheshire and Merseyside as possible. The details are below. We have organised two key meetings, the first for clinicians and commissioners, and the second for patients, carers, local LINk members and the general public. Health Overview and Scrutiny Committee members are also invited to the second meeting, and we have been invited to present our plans to some Health and Wellbeing Scrutiny Committees. We will invite

Cheshire and Merseyside MPs who are unable to attend these events to a meeting to share their views and hear the feedback from stakeholders.

In addition to events, the consultation is accessible electronically by accessing PCT websites. NHS Stakeholders and the public can view and download this consultation document, and the questions posed at the events will be uploaded on to the internet for all NHS Stakeholders and members of the public to post their feedback. Alternatively, you can request paper copies of the consultation document, and ask questions by post; a prepaid return reply will be provided. For postal requests, please contact Jackie Robinson on 0151 244 3459 or email Jacqueline.robinson@knowsley.nhs.uk

All feedback will be collated and submitted in report format for the Project Board to consider. The Project Board recommendations will be sent to Cheshire and Merseyside PCTs who will take the final decision. The outcome of their decision will be made public, all respondents will be sent this information and it will be publicised on each PCT website.

Key dates

27 January 2011	Consultation opens
27 January 2011	Consultation event for NHS stakeholders
10 February 2011	Consultation event for public and patient stakeholders, members of locality Health Overview and Scrutiny Committee
February 2011	Consultation with Cheshire and Merseyside MPs
March 2011	Consultation closes
May 2011	Recommendation announced
May to October 2011	Preparation for reconfiguration
November 2011	Reconfiguration begins. This will be undertaken in phases.

Tell us what you think

NHS staff can comment by attending a consultation event from 2.00 pm to 4.00 pm on 27 January 2011 at the Halliwell Jones Stadium, Winwick Road, Warrington WA2 7NE. If you would like to come, please register in advance with jacqueline.robinson@knowsley,nhs.uk or telephone (0151) 244 3459.

Alternatively, you can respond to the consultation questions which will be posted onto NHS Knowsley Survey Monkey. Please go to www.surveymonkey.com/s/CMVSR-Staff after 28 January 2011.

Patients and the public can comment on the consultation by attending a consultation event from 12.30 pm to 3.30 pm on 10 February 2011 at the Halliwell Jones Stadium, Winwick Road, Warrington WA2 7NE.

Attendance will need to be registered as above. Transport can be provided to support your attendance.

If you wish to comment on via the internet, please go to www.surveymonkey.com/s/CMVSR-public after 28 January 2011.

Glossary

An **abdominal aortic aneurysm** is a condition in which the main artery in the abdomen becomes stretched and prone to bursting. If it bursts, major bleeding occurs, which may be fatal.

An **angioplasty** is an interventional radiological procedure to widen an artery which is narrowed by disease.

Carotid endarterectomy is an operation to remove a narrowing from the carotid artery, which carries blood to the brain. In correctly selected patients, the operation reduces the risk of a future stroke.

Endovascular procedures are tests and treatments carried out via the inside of blood vessels.

Interventional radiologists are doctors trained to investigate people with vascular disease, to find out what and where the problem is. They can also treat vascular disease by gaining access to the site of the problem via the inside of blood vessels.

A **stroke** is a permanent disruption to the brain's blood supply. Strokes can cause problems with speech or movement, and can be fatal.

Transient ischaemic attacks occur when the blood supply to the brain is temporarily interrupted. Although full recovery occurs, they indicate a higher risk of a future more severe stroke.

Vascular centres are hospitals with enough specialist staff and facilities to ensure the best possible outcomes for all patients who are referred there.

Vascular services are for people with disorders of the arteries and veins. These include narrowing or widening of arteries, blocked vessels and varicose veins, but exclude diseases of the heart and vessels in the chest.

Vascular specialists are doctors who treat vascular disorders. Some are vascular surgeons and others are interventional radiologists.

Vascular surgeons see patients with vascular disease in outpatients, arrange investigations, perform surgical operations and follow their patients up after treatment.

Appendix 1: Quality standards for vascular services

Introduction

In June 2010, the Cheshire and Merseyside vascular review convened a Clinical Advisory Group to develop clinical standards for vascular services. These were to guide the reconfiguration of vascular services in the region, and specifically to ensure that hospitals providing arterial surgery were able to secure excellent outcomes for patients. The standards are partly based on *Quality Standards Services for People with Vascular Disease,* published by the West Midland Quality Review Service.

The standards refer to the vascular service, which is all the hospitals in Cheshire and Merseyside which provide care to patients with vascular disease, and to vascular centres, which are hospitals providing arterial surgery and higher risk interventional radiology as part of the vascular service.

Clinical standards for vascular centres

Number	Standard	Demonstration of compliance
Staffing		
1.	The centre should have a nominated lead consultant vascular specialist (surgeon or radiologist), and nominated lead surgeon, radiologist and nurse with responsibility for ensuring implementation of the quality standards across the centre's catchment area.	Name of lead consultants and lead nurse. *Note: The lead clinicians may be supported by senior clinicians who take a lead role on particular aspects of the service, for example, screening or training.*
2.	A nurse should be available with specialist expertise in each of the following areas: a. Wound, ulcer and diabetic foot management b. Claudication, and lifestyle advice	Staffing details, including cover arrangements. *Notes:* *1. The nurse with specialist expertise in vascular access may*

	c. Amputation and liaison with rehabilitation and limb-fitting services d. Vascular access for patients with renal disease e. Aneurysms. These nurses should have responsibility for leadership and service development for their area of specialist expertise. There should be arrangements for cover during absences.	*be managed by the renal service or by the vascular service.* *2. These specialist roles may be undertaken on a full-time or part-time basis and may include, for example, senior ward nurses with additional responsibilities. Sufficient time should, however, be allocated for the leadership and service development aspects of the roles.* *3. Specialist expertise should be available to all patients from the centre's catchment area. The roles may, however, be undertaken by different people in different localities.*
3.	A consultant vascular surgeon should be available at all times.	Staffing details. *Note: A minimum of a 1:6 on call rota is required to achieve this standard.*
4.	Robust middle-grade cover must be in place.	Staffing details. *Note: As an aspiration, this middle grade cover should be provided by a vascular specialist trainee.*
5.	A consultant anaesthetist with up-to-date skills and competencies in managing vascular emergencies should be available at all times.	Staffing details
6.	A nominated lead consultant anaesthetist should be identified for liaison with the vascular service.	Name of nominated lead
Organisation of care		
7.	All patients should be treated in accordance with normal standards of consent, support and provision of written information.	Written policies

8.	The service should have defined the locations on which in-patient, day case and out-patient vascular services are provided. Each vascular service should have only one in-patient arterial site. Out-patient vascular services should take place on, at least, all hospital sites accepting general medical and surgical emergency admissions.	Locations of services agreed by commissioners. *Notes:* 1. *In hospitals without on-site in-patient vascular services, out-patient and day surgery or interventional procedures may be provided by local vascular specialists or by specialists visiting from another hospital – usually the hospital with in-patient vascular services.* 2. *The best possible local access to vascular services should be achieved by providing out-patient and day case services as close to patients' homes as possible. This may include locations other than those admitting vascular, general medical and general surgical admissions.*
9.	A consultant interventional radiologist should be available at all times.	Staffing details. *Note: A minimum of a 1:6 on call rota is required to achieve this standard.*
10.	Participation in the interventional radiology service should be open to all interventional radiologists from hospitals in the centre's catchment area who wish to participate, subject to their maintaining competence.	Details of service available. *Notes:* 1. *The radiology service should satisfy the requirements in The Royal College of Radiologists' document 'Standards for providing a 24-hour interventional radiology service' (2008), The Royal College of Radiologists/British Society of Interventional Radiology document 'Achieving Standards for Vascular Radiology' (2007) and the RCR/RCN document 'Guidelines for Nursing Care in Interventional Radiology' (2006), or subsequent updates to these*

		documents. 2. *This standard does not require a separate vascular interventional radiology rota.*
11.	For arterial centres which are part of a trauma network, the on-call vascular specialist must be able to reach the trauma unit within thirty minutes.	Records of call-outs
12.	All emergency and elective vascular interventional procedures should be undertaken by consultant vascular specialists or by staff under their supervision. All vascular specialists should undertake sufficient interventional procedures (operations or interventional radiology procedures) per annum to maintain competence.	Details of staffing available. Audit results. *Note:* *For the purpose of considering interventional procedures to maintain competence, activity undertaken in hospitals other than the vascular centre may be included as part of surgeons'and radiologists' activity.* *Recommended staffing levels are one vascular surgeon per 150,000 population or one transplant surgeon with a vascular interest per 100,000 population.*
13.	Endovascular aortic aneurysm repair and carotid stenting should be undertaken only by vascular specialists with competence in these procedures.	Normal clinical governance arrangements in place and implemented. Audit results. *Note: Trust processes for introduction of new procedures should also be applied to the introduction of these procedures.*

14.	A vascular specialist and support staff with competence in interventional radiology should be available for all elective vascular radiology procedures.	Staffing details. *Notes:* 1. *Trust governance procedures must ensure that vascular specialists are competent in the procedures they propose to undertake.* 2. *In hospitals without on-site in-patient vascular services, the vascular specialist and support staff may be based in the local hospital or may travel from another hospital – usually the one where in-patient services are located.* 3. *These services should satisfy the requirements in The Royal College of Radiologists/British Society of Interventional Radiology document 'Achieving Standards for Vascular Radiology' (2007), or subsequent updates of this document.*
15.	An in-patient ward should be available, staffed by nurses and health care assistants with appropriate competence in the care of patients with vascular disease. The competence framework should cover at least: a. Acute Life-threatening Events Recognition and Treatment (ALERT) or similar b. Tissue viability and wound care c. Pain management d. Care of patients with diabetes	Staffing details, competence framework showing expected competences and summary of competence assessments.

	e. High dependency care f. Care of patients with disabilities, including patients with amputations.	
16.	Physiotherapy services should be available daily with time allocated for their work with in-patients with vascular disease.	Details of services available. *Note: These services should be available at weekends as well as Monday to Friday.*
17.	Access to the following services should be available for in-patients with vascular disease: a. Occupational therapy b. Social work. Staff providing these services should have specific time allocated to their work with the vascular service.	Details of services available. *Note: These services may be provided by staff who provide the post-discharge service or by different staff.*
18.	Vascular ultrasound should be available for all vascular out-patient services.	Staffing details. *Note: The service may be available within the out-patient clinic or imaging department. The service may be provided by a vascular technologist, radiographer, nurse or radiologist. More detail on the competences expected for these staff is available from Skills for Health.* *Further advice on competences is expected from the British Medical Ultrasound Society in the near future.* *In hospitals without in-patient vascular services, staff may be based in the local hospital or may travel from another hospital, usually the one where in-patient services are*

		located.
19.	In-patient and community-based rehabilitation services with expertise in the care of patients with vascular disease, including amputees, should be available, including at least: a. Physiotherapy b. Occupational therapy c. Limb fitting and orthoses.	Description of services available. *Note: These services should be available for the whole of the vascular centre's catchment population but may be organised in different ways in different locations.*
20.	Sufficient administrative, clerical and data collection support should be available.	Discussion with staff. *Note: 'Sufficient' is not strictly defined. Clinical staff should not be spending unreasonable amounts of time on administrative duties, including data collection, that detract from their ability to provide patient care.*
Facilities		
21.	The following facilities and services should be available at all times: a. Emergency theatre b. Vascular angiography suite c. Spiral CT d. Critical care (levels 2 and 3)	Details of facilities and staffing available. *Note:* *1. The Medicines and Healthcare Products Regulatory Agency has published guidance on facilities for endovascular aortic aneurysm repair (Joint Working Group to produce guidance on delivering an Endovascular Aneurysm Repair Service). The guidance does not require immediate cessation of endovascular*

	e. Haematology (for urgent cross-match and blood products) f. Blood biochemistry and blood gas analysis g. Facilities for electronic transfer of imaging from, or ability remotely to view imaging at, other acute hospitals within the catchment area of the vascular centre. h. As an aspiration, fixed imaging facilities in a sterile theatre environment for endovascular aneurysm repair. These facilities should have staff with appropriate vascular expertise and sufficient capacity for the expected number of patients with vascular disease, including incoming transfers and unexpected rises in demand.	*aneurysm repair in hospitals without fixed imaging facilities in a sterile theatre environment.* 2. *The angiography suite should be staffed as stated in the RCR / RCN guidance.* 3. *Images must be available via Dicom links (i.e. on PACS) not via a web based system.*
22.	A vascular laboratory should be available at the vascular centre.	Viewing facilities
23.	Magnetic resonance angiography should be available during normal working hours.	Viewing facilities.
24.	In-patient wards for patients with vascular disease should have: a. Hand-held Doppler ultrasound machine b. Portable duplex device.	Viewing facilities.
25.	All vascular surgery should take place in a theatre with: a. All standards for sterility met b. Theatre staff trained in vascular instruments, prosthetics and techniques and in the use of cell salvage devices for	Viewing facilities.

	blood conservation c. Stocks of grafts, instruments and sutures required for patients with vascular disease d. Radiolucent operating tables and X-ray C-arms. X-ray C-arm should have DSA capability. A back up C-arm of similar specification must be available. e. Hand-held Doppler ultrasound machine and portable duplex devices f. Access to blood and blood products.	
26.	Elective clinic and theatre sessions for patients needing permanent dialysis access should be sufficient to meet the needs of patients from the catchment area with end-stage renal failure.	Details of vascular access services. *Notes:* *National recommendation is one session per week for every 120 adult patients on dialysis.*
27.	All vascular out-patient clinics should have: a. Hand-held Doppler ultrasound machine b. Portable duplex scanner c. Facilities to perform ankle brachial pressure tests.	Observation of facilities and equipment.
Clinical policies		
28.	Clinical guidelines should be agreed with the ambulance service covering the clinical indications for taking emergency patients to the vascular centre and the patients who may be taken to	Written guidelines agreed with the ambulance service.

	Emergency Departments without on-site in-patient vascular services.	
29.	Arterial surgery and higher risk arterial interventional radiological procedures are carried out at the arterial centre. Varicose vein surgery and lower risk arterial interventional radiological procedures are carried out at non-arterial centres. The appropriate site at which to carry out amputation will vary. The multi-disciplinary team will decide whether each patient's procedure is sufficiently low risk that it could be carried out appropriately at non-arterial centres, or higher risk and therefore suitable for the arterial centre.	Notes of meetings held.
30.	Clinical guidelines should be in use covering direct transfer from each of the following services to the vascular centre: a. Burns services b. Stroke services c. Neurosurgery services d. Spinal surgery services e. Cardiac services f. Trauma services	Written guidelines. *Notes:* 1. *These guidelines should be based on agreed local clinical networks' or regional guidance and pathway or on the latest evidence-based national guidance, including NICE guidance.* 2. *Guidelines must be clear about the arrangements for emergency transfer of patients with head injury, sub-arachnoid haemorrhage, hyper-acute stroke, ST elevation myocardial infarction and abdominal aortic aneurysm.* 3. *The guidelines may also cover information required for referral, documentation, treatments to undertake before transfer and escorting staff.*

31.	Clinical guidelines should be in use throughout the vascular service covering assessment and management of: a. Open and endovascular repair of abdominal aortic aneurysm b. Surveillance of abdominal aortic aneurysm c. Carotid artery disease d. Diabetic foot e. Leg ulcers f. Claudication g. Varicose veins h. Limb-threatening ischaemia i. Lymphoedema. The guideline for amputation should comply with the standards published by the Vascular Society of Great Britain and Ireland, including their Quality Improvement Framework. These guidelines should cover: a. Indications for seeking advice b. Lifestyle advice c. Investigations d. Treatment options available, including surgical and	Written guidelines. *Notes:* 1. *The guidelines should be explicit about who will undertake interventional imaging (i.e. interventional radiologist or vascular surgeon). Where a vascular service covers more than one hospital, this should be specified for each hospital.* 2. *Guidelines on the assessment and management of abdominal aortic aneurysm should comply with the Vascular Society's document 'Framework for improving the results of elective AAA repair' (2009).* 3. *Guidelines on carotid artery disease assessment and management should be agreed with local stroke / TIA service(s) and should ensure that, where indicated, carotid intervention takes place within 48 hours of referral.* 4. *Guidelines on diabetic foot assessment and management should be agreed with the local diabetes service(s).* 5. *The pre-operative assessment aspects of the guidelines should have been agreed with the local cardiology service/s.*

	radiological interventions and conservative options e. Indications for choice of treatment f. Investigation and management of emergency patients g. Management of haemodynamically unstable patients h. Indications and arrangements for emergency transfer i. Indications and arrangements for non-urgent referral j. Arrangements for transfer of cross-matched blood k. Pre-operative assessment l. Post-operative monitoring m. Management of side-effects and complications of treatment n. Follow up arrangements o. Referral for rehabilitation p. Responsibilities for giving information to patients and carers.	
32.	High-risk patients including all patients undergoing aortic surgery should be seen for pre-assessment by an anaesthetist with experience in elective vascular anaesthesia. Medication should be reviewed and optimised for the intervention.	Written guidelines.
33.	Centres treating patients with thoracic or thoracoabdominal aortic	Viewing equipment

	aneurysms need to have a system in place to treat spinal cord ischaemia with lumbar CSF drainage and blood pressure augmentation at all times.	
34.	Guidelines on lifestyle advice for all patients should be in use covering, at least: a. Support for smoking cessation b. Dietary advice c. Programmes of physical activity and weight management.	Written guidelines.
35.	Clinical guidelines on monitoring and management of peripheral arterial disease risk factors should be in use covering, at least: a. Anti-platelet therapy b. Lipid reduction therapy c. Control of hypertension.	Written guidelines.
36.	Clinical guidelines on the management of patients with diabetes should be in use covering, at least: a. Management of ischaemia and sepsis in patients with diabetes b. Peri-operative management of patients with diabetes c. Indications for involvement of the diabetes service in the care of the patient.	Written guidelines agreed with the local diabetes service.

37.	Clinical guidelines on the management of patients with, or at risk of, impaired renal function should be in use, including: a. Indications for involvement of the renal service in the care of the patient b. Prevention and management of complications.	Written guidelines agreed with the local renal service.
38.	A protocol for by-pass graft surveillance should be in place.	Written protocol. *Note: The protocol may be that no surveillance is undertaken unless further evidence of effectiveness becomes available.*
39.	Clinical guidelines should be in use covering indications for involvement of cardiology services in the care of patients with vascular disease.	Written guidelines agreed with cardiology service.
40.	Clinical guidelines should be in use covering indications and arrangements for referral for psychological support.	Written guidelines.
41.	There should be a local policy covering ultrasound screening of relatives of patients with abdominal aortic aneurysm.	Written policy. *Notes:* 1. *The policy should cover relatives of patients identified by both screening and symptomatic pathways.* 2. *The policy should be consistent with the information for patients.*
42.	Discharge planning guidelines should be in use covering, at least: a. Discharge to rehabilitation facilities	Written guidelines.

	b. Discharge home with support from local rehabilitation facilities c. Referral to limb-fitting service d. Communication with the patient's GP.	
43.	Guidelines, agreed with the specialist palliative care services serving the local population, should be in use covering, at least: a. Arrangements for accessing advice and support from the specialist palliative care team. b. Indications for referral of patients to the specialist palliative care team. c. Arrangements for shared care between the vascular service and palliative care services.	Written guidelines, agreed with specialist palliative care service(s) serving the local population.
44.	A protocol on driving advice should be in use, covering establishing the type of licence and giving appropriate advice on DVLA notification.	Written protocol. *Note:* *The protocol should comply with the latest version of 'Guidance to the current Medical Standards of Fitness to Drive' produced by the DVLA and reviewed every six months*.
45.	The vascular centre's staff should be aware of local guidelines for end-of-life care.	Availability of guidelines relating to end-of-life care that are used by specialist palliative care services in the local area.
Multi-disciplinary working		
46.	A multi-disciplinary team meeting to discuss the treatment of patients with abdominal aortic aneurysms and peripheral vascular	Notes of meetings held.

	disease should be held at least weekly. Job plans must include attendance at multi-disciplinary team meetings.	
47.	All images should be discussed at a multi-disciplinary team meeting attended by a consultant radiologist.	Notes of meetings held.
48.	A ward-based multi-disciplinary team meeting to discuss the care of patients with complex rehabilitation and discharge needs should be held at least weekly, involving at least: a. Ward manager b. Nurse with specialist expertise in care of patients with amputations c. Physiotherapy d. Occupational therapy e. Social work.	Notes of meetings held. *Note: Other staff, for example, community matrons, may also attend the multi-disciplinary team meetings.*
49.	Consultant and nurse representatives of the vascular service should participate regularly in multi-disciplinary meetings with services responsible for the care of: a. Patients with renal disease b. Patients with stroke or TIA	Discussion with renal, stroke and cardiothoracic surgery services.

50.	Multi-disciplinary clinics for assessment of patients with diabetes and complex foot problems should be held involving: a. Vascular surgeons b. Diabetes services c. Orthopaedic services d. Orthotic services e. Podiatry services.	Details of services available.
51.	A meeting with local rehabilitation services should be held at least annually to review the links with the vascular service and address any problems identified.	Notes of meetings held.
52.	The vascular centre should offer an educational session on the assessment of vascular emergencies for emergency department staff, general surgeons, GPs and ambulance staff at least annually.	Details of sessions provided. *Note:* *The educational session should be offered to staff from all hospitals within the catchment area of the vascular centre.*
Clinical audit		
53.	The centre should collect and submit data to the National Vascular Database (all index procedures) and British Society of Interventional Radiology Registries. This standard is of the highest importance.	National Vascular Database reports showing risk-adjusted comparative outcomes for the centre. BSIR Registries information. *Note:* *1. Data should cover all parts of the vascular service including activity in hospitals without on-site in-patient services.*

		2. *Appropriate support staff are needed to collect and upload data.*
54.	The centre should comply with national mortality standards.	Annual report
55.	The centre should have an annual programme of audits covering at least: a. Number of interventional procedures (surgical and interventional radiology) undertaken by each vascular specialist in the centre's catchment area b. Medical management of patients with peripheral vascular disease c. Compliance with evidence-based guidelines.	Details of audit programme. *Note: Audits should cover all parts of the vascular service including activity in hospitals without on-site in-patient services and should include comparison of HES data and National Vascular Database / BSIR Registries numbers. Audits of operations by surgeon should include all vascular operations, including any undertaken by general surgeons.*
56.	The centre should produce an annual report summarising activity, compliance with quality standards and clinical outcomes. The report should identify actions required to meet expected quality standards and progress since the previous year's annual report.	Annual report. *Note: The National Vascular Database reports will provide much of the data for the annual report.*
57.	All policies, procedures and guidelines should comply with Trust document control procedures.	Policies, procedures and guidelines meeting reasonable document control quality requirements of monitoring, review and version control.

Clinical standards for non-arterial centres

Number	Standard	Demonstration of compliance
Equipment and facilities		
1.	Vascular out-patient clinics should have: a. Hand-held Doppler ultrasound machine b. Portable duplex scanner Facilities to perform ankle brachial pressure tests.	Observation of facilities and equipment.
2.	The service should have defined the locations on which in-patient, day case and out-patient vascular services are provided. Each vascular service should have only one in-patient arterial site. Out-patient vascular services should take place on, at least, all hospital sites accepting general medical and surgical emergency admissions.	Locations of services agreed by commissioners. *Notes:* 1. *In hospitals without on-site in-patient vascular services, out-patient and day surgery or interventional procedures may be provided by local vascular specialists or by specialists visiting from another hospital – usually the hospital with in-patient vascular services.* 2. *The best possible local access to vascular services should be achieved by providing out-patient and day case services as close to patients' homes as possible. This may include locations other than those admitting vascular, general medical and general surgical admissions.*

3.	Vascular ultrasound should be available for all vascular out-patient services.	Staffing details. *Note: The service may be available within the out-patient clinic or imaging department. The service may be provided by a vascular technologist, radiographer, nurse or radiologist. More detail on the competences expected for these staff is available from Skills for Health.* *Further advice on competences is expected from the British Medical Ultrasound Society in the near future.* *In hospitals without in-patient vascular services, staff may be based in the local hospital or may travel from another hospital, usually the one where in-patient services are located.*
4.	Non-arterial centres should have available sets of instruments for common arterial procedures, in case they are unexpectedly required.	Inspection
Organisation of care		
5.	Arterial surgery and higher risk arterial interventional radiological procedures are carried out at the arterial centre. Varicose vein surgery and lower risk arterial interventional radiological procedures are carried out at non-arterial centres. The appropriate site at which to carry out amputation will vary. The multi-disciplinary team will decide whether each patient's procedure is sufficiently low risk that it could be carried out appropriately at non-arterial centres, or higher risk and therefore suitable for the arterial centre.	Notes of meetings held.

Clinical audit		
6.	All policies, procedures and guidelines should comply with Trust document control procedures.	Policies, procedures and guidelines meeting reasonable document control quality requirements of monitoring, review and version control.
7.	The centre should collect and submit data to the National Vascular Database (all index procedures) and British Society of Interventional Radiology Registries.	National Vascular Database reports showing risk-adjusted comparative outcomes for the centre. BSIR Registries information. *Note:* *1. Data should cover all parts of the vascular service including activity in hospitals without on-site in-patient services.* *2. Appropriate support staff are needed to collect and upload data.*
8.	The centre should have an annual programme of audits covering at least: a. Number of interventional procedures (surgical and interventional radiology) undertaken by each vascular specialist across the centre's catchment area. b. Medical management of patients with peripheral vascular disease. c. Compliance with evidence-based guidelines.	Details of audit programme. *Note:* *1. Audits should cover all parts of the vascular service including activity in hospitals without on-site in-patient services and should include comparison of HES data and National Vascular Database / BSIR Registries numbers. Audits of operations by surgeon should include all vascular operations, including any undertaken by general surgeons.* *2. Data should cover all parts of the vascular service including activity in hospitals without on-site in-patient*

		services. 3. *Appropriate support staff are needed to collect and upload data.*

Clinical Advisory Group

Mr Andrew Guy, consultant general and vascular surgeon, Mid Cheshire Hospitals (chair)
Dr Gian Abbott, consultant radiologist, Countess of Chester Hospital
Mr Stephen Blair, consultant vascular surgeon, Arrowe Park Hospital
Mr John Brennan, consultant vascular surgeon, Royal Liverpool and Broadgreen Hospitals
Mr Sameh Dimitri, consultant vascular surgeon, Countess of Chester Hospital
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Mr Frank Mason, consultant vascular surgeon, Southport and Ormskirk Hospitals
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Mr Francesco Torella, consultant vascular surgeon, Aintree Hospital
Dr Salman Zaman, consultant radiologist, Mid Cheshire Hospitals
Dr Oliver Zuzan, consultant anaesthetist, Royal Liverpool Hospital

Appendix 2: Inter-dependent clinical services

Patients often have more complex care needs which overlap several clinical services. We need to make sure that, after the change in vascular services, patients get care that is at least as joined up as at present.

The most important of these linked services are those for people with kidney failure, stroke, diabetes and trauma. Clinicians have recommended arrangements to ensure services work well together:

Stroke

The National Stroke Strategy requires that patients presenting with a high-risk transient ischaemic attack or minor stroke should be assessed for possible carotid endarterectomy within 24 hours, and within seven days in all other cases, with carotid intervention within 48 hours of referral where clinically indicated.

The future model of care in Cheshire and Merseyside is that patients with an obvious stroke will be taken direct to a hyper-acute stroke centre for immediate imaging, thrombolysis and other urgent management. After a few days, they will be transferred to a more local hospital to continue rehabilitation.

- It is highly desirable, but not essential, that arterial centres are co-located with hyper-acute stroke centres. This is because it will expedite carotid endarterectomy for those patients admitted there.
- The arterial centre will need to be able to offer treatment in line with these standards to patients presenting there and at other hospitals.
- The selection of a hospital as a hyper-acute stroke centre will be a factor in its favour when identifying arterial centres.

Diabetes

Most patients with diabetes presenting with vascular disease can be investigated at a non-arterial centre hospital and referred if necessary as an outpatient. Inpatients can be investigated and in most cases treated with angioplasty without recourse to open vascular surgery. The minority of patients presenting with an acutely ischaemic limb or other vascular emergency would need transfer to the arterial centre. Inpatients with diabetes benefit from specialist diabetic input, and there is evidence that this may shorten length of stay.

- The arterial centre will need to be able to offer immediate admission to diabetic patients with vascular emergencies.
- Arterial centres will need to ensure adequate input from the diabetes team.

Critical care and trauma

The reconfiguration of trauma services on Cheshire and Merseyside is likely to culminate in the designation of four or five hospitals as trauma units; no hospital in the North-West has all the clinical components necessary for trauma centre status. Only a small minority of trauma cases involve vascular injury, so it is desirable but by no means essential that these hospitals should be arterial centres – in any case, the likely number of these centres is fewer than the number of trauma units.

When a patient with vascular trauma is admitted to a hospital without arterial surgery on site, a general surgeon can treat the haemorrhage and stabilise the patient, while a vascular surgeon is called from elsewhere. The vascular surgeon's role is to repair and reconstruct the damaged vessels, and s/he would need to be onsite within thirty minutes of being called.

With regard to critical care, all hospitals in Cheshire and Merseyside are expected to have a 24/7 intensivist rota, and nearly all do. Any hospital offering arterial surgery should offer this level of cover.

- The selection of a hospital as a trauma unit, and especially as a trauma unit plus, will be a factor in its favour when identifying arterial centres.
- Critical care capacity should be considered in the configuration of vascular services, with a requirement for 24/7 intensivist cover.

Renal services

Hospitals fall into three categories: those with no haemodialysis facilities, those offering nurse-led haemodialysis to outpatients supported by a visiting nephrologist, and those with a full-scale renal unit. There are three of the latter in Cheshire and Merseyside: the Royal Liverpool, Aintree and Arrowe Park.

There are three areas where renal and vascular services intersect:

Creating and maintaining arterio-venous fistulae for haemodialysis patients
From April 2011, Trusts will face financial penalties if more than 20% of patients on long-term haemodialysis lack permanent vascular access via an arterio-venous fistula. Fistulae need to be created within six weeks of referral to a surgeon. Fistulae sometimes stenose or thrombose, both of which need prompt interventional radiology to maintain or restore patency.

For this reason, onsite vascular services contribute substantially to the success of a haemodialysis centre.

The management of acute renal failure after vascular surgery
Patients with acute renal failure after surgery need expert management, not least to shorten the length of stay in critical care. Nephrologists are helpful in such situations, but an appropriately trained intensivist is also fully satisfactory.

The management of peripheral vascular disease in patients on dialysis
Cardiovascular and peripheral vascular disease is common among patients on dialysis. When they are admitted for any reason, patients on dialysis need particularly expert

treatment because of their renal failure. Therefore, many hospitals without a full renal service have a policy of not admitting patients on dialysis for any indication. So substantial clinical difficulties would arise for a renal centre which was not also an arterial centre, unless existing clinical relationships could mitigate the problem.

- Ideally renal and vascular units should co-exist on the same site. Any other arrangement requires close discussion between hospitals to ensure that these standards are achieved.

A renal unit's key requirements for vascular support are:

1. Access to imaging for work up of a new vascular access (within four weeks).
2. Access to imaging for diagnosis in cases of sub-optimally performing fistulas (within two weeks, degree of urgency will depend of degree of fistula underperformance).
3. Facilities for long-line placement with radiology imaging and interventional radiologist expertise (within 24 hour interval to reduce the number of temporary procedures and duration of in-patient stay)
4. Elective list time for placement of Tenchkoff catheters and peripheral haemodialysis access (enough list space so that 80% of patients known to nephrology for over 90 days and planned for peritoneal dialysis start on that treatment and 80% of patients start haemodialysis with peripheral access).
5. Access to theatres (and surgical staff) for uncontrollable haemorrhage, or graft or peritoneal sepsis (within hours).
6. Access to ultrasound for diagnosis of acutely thrombosed fistulae (09.00 to 17.00 seven days a week)
7. Access to interventional radiology for diagnosis, angioplasty and thrombolysis (09.00 to 17.00 7 days a week).
8. Access to theatres and surgical staff for fistula thrombectomy (09.00 to 17.00 seven days a week).

Vale Royal Commissioning Consortium
Working Together

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31st March 2011

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Dear Mr. Dent

Re: Cheshire and Merseyside Vascular review

Thank you for your recent correspondence regarding the Cheshire & Mersey Vascular Review. Within Central and Eastern Cheshire the South Cheshire & Vale Royal Consortia's strategic vision is to commission care for its patient's from a vascular provider that can provide a robust complete service.

University Hospital of North Staffordshire NHS Trust is currently achieving the national AAA Quality Improvement programme markers and aims to reduce elective AAA mortality to 3.5% or less by 2013. In addition they already provide vascular services to our area. Furthermore we believe that cardiothoracic and renal components are significant elements to managing Vascular conditions, both of which we currently commission from the University Hospital of North Staffordshire NHS Trust. Therefore our current position is to strengthen our links with the University Hospital of North Staffordshire NHS Trust and we request that the Cheshire and Mersey Vascular review board consider this position within the review process.

It is our understanding that this is also the view that has been taken by Mid Cheshire Hospitals NHS Foundation Trust.

It is important to stress that we would hope that it does not preclude future discussions around service delivery and pathway development. We would like to take this opportunity to wish you well with the Cheshire and Merseyside Vascular Review

Yours sincerely

Dr Andrew Wilson
Chair
South Cheshire Commissioning Consortium

Dr Jonathan Griffiths
Chair
Vale Royal Commissioning Consortium

CHESHIRE AND WIRRAL COUNCILS' JOINT SCRUTINY COMMITTEE **11 JULY 2011**

(2.00 pm - 3.35 pm)

PRESENT: Councillors Keith Butcher, Andrew Dawson, Louise Gittins, Eveleigh Moore Dutton, Charles Fifield, Gill Boston, Paul Edwards, Brian Silvester, Bridson, Clements, Glasman and Salter

Apologies for absence were received from Councillors Paul Dolan, Gordon Baxendale, Carolyn Andrew, Jacquie Weatherill, Cherry Povall and Tony Smith

Officers in attendance:	Ros Francke	– CWP Director of Finance NHS Foundation Trust
	Andy Styring	– Director of Operations, CWP NHS Foundation Trust
	David Jones	– Scrutiny Team
	Deborah Ridgeley	– Democratic Services Officer

1 APPOINTMENT OF CHAIRMAN

Councillor Brian Silvester nominated Councillor Andrew Dawson as Chairman of the Committee, seconded by Councillor Eveleigh Moore Dutton. There were no other nominations.

DECIDED: That

Councillor Andrew Dawson be appointed Chairman of the Cheshire and Wirral Council's Joint Scrutiny Committee for the ensuing 2011/2012 Municipal year.

Councillor Andrew Dawson in the Chair

2 APPOINTMENT OF VICE CHAIRMAN

Councillor John Salter nominated Councillor Patricia Glasman as Vice-Chairman and was seconded by Councillor Ann Bridson.

DECIDED: That

Councillor Patricia Glasman be appointed as Vice-Chairman of the Cheshire and Wirral Council's Joint Scrutiny Committee for the ensuing 2011-2012 Municipal Year.

3 NOTIFICATION OF SPOKESPERSON

DECIDED: That

Councillor Brian Silvester was appointed as Spokesperson from Cheshire East Council for the ensuing 2011 – 2012 Municipal Year.

4 APPOINTMENT OF SECRETARY

Members considered the appointment of a Secretary to the Joint Committee.

DECIDED: That

Cheshire West and Chester Council provide the Secretariat for the Cheshire and Wirral Council's Joint Scrutiny Committee for the ensuing 2011 – 2012 Municipal Year.

5 DECLARATIONS OF INTERESTS

Members did not declare any personal or prejudicial interests.

6 MINUTES

Members referred to Minute number 81, in relation to the presentation about the Dementia Pathway and requested clarity as to the percentages quoted.

DECIDED: That

subject to the above information being circulated, the minutes of the meeting of the Cheshire and Wirral Council's Joint Health Scrutiny Committee held on 4 April 2011 be agreed as a correct record.

7 CHESHIRE AND WIRRAL COUNCILS JSC - PROTOCOL AND PROCEDURAL RULES

The Protocol for the Joint Scrutiny Committee had been provided for Members and consideration as to possible changes was requested. Members stated that until more experience of the work of the Committee had been gained, it was perhaps premature to consider changes.

The Committee considered the definitions contained in the protocol and it was suggested that the wording in paragraph 7.1 of the report was the most accurate:-

"Overview and scrutiny powers cover any matter relating to the planning, provision and operation of health services. Health services are as defined in the NHS Act 1977 and cover health promotion, prevention of ill health and treatment".

The number of meetings was also discussed, and although the scheduled meetings had been previously agreed at 4, flexibility to arrange further meetings and for task and finish groups to meet was deemed to be necessary.

DECIDED: That

the Procedure Rules appended to the agenda be noted, and submitted for further consideration at a future meeting of the Joint Committee.

8 CO-OPTION

Members considered the Joint Committee's Procedural Rules, which provided that it "may choose to co-opt other appropriate individuals in a non-voting capacity, to the Committee or for the duration of a particular review or Scrutiny".

Members were reminded that at the last meeting of the Joint Scrutiny Committee, Mr Phil Hough had been in attendance as a co-opted member. Mr Hough was asked if he wished to continue as the co-optee, which he confirmed. He brings

over 20 years experience as a carer of people with mental health issues and was a representative on local and national organisations.

DECIDED: That

Mr Phil Hough be appointed as a co-opted member on the Cheshire and Wirral Council's Joint Scrutiny Committee.

9 INTRODUCTION TO THE TRUST

The Joint Committee considered a report which set out a brief introduction to the services currently provided by the Cheshire and Wirral Partnership NHS Foundation Trust (CWP). The services provided included inpatient and community mental health services for children, adults and older people as well as learning disability services and drug and alcohol services across Cheshire and Wirral.

The Chairman reminded Members that the boundaries of the Partnership were not co-terminus with the Council boundaries, and that the population figures also differed between the three local authorities.

The CWP was not the only service provider for residents with mental health issues, and there were many other organisations with an impact on service provision. The directory attached to the report set out which services were currently provided in each local authority area, and Members noticed there were a few gaps where services were not provided across all three authorities.

To enable Members to have a better understanding of all the elements of the CWP's work and the role of the Scrutiny Committee a programme of training was suggested. (Training discussed as a separate item on the agenda)

DECIDED: That

the introduction to the Trust be noted and an appropriate training programme be developed.

10 AREAS FOR IMPROVEMENT IDENTIFIED IN THE QUALITY ACCOUNTS 2010/11

Members considered the Areas for Improvement Identified in the Cheshire and Wirral Partnership's Quality Accounts 2010/2011. The summary document had been requested following the last meeting of the Joint Committee, where a detailed report had been submitted but described as difficult to interpret.

The document listed 16 areas for improvement, and each area contained a summary covering detailed information for each ward. The detailed information was available should Members require it.

Members agreed to also look at those services that performed well. This would aid Members to compare them with other service providers. It was confirmed that regular benchmarking on a national and regional level occurred, and this information could also be made available to the Joint Committee.

Members discussed the areas which could be the subject of task and finish groups, minute number 12/2011 refers.

DECIDED: That

the Areas for Improvement be noted.

11 TRAINING

The Chairman referred to the membership of the Joint Committee, and of the number of new Members. Because of this, it was considered necessary to hold a number of training and awareness sessions to increase Members' knowledge of the work of the Cheshire and Wirral Partnership (CWP) before undertaking scrutiny projects.

Ros Francke, confirmed that the CWP would offer any training or support Members felt they required to undertake their role on the Joint Committee. It was understood that the geographical area covered by the Joint Committee was extensive and that it would be a steep learning curve given the number of scheduled meetings. A package of training and awareness sessions could be arranged, and Members were encouraged to reply to emails about training as soon as possible, providing information about their availability for full or half day sessions.

Members were also informed about a number of workshops currently run by the CWP on various topics, which could be opened up to the Joint Committee. These workshops were also attended by representatives of Cheshire Police, Cheshire Fire Authority and housing associations.

Once all emails had been received by Members of the Joint Committee, a training programme would be drawn up by the Chairman in conjunction with the Secretariat and Ros Francke.

DECIDED: That

a training programme be developed once Members availability was known, and circulated to the Joint Committee as soon as possible.

12 WORK PLAN

Members considered a Work Plan for the Municipal Year 2011 – 2012. The Chairman referred to emails concerning Community Treatment Orders which had been forwarded to a number of Members and suggested that the process could be a likely topic for scrutiny to look at.

The Chairman suggested that three task and finish groups be set up to look at certain subject and report back to the Joint Committee. Members discussed the topics listed in the Areas For Improvement Identified in CWP Quality Accounts 2010/2011 (minute 10/2011 refers). Following a detailed discussion, Members volunteered to start the task and finish groups, with the aim of reporting back to the Joint Committee at the October meeting initially, and make recommendations to the meeting in January 2012.

DECIDED: That

the following task and finish groups be established:-

Improving Physical Health Care for Trust Service Users: to comprise of Councillors Gill Bidston; Ann Bridson; Wendy Clements; Eveleigh Moore Dutton and Paul Edwards.

Processes Involved in Community Treatment Orders: to comprise of Councillors Andrew Dawson; Patricia Glasman; Eveleigh Moore Dutton and Charles Fifield.

Alcohol Acquired Brain Injury: to comprise of Councillors John Salter; Patricia Glasman; Louise Gittins and Keith Butcher.

13 ANY OTHER BUSINESS THE CHAIRMAN CONSIDERS URGENT

The Chairman agreed to consider one item of urgent business.

Care Home Provision for Vulnerable People

Councillor Gill Bidston referred to the recent publicity about Winterburn View in Bristol. Officers reassured Members that after the television programme was first shown, assessments of the care provision were undertaken to ensure that the poor practices highlighted were not repeated in any establishments within the Cheshire and Wirral areas. A rolling programme of assessments was undertaken.

The whistle-blowing policies of organisations was also referred to, and it was suggested that this area could also be the subject of scrutiny in the future to ensure that the policy was adopted and employees protected appropriately.

The Chairman agreed to consider the item as urgent business on the grounds that reassurance of service provision was required for all Members before the next meeting of the Joint Committee.

Chairman .....

Date .....

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Agenda Item 7

CHESHIRE EAST COUNCIL

REPORT TO: HEALTH AND WELLBEING SCRUTINY COMMITTEE

Date of Meeting: 5 October 2011
Report of: Borough Solicitor
Subject/Title: Work Programme update

1.0 Report Summary

1.1 To review items in the 2011/12 Work Programme, to consider the effectiveness of existing items listed in the schedule attached, together with any other items suggested by Committee Members.

2.0 Recommendations

2.1 That the work programme be reviewed as necessary.

3.0 Reasons for Recommendations

3.1 To progress the work programme in accordance with the Council's procedures.

4.0 Wards Affected

4.1 All

5.0 Local Ward Members

5.1 Not applicable.

6.0 Policy Implications including - Climate change
- Health

6.1 Not known at this stage.

7.0 Financial Implications for Transition Costs

7.1 None identified at the moment.

8.0 Legal Implications (Authorised by the Borough Solicitor)

8.1 None.

9.0 Risk Management

9.1 There are no identifiable risks.

10.0 Background and Options

10.1 In reviewing the work programme, Members must pay close attention to the Corporate Plan and Sustainable Communities Strategy.

10.2 The schedule attached, has been updated in line with the Committee's recommendations on 8 September 2011. Following this meeting the document will be updated as necessary.

10.3 In reviewing the work programme, Members must have regard to the general criteria which should be applied to all potential items, including Task and Finish reviews, when considering whether any Scrutiny activity is appropriate. Matters should be assessed against the following criteria:

- Does the issue fall within a corporate priority
- Is the issue of key interest to the public
- Does the matter relate to a poor or declining performing service for which there is no obvious explanation
- Is there a pattern of budgetary overspends
- Is it a matter raised by external audit management letters and or audit reports?
- Is there a high level of dissatisfaction with the service

10.4 If during the assessment process any of the following emerge, then the topic should be rejected:

- The topic is already being addressed elsewhere
- The matter is subjudice
- Scrutiny cannot add value or is unlikely to be able to conclude an investigation within the specified timescale

10.5 The Committee will also be aware that a Task/Finish Group has been set up by the Children and Families Scrutiny Committee to look at health and Cared for Children, to which Members of this Committee have been invited to submit nominations.

11.0 *Access to Information*

The background papers relating to this report can be inspected by contacting the report writer:

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Designation: Scrutiny Officer
Tel No: 01270 686464
Email: denise.french@cheshireeast.gov.uk

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HEALTH AND WELLBEING SCRUTINY COMMITTEE – WORK PROGRAMME

Issue	Description/ Comments	Suggested by	Portfolio Holder	Corporate Priority	Current position	Date for completion
North West Ambulance Service (NWAS) Performance Issues and Foundation Trust status	Committee to be kept updated on performance of NWAS in Cheshire East; NWAS and Adult Social Care to meet to discuss how the two organisations can work together to make improvements to response times including sampling of cases where alternative services to an ambulance may have been appropriate but lack of knowledge meant this was not possible.	Committee	Health and Wellbeing; Adult Services	To improve life opportunities and health for everybody in Cheshire East	Report to committee in November 2011 with current performance figures; update on Foundation Trust status; cross boundary work and the work of the Community First Responders	On-going

Diabetes/Obesity – Scrutiny Review	Task/Finish Group now submitted final report to Cabinet on 20 September 2010.	Committee	Health and Wellbeing; Children and Families	To improve life opportunities and health for everybody in Cheshire East	Keep Action Plan under review - 2012	2012
Annual Public Health Report	To receive a presentation on the Annual Public Health report and assess whether any issues should be a focus for Scrutiny	Committee	Health and Wellbeing	To improve life opportunities and health for everybody in Cheshire East	Presentation to Committee in November 2011	Annual item in November
Health and Wellbeing Board and Clinical Commissioning Groups	Development of new arrangements		Health and Wellbeing; Adult Services	To improve life opportunities and health for everybody in Cheshire East	Update on progress early in 2012	On-going
Cheshire East Community Health (CECH) – now transferred to East Cheshire Hospital Trust		PCT	Health and Wellbeing; Adult Services	To improve life opportunities and health for	Update on CECH following transfer to East Cheshire Hospital Trust;	November 2011

				everybody in Cheshire East	progress of ECHT in becoming a Foundation Trust	
Alcohol Services – commissioning and delivery in Cheshire East		The Cheshire and Wirral Councils Joint Scrutiny Committee	-	To improve life opportunities and health for everybody in Cheshire East	Await Annual Public Health report	TBA
Review of Joint Strategic Needs Assessment	The Joint Strategic Needs Assessment is a joint document produced by the PCT and the Council and is regularly updated. It will be a useful tool for informing Scrutiny of areas on which to focus work. The production of the JSNA will be a major role for the new Health and	Committee		To improve life opportunities and health for everybody in Cheshire East	Training session initially – what is the JSNA and how can it be used by Scrutiny? Training to be carried out in October or November 2011	TBA

	Wellbeing Board					
Health Inequalities including life expectancy and Marmot Report		Committee	Health and Wellbeing	To improve life opportunities and health for everybody in Cheshire East	Update to Committee in early 2012	TBA
Quality Accounts:	NHS Providers publish Quality Accounts on a yearly basis and are required to give Scrutiny the opportunity to comment.		-	To improve life opportunities and health for everybody in Cheshire East	March/April 2012	Regular annual item – March/April
Local Involvement Network (LINk) – Work Programme; Future arrangements and transition to Local Healthwatch	It is important to develop good working relationships with the LINk.	Committee	Health and Wellbeing; Adult Services	To improve life opportunities and health for everybody in Cheshire East	Update when required	On-going
The Cheshire and Wirral Councils' Joint Scrutiny Committee		Committee	Health and Wellbeing; Adult Services	To improve life opportunities and health	Share work programmes to see if there are any areas of	On-going

				for everybody in Cheshire East	common interest	
Lifestyle Concept	Pilot taken place and initiative being developed	Committee	Health and Wellbeing; Adult Services	To improve life opportunities and health for everybody in Cheshire East	Update to committee on regular basis – at least quarterly	On-going
Commissioning Strategy/Whole System Commissioning	Outline of the strategy and reassessment of building based care requirements.		Health and Wellbeing; Adult Services	To improve life opportunities and health for everybody in Cheshire East; To give the people of Cheshire East more choice and control around services and resources	Due to undergo pilot with GP Consortia	TBA

Committee meetings:
5 October 2011
10 November 2011
12 January 2012
8 March 2012

22 September 2011/djf