**SPECIAL HEALTH POLICY AND PERFORMANCE BOARD**

*At a Special meeting of the Health Policy and Performance Board held on Monday, 28 March 2011 at Council Chamber, Runcorn Town Hall*

Present: Councillors E. Cargill (Chairman), J. Lowe (Vice-Chairman), Austin, Fry, Gilligan, Horabin, M Lloyd Jones and P. Cooke

Apologies for Absence: Councillor Dennett and E. Ratcliffe

Absence declared on Council business: None

Officers present: L. Derbyshire and A. Williamson

Also in attendance: Mr S Banks – NHS Halton & St Helens, Mr T Dent – NHS Knowsley, Ms C O'Donnell – NHS North West Specialist Commissioning, Ms J Robinson, NHS Knowsley and one member of the public.

**ITEMS DEALT WITH UNDER DUTIES EXERCISABLE BY THE BOARD**

*Action*

*(Note: Councillor M Lloyd Jones declared a Personal Interest in the following item of business due to her husband being a Non Executive Director of Halton & St Helens Primary Care Trust.)*

HEA63 CHESHIRE AND MERSEYSIDE VASCULAR REVIEW

The Board considered a report from the NHS in Cheshire and Merseyside who were considering how they could improve the organisation of vascular services.

The Board was advised that vascular services were for people with disorders of the arteries and veins. These included narrowing or widening of arteries, blocked vessels and varicose veins, but not diseases of the heart and vessels in the chest. A document was attached to the report which explained what was proposed and why.

The Board was further advised that there was mounting evidence that patients who had their vascular operations in hospitals had fewer complications and lower death rates. The NHS Cheshire and Merseyside were currently engaging with the public and other stakeholders about the way they proposed to change services in Cheshire and Merseyside. It was reported that they would like to achieve a balance

between continuing to have more routine vascular services available locally and centralising major vascular operations to get the best outcomes for patients. The hospital consultants who delivered the service were fully supportive of the changes.

It was reported that a meeting had been organised for NHS stakeholders and a public meeting had taken place in February 2011. In addition, joint meetings with several Merseyside oversight and scrutiny committees would also be taking place. Once this process had been completed, it was reported that the quality standards that arterial centres would need to deliver and the approximate number of such centres in Cheshire and Merseyside would be determined. In addition, it was anticipated that the work would be completed by May 2011.

The report advised that the engagement provided a valuable opportunity to learn more about stakeholders' reactions to these changes. The main purpose of the change was to improve safety by ensuring that patients only had higher risk arterial surgery at sites able to achieve the best results. The change in the service was limited, however, for many patients using vascular services there would be no change, and for others the change would be confined to where their admission took place, with the rest of their care as it was now. For these reasons, it was highlighted that this did not represent a substantive change of service and a formal consultation process was unlikely to be required, but this was also a matter for the Board to determine.

In conclusion, it was reported that the recommendation would be announced in May 2011 and then from May to October 2011 preparation for reconfiguration would commence. Reconfiguration would begin in November 2011 in phases and an update report would be presented to a future meeting of the Board.

The following comments arose from the discussion:-

- It was noted that some areas of Halton had high levels of deprivation and travelling to hospital services further away would create financial problems. It was suggested that the service changes were being made to save money and clarity was sought on whether there would be any job losses as a result of these changes. In response, it was reported that it was not anticipated that savings would be made from the proposals as

there would be the same number of patients with the same costs incurred per patient. It was also reported that there were no plans to reduce staffing levels. Staff would, however, be working in a different way. In addition, it would be unlikely that surgical wards would close as a result of vascular patients receiving treatment elsewhere;

- The importance of introducing an abdominal screening service for men over 65 years of age was noted. It was also noted that the proposals would enable the screening programme to be introduced and rolled out across Cheshire and Merseyside;

- It was noted that later in the year discussions would take place on the arrangements and locations of the Cheshire and Merseyside specialist vascular centres. It was also noted that there were several areas of deprivation within Cheshire and Merseyside and this would need to be taken into account when decisions were made on the location of the new centres;

- It was reported that the internet survey had identified that safety was the highest priority for members of the public. In addition, local access had not been rated as high as safety as most people were prepared to travel within a 20 / 30 minute radius for a better quality service;

- It was noted that the proposals for the vascular services would give nurses in specialist vascular care an opportunity for more support, advice and to be more proactive;

- It was noted that vascular surgeons would split their time between the vascular centres and local hospitals on a rota basis. Simple procedures and follow up appointments would be done at the local hospitals and operations at the arterial centre;

- The difficulties in respect of co-location was noted;

- Clarity was sought on how paramedics would know when to take an emergency patient to the arterial unit or the nearest A&E department and whether they could be trained to reduce the risk during the transfer to the unit. In response, it was reported that it was very difficult to diagnose a ruptured aneurism and it was likely that patients would only

be diagnosed in the A&E Department and then be transferred to the arterial centre. The delay during the transfer was not considered to be a high risk as most patients could be stabilised fairly quickly before transportation. It was also reported that it was within a paramedics competency to be trained to recognise a ruptured aneurism; and

- It was noted that technology was advancing at a significant pace and it was easier to keep centres up to date if there were fewer more specialised centres.

RESOLVED: That

(1) the report and comments made be noted;

(2) Mr Banks, Mr Dent, Ms O'Donnell and Ms Robinson be thanked for their informative verbal presentation; and

(3) The Board be presented with an update on the proposals as soon as possible.

*Meeting ended at 8.50 p.m.*