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Friday 14 February 2020

Notice of Meeting

Dear Member

North Yorkshire and West Yorkshire Joint Health Overview and Scrutiny Committee (vascular services)

The **North Yorkshire and West Yorkshire Joint Health Overview and Scrutiny Committee (vascular services)** will meet in the **Council Chamber - Town Hall, Huddersfield** at **10.30 am** on **Monday 24 February 2020.**

This meeting will be live webcast. To access the webcast please go to the Council's website at the time of the meeting and follow the instructions on the page.

The items which will be discussed are described in the agenda and there are reports attached which give more details.

Julie Muscroft
Service Director – Legal, Governance and Commissioning

Kirklees Council advocates openness and transparency as part of its democratic processes. Anyone wishing to record (film or audio) the public parts of the meeting should inform the Chair/Clerk of their intentions prior to the meeting.

The North Yorkshire and West Yorkshire Joint Health Overview and Scrutiny Committee (vascular services) members are:-

Member
Councillor Stephen Baines, Calderdale Council
Councillor Jim Clark, North Yorkshire County Council
Councillor Paul Godwin, Bradford Council
Councillor Robert Hargreaves, Bradford Council
Councillor Helen Hayden, Leeds Council
Councillor Colin Hutchinson, Calderdale Council (Joint Chair)
Councillor Graham Latty, Leeds Council
Councillor Betty Rhodes, Wakefield Council
Councillor Liz Smaje, Kirklees Council (Joint Chair)
Councillor Andy Solloway, North Yorkshire County Council
Councillor Lynne Whitehouse, Wakefield Council

Agenda
Reports or Explanatory Notes Attached

Pages

1: Minutes of Previous Meeting

1 - 10

To approve the minutes of the meeting of the Committee held on 17 January 2019.

2: Interests

The Councillors will be asked to say if there are any items on the Agenda in which they have disclosable pecuniary interests, which would prevent them from participating in any discussion of the items or participating in any vote upon the items, or any other interests

3: Admission of the Public

Most debates take place in public. This only changes when there is a need to consider certain issues, for instance, commercially sensitive information or details concerning an individual. You will be told at this point whether there are any items on the Agenda which are to be discussed in private.

4: Deputations and Petitions

The committee will receive any petitions and hear any deputations from members of the public. A deputation is where up to five people can attend the meeting ad make a presentation on some particular issue of concern. A Member of the public can also hand in a petition at the meeting but that petition should relate to something on which the body has powers and responsibilities.

In accordance with Council Procedure Rule 10 (2), Members of the Public should provide at least 24 hours' notice of presenting a deputation.

To register please contact richard.dunne@kirklees.gov.uk or phone Richard Dunne on 01484 221000 (extension 74995)

5: Consultation Feedback Report on proposed changes to specialised commissioned vascular services across West Yorkshire

11 - 84

Representatives from North East & Yorkshire Region Specialised Commissioning Team, NHS England, will present the outcomes and findings from the consultation on the proposed changes to specialised commissioned vascular services across West Yorkshire including details of NHSE's recommended option for the delivery of the service.

Contact: Richard Dunne Principle Governance and Democratic Engagement Officer Tel: 01484 221000 or Mike Lodge Senior Scrutiny Support Officer Tel: 01422 393249

6: Next Steps

The Committee will take account of the information presented and consider the next steps it wishes to take.

Contact: Richard Dunne Principle Governance and Democratic Engagement Officer Tel: 01484 221000 or Mike Lodge Senior Scrutiny Support Officer Tel: 01422 393249

CALDERDALE COUNCIL

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

FRIDAY, 17TH JANUARY 2020

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

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

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

1 Apologies for Absence

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

2 Members Interests

There were none to declare.

3 Admission of the Public

All items were taken in public session.

4 Election of Chair

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

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

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

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

5 Deputations from the Public

There were no deputations made at the meeting.

6 Proposed changes to specialised commissioned vascular services across West Yorkshire

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

numbers, training, lack of staff etc.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 Next Steps

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

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

(The meeting closed at 13:00 hours).

West Yorkshire Vascular Service Consultation

Analysis Response Report

Joint Health Overview & Scrutiny Committee 24 February 2020

Introduction

NHS England has been consulting on proposals for specialised vascular services in West Yorkshire.

Following on from previous discussions and presentations with West Yorkshire JHOSC and the closure of the public consultation on 17 January 2020 this report accompanies an independent consultation feedback report (Appendix A). It sets out:

- Background to the consultation
- An overview of consultation methodology
- An overview of the consultation responses and key findings
- Concerns raised and NHS considerations in response
- Conclusion

Background to the consultation

NHS England has worked with independent Yorkshire and The Humber Clinical Senate and the West Yorkshire Association of Acute Trusts to carefully assess different options for the delivery of specialised vascular services in West Yorkshire.

The preferred option identified in this appraisal process was to have two specialised vascular centres instead of three; one at Leeds General Infirmary (LGI) due to its status as a major trauma centre and the other at Bradford Royal Infirmary (BRI) due to its co-location with renal care.

This would mean that under this reconfiguration, all specialised vascular surgery that requires an overnight stay would be transferred from Huddersfield Royal Infirmary (HRI) to Bradford Royal Infirmary (BRI), potentially affecting up to 800 patients per year.

The majority of patients would continue to access vascular day-case surgery, diagnostics, outpatient appointments and rehabilitation services in local hospitals throughout West Yorkshire.

There are three main reasons for the recommended change to services:

- Specialised vascular centres must be able to deliver a safe and sustainable service to comply with NHS England's national service specification.
- There are significant staffing pressures at both the Bradford and Huddersfield centres, and while teams are working very hard to maintain good patient outcomes and deliver the appropriate volume of activity for specialised vascular procedures, the service cannot continue in its current form.
- Calderdale and Huddersfield NHS Foundation Trust and Bradford Teaching Hospitals NHS Foundation Trust currently run a shared out-of-hours on-call rota for emergency vascular services between the two sites, which is not supported as an acceptable or long-term solution by NHS England or Yorkshire and Humber Clinical Senate.

A public consultation was launched on the 28 August 2019 asking patients and members of the public their views of this proposal.

The consultation was originally planned to run from the 28 August to the 30 November 2019, however, due to the general election, the consultation was extended and ran to 17 January 2020.

The North of England Commissioning Support Unit were commissioned to provide an independent analysis of the consultation. The full report can be found in Appendix A.

Overview of consultation methodology

A comprehensive programme of communications and engagement activity was planned to raise awareness of the consultation and maximise opportunities for members of the public and other stakeholders to share their views.

The planned approach was adapted to take account of feedback provided by members of the West Yorkshire discretionary JHOSC, with additional engagement events targeting the Huddersfield and Calderdale communities.

A wide range of communication and engagement approaches were used to ensure as many opportunities as possible for patients, staff and members of the public to be aware of the planned changes and contribute their feedback. This included:

- Online presence of the consultation on all West Yorkshire Association of Acute Trust and CCG websites (with the exception of the West Yorkshire and Harrogate Integrated Care System website), NHS England's regional website and national involvement hub.
- Six public engagement events, across Huddersfield, Bradford and Halifax, to provide an opportunity for members of the public to find out more about the proposals and ask questions of clinical leaders.
- A targeted mail out to patients with experience of using specialised vascular services in Huddersfield and Bradford hospitals, advising of the consultation and the public engagement events.
- A targeted mail out to a wide range of stakeholders including local authority partners, MPs, Healthwatch organisations and professional bodies with an interest in vascular services – issued both at the start of the consultation and as a reminder ahead of the consultation closing.
- Press release activity at the launch of the consultation, participation in media interviews to promote public engagement events and further media promotion ahead of the consultation closing, resulting in two high profile regional BBC television news features, as well as local media coverage across Halifax, Huddersfield and Bradford.
- A schedule of social media activity using NHS England's regional Twitter account to promote the consultation and public engagement events.
- Surveys being available in vascular inpatient and outpatient clinical areas for the duration of the consultation.
- Regular reminders of the consultation featuring in hospital staff briefings/bulletins, as well as in the West Yorkshire and Harrogate Integrated Care System bulletin distributed to a wider range of stakeholders.
- Targeted face-to-face engagement with renal inpatients and dialysis patients to explain the consultation and encourage feedback.

Overview of consultation response and key findings

The consultation feedback report shows 385 people or organisations participated in providing feedback during the consultation period as members of the public, past or current vascular patients, carers, NHS staff and/or stakeholders.

Analysis shows an overall balanced position, but with some significant regional variation in the feedback received.

In terms of support for the proposal of having specialised vascular services delivered at two centres across West Yorkshire, 36% of survey respondents strongly supported it, with a further 8% tending to support it.

In contrast, the report highlights an equal proportion objected to the proposal with 35% strongly opposing it and 9% tending to oppose it. Furthermore, 12% of respondents neither supported nor objected to the proposal.

Support for the proposal was found to be higher amongst:

- Those who indicated that their closest hospital was Bradford or Airedale (79% and 71% supporting the proposal, respectively), compared to those whose closest hospital was Huddersfield (14% supporting the proposal and 82% opposing it).
- Vascular patients, with 57% supporting the proposal compared to 50% of NHS staff and 14% of members of the public (a much greater proportion of members of the public objected to the proposal - 85%, compared to 47% of NHS staff and 25% of vascular patients).

Respondents were asked to prioritise a number of factors on a scale of 1 to 6, with 1 being the most important and 6 the least important. Based on the analysis of 233 individuals the feedback report shows:

- The most important factor for respondents is ‘being seen by a specialist team, available 24 hours a day, 7 days a week’.
- This was closely followed by ‘knowing the place you are being treated has good patient outcomes/success rates’ and ‘the level of expertise of people treating you is of a high standard due to the large number of patients they see each year’.
- The remaining three factors which related to being treated close to home, ease of getting to and from appointments and links with other specialist doctors (i.e. renal care) were ranked equally as the least important.

The main reasons given by respondents who supported the proposal related to the advantages of a more centralised model of care (19%). These included 24/7 care provision, improved staffing and expertise, more effective use of resources with potential cost-savings, better outcomes for patients and developing a more sustainable model of care.

Other key reasons provided in support of the proposal included BRI and LGI being accessible and/or close to where the respondent lived (14%) and both hospitals having a good reputation/providing good patient care (9%).

In contrast, two main reasons were provided in objection to the proposal - the travel implications for patients and visitors, who would normally access the specialised vascular service at HRI (19%) and the negative impact that removal of the service will have on HRI and its local community (15%).

Alternative options and matters for consideration suggested by respondents include:

- Moving the renal service back to HRI, so the specialised vascular centre could be located at HRI.
- Making HRI one of the two specialised centres instead of BRI or LGI.
- Continuing to operate from all three centres with a recruitment drive and greater staff training to help address staff shortages.
- Considering other locations for the specialised vascular centre such as Calderdale Royal Hospital, Airedale General Hospital or Dewsbury Hospital.
- Aligning the centres with population distribution.
- Creating a fair geographical distribution of services.

The alternative options set out in the full feedback report, as well as other points for concern, have been fully reviewed by NHS England, using the same criteria as the proposed options and this forms the basis for the following section of the report.

Suggestions from respondents around information in the consultation document that would benefit from further explanation are also set out in Appendix B.

Concerns raised and alternative options put forward

Concerns raised and alternative options put forward by responders and consultation event attendees	Points considered/mitigating actions	Consideration Outcome
Concerns associated with the longer-term sustainability of this proposal		
The long-term suitability of the proposed changes and whether the changes are being proposed for financial rather than clinical reasons.	The proposals are driven by the need to maintain high quality clinical services, not to save money. We will be investing in more staff to make the service more resilient and designing different models of working to provide quicker access to care.	This is about meeting the service specification and making services sustainable, it is not driven by financial considerations.
Attendees were concerned that the continual removal of specialised services from Huddersfield Royal Infirmary will cause the future of the hospital to become more uncertain, creating a knock-on effect with more specialised services being moved due to difficulties in attracting staff.	A small number of specialised services are provided by Calderdale and Huddersfield NHS Foundation Trust across the sites at Huddersfield Royal Infirmary (HRI) and Calderdale Royal Hospital (CRH) e.g. chemotherapy, children and young adult cancer services, neonatal intensive care, adult critical care, specialised ear and ophthalmology, some cardiothoracic services. HRI/CRH will continue to have a role in the delivery of specialised services.	Not expecting an impact on other specialised services provided by the Trust as a result of this vascular proposal.

Concerns raised and alternative options put forward by responders and consultation event attendees	Points considered/mitigating actions	Consideration Outcome
Travel and concerns with distances, transport and parking		
Concern about the distance and time it would take to travel including the cost. Concern was raised with regard to the elderly population (who were felt to be the most frequent users of this service and are less able to travel) and those on a low income who wouldn't be able to afford to travel.	This proposed change will only impact on inpatient vascular care for those that require the most complex interventions. Consolidating from three to two centres will mean travel implications for those populations living furthest from the centre. To reduce the need to travel to the centre, local hospitals will provide the majority of vascular care whenever possible, so avoiding the need for admission by increasing day surgery and outpatient appointments. We anticipate this will only impact on approximately 7% of overall total of vascular patients in West Yorkshire. At Calderdale and Huddersfield NHS Foundation Trust, there are approximately 2,100 inpatient episodes (a stay or attendance in hospital which is not a clinic appointment) under vascular surgery or interventional radiology in one year. This includes both planned lower risk day case surgery, such as varicose vein treatment, and the more complex emergency vascular treatments with a long stay in hospital. Therefore, this will affect approximately 800 patients per year (38%) out of the 2,100. The remaining 1,300 (62%) surgical and interventional radiology treatments would remain locally at the hospital, alongside all the existing diagnostic tests and outpatient/follow up care which will also continue at the local hospital (this equates to approximately 4,800 outpatient appointments per year). Transport services will be available for planned admissions and emergency ambulances will take all urgent and emergency cases.	Currently the two services (HRI & BRI) do not meet the appropriate service standards and there is a need to consolidate services delivered at these centres to ensure clinical quality and good outcomes for patients can be maintained.

Concerns raised and alternative options put forward by responders and consultation event attendees	Points considered/mitigating actions	Consideration Outcome
Travel and concerns with distances, transport and parking		
The impact on patients when their friends and family are unable to visit them as frequently.	The small number (7 %) of patients who would be treated at a different site under these proposals would then be discharged or transferred back to their local hospital once they are well enough.	A protocol will ensure speedy transfers of care to avoid delaying repatriation.
There are poor public transport routes as well as parking at these hospitals.	NHS England recognises the difficulties with public transport, which is why only those patients in need of essential care will be affected by this proposal. NHS England intends to raise the car parking issues with the Chief Executive Officer (CEO) of Bradford Teaching Hospitals Foundation Trust. NHS England will inform transport authorities of any planned change and ask them to consider if any additional capacity or services may be required.	NHS England will actively raise the parking issues with Bradford Teaching Hospitals Trust and advise transport authorities of any planned change.

Concerns raised and alternative options put forward by responders and consultation event attendees	Points considered/mitigating actions	Consideration Outcome
Travel and concerns with distances, transport and parking		
The increased risk to patients who would be required to travel further distances when in a life-threatening condition.	The evidence indicates that vascular centres provide the best outcomes for patients as all the skill is consolidated in one place. The formation of specialist centres improves care and sustainability, as seen with the Major Trauma reorganisation reducing mortality by 19%. For other specialised services such as cardiology or burns, patients already travel further to regional centres in an emergency situation for the best care. The two trusts have been sharing the on call/out-of-hours rota for specialised vascular services for a number of years, so patients are already travelling for emergency care to the on-call centre with no reported detrimental effect. Currently anyone from Huddersfield, taken into hospital outside normal hours with a vascular emergency, has a 50% chance of being admitted to BRI under the alternating rota arrangements.	The service specification is written by clinical experts who consider risks verses improved outcomes.
Impact on ambulance services who will be required to transport critically ill patients further distances.	The ambulance service welcomes this proposal which will eliminate the current shared out-of-hours rota and the uncertainty about which hospital is on call each week. Providing greater clarity on where to take patients rather than an alternating arrangement. NHS England has received a supporting letter from the Yorkshire Ambulance Service.	This proposal will create clarity for the out-of-hours pathway.

Concerns raised and alternative options put forward by responders and consultation event attendees	Points considered/mitigating actions	Consideration Outcome
Staffing and access to specialist care		
Continuing to operate from all three centres with a recruitment drive and greater staff training to help address staff shortages.	There are national shortages of both vascular surgeons and vascular interventional radiologists. Whilst there are national recruitment drives and training initiatives in progress to address shortages, there remains challenges in the workforce meeting a growing demand for these services, given an aging population living with co-morbidities. The West Yorkshire position is not sustainable and continuing to operate from all three centres will not support services to meet the NHS England service specification in terms of population and staffing/rota numbers.	The services at BRI & HRI do not meet the service specification in terms of staffing numbers or population numbers.
Train more surgeons and specialised doctors and nurses.	Clinical advice set out by The Vascular Society of Great Britain and Ireland and the Royal College of Radiologists indicates that there is a national shortage of interventional radiologists and a recruitment drive is unlikely to reverse the current position.	NHS England needs a timely solution for West Yorkshire to ensure compliance with the service specification. The specification provides the necessary requirements to support safe and sustainable services.

Concerns raised and alternative options put forward by responders and consultation event attendees	Points considered/mitigating actions	Consideration Outcome
Staffing and access to specialist care		
Difficulty attracting staff to HRI in the future if the future of the hospital is uncertain.	Feedback from the clinical teams at Calderdale and Huddersfield Foundation Trust (CHFT) and presented to the West Yorkshire Joint Health & Overview Scrutiny Committee (JHOSC) suggested that there would not be issues recruiting into other clinical teams e.g. emergency department and general surgery. Neither has this been an issue in other centres around the country.	Recruitment is not expected to be an issue for other clinical areas.
Will extra beds be available at Bradford?	There would be additional bed capacity at Bradford Royal Infirmary. Some modelling has taken place as part of the initial plans which included looking at extra beds, theatre and interventional radiology capacity at all three locations. Performance indicators would be put in place to monitor the Bradford vascular service e.g. cancelled procedures. Through new models of working it is expected that waiting lists may be shared to avoid lengthy delays to interventions and surgery, which will reduce waiting times and result in patients being treated sooner.	This would support the compliance against the service specification standards and provide sufficient capacity across West Yorkshire.

Concerns raised and alternative options put forward by responders and consultation event attendees	Points considered/mitigating actions	Consideration Outcome
The clinical interdependency with renal care		
Moving the renal service back to HRI, so the specialised vascular centre could be located at HRI, improve/invest in services at HRI.	The renal inpatient service has never been provided by Calderdale and Huddersfield Foundation Trust, it has been provided by Leeds Teaching Hospitals NHS Trust (LTHT) and patients are transferred to Leeds for their renal inpatient care. There are two consultants employed by CHFT but no inpatient renal beds. The onsite renal day dialysis unit at Huddersfield Royal Infirmary is provided by LTHT. There is sufficient capacity of renal inpatient beds in West Yorkshire and NHS England has no plans to increase inpatient provision.	There is sufficient capacity of renal inpatient beds in West Yorkshire and NHS England has no plans to increase inpatient provision.
A small number of attendees from across the localities questioned the inter-dependency of specialised vascular and renal services, with one individual who attended an event in Bradford requesting the exact figures on how many vascular patients require renal care and whether this figure is significant.	Renal patients can have vascular complexities which requires inpatient renal daily dialysis and inpatient vascular care. Bradford has over 300 renal dialysis patients per year, who are potentially at risk of vascular complexities. Bradford also has the fastest renal disease population growth in England, meaning that continuation and development of renal services at Bradford is an essential aspect to the care of this population.	The independent Clinical Senate recommended the need to collocate renal inpatient care a with vascular centre.

Concerns raised and alternative options put forward by responders and consultation event attendees	Points considered/mitigating actions	Consideration Outcome
Consider other locations for the specialised vascular centres		
Consider other locations for the specialised vascular centre such as Calderdale Royal Hospital, Airedale General Hospital or Dewsbury Hospital.	NHS England commissions services from centres such as large teaching hospitals that provide a wide variety of quality services, usually in central locations to attract sufficient skilled staff. Airedale General Hospital does provide a small number of specialised services; however, it is geographically isolated. Dewsbury Hospital does not provide specialised services and would not have the infrastructure to become a specialised services provider. Some specialised services are provided at Calderdale Royal Hospital, however due to the interdependency of specialised vascular services with renal inpatient care this would need a separate plan to relocate the Bradford renal unit to Halifax. Given there is currently sufficient renal inpatient capacity across West Yorkshire, additional inpatient renal beds are not required.	The service specification provides details of other services and skills that should be available at a specialised vascular centre.
Consider a 4-centre option.	NHS England are unable to build a fourth centre, increasing centres would dilute the patient population across West Yorkshire further (an 800,00 population is required to ensure a sufficient mix of patient complexity and numbers).	Would not meet the standards set out in the service specification.

Concerns raised and alternative options put forward by responders and consultation event attendees	Points considered/mitigating actions	Consideration Outcome
Consider other locations for the specialised vascular centres		
Making HRI one of the two specialised centres instead of BRI or LGI.	As explained previously, the clinical interdependency with renal services at Bradford Royal Infirmary (BRI) and the location of the major trauma centre at Leeds General Infirmary (LGI) makes these the two most viable options.	Huddersfield Royal Infirmary (HRI) does not provide inpatient renal care. There is sufficient renal bed capacity across West Yorkshire, should HRI become the second vascular centre it would require a transfer of beds and staffing from BRI to HRI.
Aligning the centres with population distribution or creating a fair geographical distribution of services.	Bradford has the fastest growing population with renal disease and the second highest deprivation levels in England. This means that continuation and development of renal services at Bradford is an essential aspect to the care of this population.	The proposal is the best fit for the population distribution, given we can only include existing centres in West Yorkshire.

Concerns raised and alternative options put forward by responders and consultation event attendees	Points considered/mitigating actions	Consideration Outcome
Consider other locations for the specialised vascular centres		
The relatively close distance between BRI and LGI, in comparison to HRI creating an unfair geographical distribution of service provision.	The larger populations are resident in the compact areas around Bradford and Leeds. Whereas Calderdale and Huddersfield have a higher ratio of residents living in rural locations, particularly Calderdale which has a population density of 5.77 per hectare which is the lowest in West Yorkshire.	The proposal is based on a number of factors including population density, ease of access and availability of other clinical services that are vital to the safe delivery of specialised vascular care.
Those who attended the Huddersfield events felt that the proposed changes would not be in the best interests of the Huddersfield population - moving away from the priority of delivering care closer to home.	The majority of care will be delivered close to home, only those patients requiring complex inpatient vascular care will be affected. Currently anyone from Huddersfield, taken into hospital outside normal hours with a vascular emergency has 50% chance of being admitted to BRI under the alternating rota arrangements.	The majority of care will be delivered at local hospitals. The shared on-call rota is not a sustainable long-term solution.

Concerns raised and alternative options put forward by responders and consultation event attendees	Points considered/mitigating actions	Consideration Outcome
Impact on other services including demand		
Increased demand at BRI and LGI and the impact this will have on patient waiting times.	The aim will be to deliver the majority of vascular care closer to home e.g. virtual wards, admission avoidance clinics, increasing day surgery unit capabilities. Therefore, reducing the number of patients needing admission and reducing the impact on the 2 centres. Through a regional approach it would offer greater flexibility to patients, with the ability to manage the waiting lists more effectively. BRI has provided assurances that they can manage the additional demand. Performance indicators would be put in place to monitor the Bradford vascular service e.g. cancelled procedures. Through new models of working it is expected that waiting lists may be shared to avoid lengthy delays to interventions and surgery, which will reduce waiting times and results, leading to patients being treated sooner.	This proposal is not expected to impact on other services. It will support delivery against the service specification.
Submissions by the Royal College of Radiologists and the British Society of Interventional Radiology emphasised the importance of ensuring that the reconfiguration does not negatively impact on the delivery of non-vascular interventional services and that a robust plan is developed to ensure the sustainability of these services during and after the reconfiguration.	Whilst this lies outside the scope of the NHS England review, WYAAT would be required to develop a regionally robust solution around Non-Vascular Interventional Radiology (NVIR), to ensure this cover is provided safely and effectively. Services would need to work towards a regional National Vascular Interventional Radiology (NVIR) cover arrangement for those very small numbers or infrequent events e.g. true out-of-hours interventions such as post-partum haemorrhage requiring IR.	This issue would be addressed in a Memorandum of Understanding and assurances from WYAAT would be sought.

Concerns raised and alternative options put forward by responders and consultation event attendees	Points considered/mitigating actions	Consideration Outcome
Uncertainty about why the changes are needed and what the impact will be		
Confusion as to why change is needed when HRI is currently providing a good service.	The service is neither sustainable nor resilient, there is a lack of compliance with service specification and clinicians are working under pressure to maintain good outcomes.	Current services are not compliant with the service specification
Continue to provide outpatient appointments at local hospitals.	Outpatient appointments will continue to be provided at local hospitals, this change only applies to patients who require complex inpatient care.	No change to current services, outpatient appointments will continue to be provided at local hospitals.

Concerns raised and alternative options put forward by responders and consultation event attendees	Points considered/mitigating actions	Consideration Outcome
Repatriation process		
Concern about continuity of care with some patients being operated on at one hospital and then receiving post-operative care/rehabilitation at another, or within their home. Based on past experiences of stroke services, there was concern amongst some who attended the consultation events that patients would face lengthy delays when waiting to be transferred. Delays with transport to repatriate patients to their local hospitals.	The aim is to have an agreed memorandum of understanding across the trusts, to replicate that within the major trauma centre model, to ensure repatriation is timely. Clinical view would determine that ONLY those patients who need rehabilitation or on ongoing medical (not surgical) issues would be repatriated. If patients need ongoing surgical care they would remain in the arterial centre. There would be a clinically agreed protocol around appropriateness of repatriation following senior surgeon review and work would take place with the non-arterial sites as part of implementation phase to determine the safest way to care for repatriated patients.	Repatriation process will be worked through.

Concerns raised and alternative options put forward by responders and consultation event attendees	Points considered/mitigating actions	Consideration Outcome
Concerns about the quality & data		
The accuracy of and absent figures in the consultation document.	NHS England confirms Bradford has over 300 renal dialysis patients who are potentially at risk from vascular complexities.	Further information has been provided where available.
Drop in quality as seen in for example stroke services.	Measures would be monitored to ensure there is no negative impact for vascular services e.g. waiting list times, outcome measures, referral to treatment times (RTT), staffing ratios.	Quality markers would be developed to mitigate this.
No evidence that mortality will decrease.	Due to consolidation and development of experience, a more skilled, resilient and sustainable workforce would be created resulting in improved outcomes, which should mirror those seen as a result of the Major Trauma Centre reconfiguration.	Evidence from the Trauma Audit and Research Network supports improved outcomes at centres.
It was suggested in the events in Huddersfield that NHS provision should be looked at as a whole across the region, as opposed to decisions being made about individual services.	This is a West Yorkshire vascular approach to ensure future sustainability and more flexibility to respond to demand. The waiting lists can be shared between the two hospitals, so patients have more choice with faster access to treatment. This is separate from the CCG acute service review.	The need to make services compliant with the service specification

Concerns raised and alternative options put forward by responders and consultation event attendees	Points considered/mitigating actions	Consideration Outcome
Other		
The perception that decisions have already been made.	No decision has yet been made. This proposal has been subject to a public consultation, with further consideration to be given to the independent feedback report, ahead of a final decision being reached by NHS England.	Final decision expected to be reached by NHS England by late March 2020.
Page 6 of the consultation booklet references the outcome of the acute services review with 'will' it is 'if'. You have stated it takes into account the move of services. The statement is wrong. You've based your plans on this, it is pre-determined.	This comment was associated with the proposed internal transfer of some services from HRI to CRH as part of the acute service review. Specialised vascular care needs to align with critical care. The vascular reconfiguration being proposed is not based on the outcome of the acute service review.	NHS England was identifying that in the future, should urgent care move from HRI to CRH, the vascular centre would also need to move to ensure rapid access to critical care beds.

Conclusion

NHS England has taken all the information presented in the consultation analysis report into account.

Analysis shows that support for the proposal of having specialised vascular services delivered at two centres across West Yorkshire varies significantly depending on where respondents live. This is likely to be because of the perceived impact for the respondent i.e. the majority of respondents from the Huddersfield population oppose the proposal, whereas the majority of respondents from the Bradford population support the proposal. Feedback specific to vascular patients shows 57% of respondents support the proposal for two centres.

The main driver for this proposed change is to commission services to meet the standards set out in the vascular service specification and address significant workforce pressures. This is to ensure that high quality care and good outcomes are delivered for patients and that this is sustainable into the future.

Under the current arrangements between Bradford and Huddersfield the out-of-hours service is shared, with each hospital providing out-of-hours care for periods of 14 days in turn. This is not supported as an acceptable or long-term solution by NHS England or Yorkshire and Humber Clinical Senate and adds unnecessary complexity to the pathway for emergency transport.

In view of this, as part of the consultation process, NHS England set out clear criteria against which it considered options for the future delivery of specialised vascular services, which included an assessment of whether the proposed option would:

- Stabilise workforce pressures;
- Meet NHS standards for vascular services;
- Cover an appropriate population size;
- Provide a clear pathway for Yorkshire Ambulance Service;
- Support continued co-location with current major regional trauma services;
- Maintain access to existing dedicated renal inpatient services;
- Impact on travel by car and public transport;
- Be deliverable in terms of ease of implementation.

Following the consultation feedback, NHS England has applied an assessment of the same criteria to the alternative options put forward by respondents and ruled out any of those suggested as being viable or suitable for taking forward.

Further comments and concerns raised by respondents as part of the consultation feedback have also been reviewed by NHS England. This work has identified a series of actions that NHS England will now take forward including:

- A requirement for West Yorkshire Association of Acute Trusts (WYAAT) to develop a regionally robust solution around Non-Vascular Interventional Radiology to ensure cover for this service is provided safely and effectively.
- A commitment to write to the CEO of Bradford Teaching Hospitals NHS Foundation Trust to share details of the parking concerns raised by respondents, as well as writing to transport authorities to notify them of any planned service change.
- A commitment to continued engagement with vascular patients and wider stakeholders throughout any transition phase, with further assurances provided on quality and performance metrics as well as patient experience of services.

The wider consideration of the feedback provided shows that many of the comments received focus on issues previously identified or anticipated by NHS England and WYAAT, with plans aimed at mitigating the disbenefits either being in place or identified for development as part of any transition phase.

Proposals ensure that only patients requiring specialised vascular surgery that requires an overnight stay would be transferred to the specialised service at Bradford Royal Infirmary. This would potentially affect up to 800 patients per year who would have previously been treated at Huddersfield Royal Infirmary.

Patients will continue to access vascular day-case surgery, diagnostics, outpatient appointments and rehabilitation services in local hospitals throughout West Yorkshire. This minimises travel for patients and their relatives and friends.

The recommendation that will be made to NHS England is the preferred option that has been consulted upon: Two specialised vascular centres instead of three, one at Leeds General Infirmary due to its status as a major trauma centre and the other at Bradford Royal Infirmary due to its co-location with renal care. Calderdale and Huddersfield Foundation Trust will continue to provide vascular day-case surgery, diagnostics, outpatient appointments and rehabilitation services.

The Joint Health Overview & Scrutiny Committee Members are asked to note the content of the feedback report and the recommendations for decision by NHS England. Members are also asked if there are any further recommendations for NHS England to consider in light of this report, ahead of a final decision being reached by NHS England regarding vascular services in West Yorkshire.

Partners in improving local health

North of England Commissioning Support

The Future of West Yorkshire Vascular Services

Public Consultation – Findings Report

January 2020

Contents

Executive Summary

Introduction

On the 28th August 2019, NHS England Specialised Commissioning launched a public consultation, working with West Yorkshire Association of Acute Trusts, to seek views of patients and members of the public on proposals for the future of specialised vascular services in West Yorkshire.

Approximately 11,000 patients in West Yorkshire receive vascular treatment each year; 4,000 specialised and 7,000 non-specialised.

In West Yorkshire, non-specialised vascular services are currently delivered at Airedale General Hospital, Pinderfields General Hospital and Harrogate District Hospital, whilst specialised vascular services, which provide complex vascular treatments, are delivered in three hospitals:

- Leeds General Infirmary (LGI)
- Bradford Royal Infirmary (BRI)
- Huddersfield Royal Infirmary (HRI).

In order to ensure that vascular services are fit for the future, surgeons and other clinical experts recognised that changes need to be made. There are three main reasons for this:

1. Specialised vascular centres must be able to deliver a safe and sustainable service to comply with NHS England's national service specification.

2. There are significant staffing pressures at both the Bradford and Huddersfield centres, and while teams are working very hard to maintain good patient outcomes and deliver the appropriate volume of activity for specialised vascular procedures, the service cannot continue in its current form.

3. Calderdale and Huddersfield NHS Foundation Trust and Bradford Teaching Hospitals NHS Foundation Trust currently run a shared out of hours on-call rota for emergency vascular services between the two sites, which is not supported as an acceptable or long-term solution by NHS England or the Yorkshire and the Humber Clinical Senate.

Taking findings from the 2016 initial engagement with vascular patients into account, NHS England worked with the Yorkshire and the Humber Clinical Senate and the West Yorkshire Association of Acute Trusts to carefully assess different options for the delivery of specialised vascular services in West Yorkshire.

The preferred option from this appraisal process was to have two specialised vascular centres instead of three; one at LGI due to its status as a major trauma centre, and the other at BRI due to its co-location with renal care.

This would mean that under this new configuration, the majority of patients who require vascular day-case surgery, diagnostics, outpatient appointments and

rehabilitation services would still be able to do this in local hospitals throughout West Yorkshire. However, all specialised vascular surgery that requires an overnight stay would be transferred from HRI to BRI, potentially affecting up to 800 patients per year.

The consultation process

A public consultation was launched on the 28th August 2019 asking patients and members of the public on their views of this proposal. The consultation was originally planned to run from the 28th August to the 30th November 2019, however due to pre-election guidance restrictions the consultation was paused and extended until the 10th January 2020. Furthermore, a misprint of the consultation email address in one of the media outlets covering the consultation in early January, resulted in the consultation deadline being further extended until 17th January 2020.

In total, 385 people or organisations participated during the consultation period as members of the public, past or current vascular patients, carers, NHS staff and/or stakeholders.

The specific methods used as part of the consultation and included in this analysis are shown in the table below.

Response method	Number of responses / participants
Consultation events	38
Paper and online survey	295
Engagement with renal dialysis patients	11
Other submissions	41
Total responses	**385**

The North of England Commissioning Support Unit were commissioned to provide an independent analysis of the consultation.

Specialised vascular services

Survey respondents were asked to prioritise a number of factors relating to specialised vascular services, this was done a scale of 1 to 6, with 1 being the most important and 6 the least. This allowed the calculation of an average rating with lower scores denoting more important factors.

‘Being seen by a specialist team, available 24 hours a day, 7 days a week’ was found to be the most important, with an average rating of 2.5. This was closely followed by ‘knowing the place you are being treated has good patient outcomes / success rates’ (average rating 2.9) and ‘the level of expertise of people treating you is of a high standard due to the large number of patients they see each year’ (average rating 3.0).

The remaining three factors which related to being treated close to home, ease of getting to and from appointments and links with other specialist doctors (i.e. renal care) were ranked equally as the least important (average rating 3.6).

These findings were similar for the small sample of renal dialysis patients who were engaged with; 'having access to a specialist team that are available 24 hours a day, 7 days a week' was ranked as the most important (average rating 1.9) and 'ease of getting to and from your hospital appointment' the least important (average rating 3.7). However for these dialysis patients, 'knowing that your vascular specialist is able to work closely with other relevant specialist doctors' was perceived to be more important than for the main survey sample (average rating 2.6 & 3.6, respectively).

The proposal for specialised vascular services

In terms of support for the proposal of having specialised vascular services delivered at two centres across West Yorkshire, 36% of survey respondents strongly supported it, with a further 8% tending to support it.

In contrast however, an equal proportion objected to the proposal with 35% strongly opposing it and 9% tending to oppose it. Furthermore, 12% neither supported nor objected to the proposal.

Support for the proposal was found to be higher among:

- Those who indicated that their closest hospital was Bradford or Airedale (79% & 71% supporting the proposal, respectively) compared to those whose closest hospital was Huddersfield (14% supporting the proposal & 82% opposing it).

- Vascular patients, with 57% supporting the proposal compared to 50% of NHS staff and 14% of members of the public (a much greater proportion of members of the public objected to the proposal - 85%, compared to 47% of NHS staff and 25% of vascular patients).

- Older age groups, with those aged 75 and over showing the greatest support for the proposal (51%) and those aged 31-45 years the least (26%).

- Those who had a disability, with 50% supporting the proposal compared to 42% of those who don't have a disability.

Among the renal dialysis patients engaged with, a slightly higher number supported the proposal (3 strongly supporting & 3 tending to support) compared to those who opposed it (3 strongly opposing and 1 tending to oppose).

Reasons to support the proposal

The main reasons given by survey respondents who supported the proposal related to the benefits of a more centralised model of care. These included 24/7 care

provision, improved staffing and expertise, more effective use of resources with potential cost-savings, better outcomes for patients and developing a more sustainable model of care.

Other key reasons given by survey respondents included BRI and LGI being accessible and/or close to where the respondent lived and both hospitals having a good reputation and/or providing good patient care.

The aforementioned points were also cited by some of the renal patients who supported the proposal. These individuals also recognised the importance of the co-location of vascular and renal services.

Objections against the proposal

Throughout the consultation methods, a variety of arguments were put forth against the proposal. This was particularly the case for the consultation events were the discussion focused upon the issues that the proposal would create. A summary of these concerns is provided below.

Grave concern was expressed about the impact that the removal of the specialised vascular service will have on HRI and its local community. Consultees felt strongly that the specialised vascular service should remain at HRI, given Huddersfield's large and increasing population, and that removal of this service will be detrimental to the health of local people that need the service. Additionally, individuals raised strong concern about the future of HRI, as it was their view that other specialised services have been moved to other hospitals.

Furthermore, consultees had strong concerns about the travel implications that they, or others who rely on the service at HRI, would have in accessing the specialised service at BRI or LGI. This included concern about the distance and time it would take to travel, the cost, the poor public transport routes as well as parking at these hospitals. Great concern was raised with regard to the elderly population who were felt to be the most frequent users of this service and are less able to travel, those on a low income who wouldn't be able to afford to travel, as well as the impact on patients when their friends and family are unable to visit them as frequently.

In relation to the above, concern was additionally raised about the increased risk to patients who would be required to travel further distances when in a life-threatening condition.

Further objections, identified to a slightly lesser extent, included;

- Increased demand at BRI and LGI and the impact this will have on patient waiting times

- Impact on ambulance services who will be required to transport critically ill patients, further distances

- The relatively close distance between BRI and LGI, in comparison to HRI creating an unfair geographical distribution of service provision

- Confusion as to why change is needed when HRI is currently providing a good service

- Concern about continuity of care with some patients being operated on at one hospital and then receiving post-operative care / rehabilitation at another, or within their home. Based on past experiences of stroke services, there was concern among some who attended the consultation events that patients would face lengthy delays when waiting to be transferred.

Across the different consultation methods, a number of issues were raised with regard to the consultation process. Concerns related to the perception that decisions have already been made, the accuracy of and absent figures in the consultation document, the long-term suitability of the proposed changes and whether the changes are being proposed for financial rather than clinical reasons.

Alternative options / points for consideration

A number of alternative options were suggested by consultees, these included:

- Moving the renal service back to HRI, so the specialised vascular centre could be located at HRI

- Making HRI one of the two specialised centres instead of BRI or LGI

- Continuing to operate from all three centres with a recruitment drive and greater staff training to help address staff shortages

- Considering other locations for the specialised vascular centre such as Calderdale Royal Hospital, Airedale General Hospital or Dewsbury Hospital

- Aligning the centres with population distribution

- Creating a fair geographical distribution of services.

Submissions by the Royal College of Radiologists and the British Society of Interventional Radiology emphasised the importance of ensuring that the reconfiguration does not negatively impact on the delivery of non-vascular interventional services and that a robust plan is developed to ensure the sustainability of these services during and after the reconfiguration.

Next steps

The findings of this report will now be discussed by representatives from NHS England and the West Yorkshire Association of Acute Trusts before any decision is made with regard to the future of West Yorkshire vascular services.

On behalf of the NHS England Specialised Commissioning Team, the North of England Commissioning Support Unit would like to thank all consultees who took the time to take part in the consultation.

1 Introduction

On the 28th August 2019, NHS England Specialised Commissioning launched a public consultation, working with West Yorkshire Association of Acute Trusts (WYAAT), to seek views of patients and members of the public on proposals for the future of specialised vascular services in West Yorkshire.

The main aim of vascular services is to reconstruct, unblock or bypass arteries to restore blood flow to organs. These are often one-off procedures, in the main, to reduce the risk of sudden death, prevent stroke, reduce the risk of amputation and improve function. Vascular services also provide support to patients with other problems such as kidney disease.

Specialised vascular services provide complex vascular treatments. Not all patients admitted to a specialised vascular service require complex surgical or an interventional radiology procedure, however due to the nature of their condition these patients need specialist assessment and care provided at a specialised vascular centre.

Approximately 11,000 patients in West Yorkshire receive vascular treatment each year (about 4,000 specialised and 7,000 non-specialised). Services are currently delivered by six hospitals of which only three are specialised vascular centres and provide the full range of complex vascular care:

- Leeds General Infirmary (LGI)
- Bradford Royal Infirmary (BRI)
- Huddersfield Royal Infirmary (HRI).

In order to ensure that vascular services are fit for the future, surgeons and other clinical experts recognised that changes need to be made. There are three main reasons for this:

1. Specialised vascular centres must be able to deliver a safe and sustainable service to comply with NHS England's national service specification.

2. There are significant staffing pressures at both the Bradford and Huddersfield centres, and while teams are working very hard to maintain good patient outcomes and deliver the appropriate volume of activity for specialised vascular procedures, the service cannot continue in its current form.

3. Calderdale and Huddersfield NHS Foundation Trust and Bradford Teaching Hospitals NHS Foundation Trust currently run a shared out of hours on-call rota for emergency vascular services between the two sites, which is not supported as an acceptable or long-term solution by NHS England or the Yorkshire and The Humber Clinical Senate.

In 2016, NHS England commissioned the School of Health and Related Research to run initial discussion groups with vascular patients across Yorkshire and the Humber. Most frequently mentioned as valued by patients regarding their experiences of vascular services were:

- Professional and friendly staff
- Rapid and convenient access to treatment
- Personal nature of the service
- The importance of integrated (joined-up) specialist teams
- Involvement in shared decision making.

Taking these engagement findings into account, NHS England worked with the Yorkshire and the Humber Clinical Senate and the WYAAT to carefully assess different options for the delivery of specialised vascular services in West Yorkshire.

The preferred option identified in this appraisal process was to have two specialised vascular centres instead of three; one at LGI due to its status as a major trauma centre, and the other at BRI due to its co-location with renal care.

This would mean that under this reconfiguration, all specialised vascular surgery that requires an overnight stay would be transferred from HRI to BRI, potentially affecting up to 800 patients per year. The majority of patients would continue to access vascular day-case surgery, diagnostics, outpatient appointments and rehabilitation services in local hospitals throughout West Yorkshire.

A public consultation was launched on the 28th August 2019 asking patients and members of the public on their views of this proposal. The consultation was originally planned to run from the 28th August to the 30th November 2019, however due to pre-election guidance restrictions the consultation was paused and extended until the 10th January 2020. Furthermore, a misprint of the consultation email address in one of the media outlets covering the consultation in early January, resulted in the consultation deadline being further extended until 17th January 2020.

The North of England Commissioning Support Unit were commissioned to provide an independent analysis of the consultation.

2 Methodology

2.1 Communications and PR activity

A comprehensive programme of communications and PR activity was planned to engage with as wide an audience as possible, to raise awareness of the consultation and allow anyone the opportunity to participate.

Due to the nature of the consultation, there was a specific focus on promoting the consultation to patients who are currently using specialised vascular services in West Yorkshire and those who have accessed these services in the past.

2.1.1 Online information

Information about the consultation was posted on the following websites, with links for individuals to download the consultation documents and provide their feedback through the online survey:

- WYAAT - Airedale District Hospital NHS Foundation Trust, Bradford Teaching Hospitals NHS Foundation Trust, Calderdale & Huddersfield NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust and Mid Yorkshire Hospitals NHS Foundation Trust
- Clinical Commissioning Groups (CCGs) – websites for Bradford, Calderdale, Kirklees, Leeds and Wakefield
- NHS England's Involvement Hub
- NHS England and NHS Improvement North East and Yorkshire
- West Yorkshire and Harrogate Integrated Care System.

Figure 1: Screenshot – promotion of the consultation on NHS England's Involvement Hub

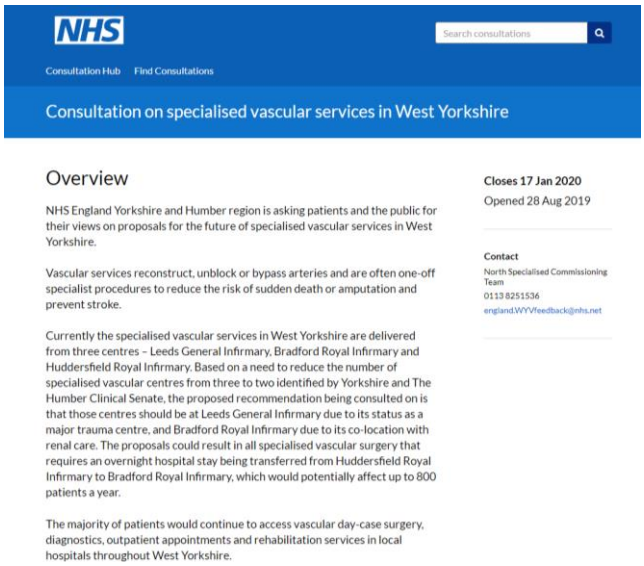
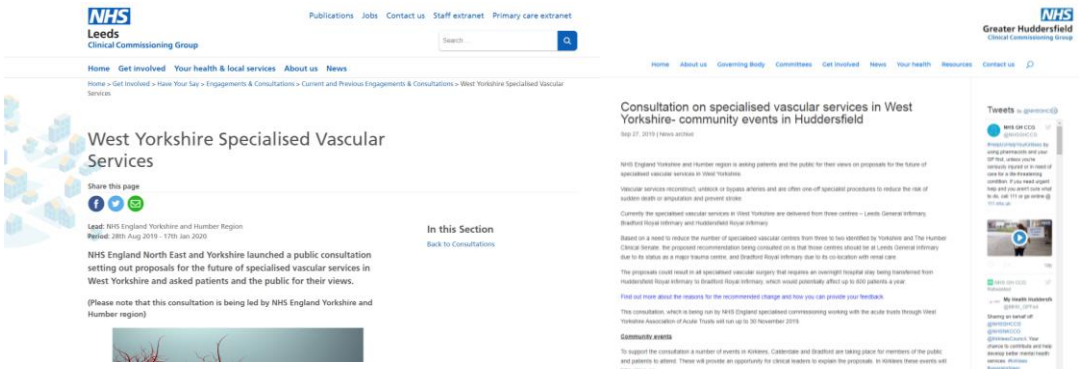


Figure 2: Screenshot – online promotion by Leeds and Greater Huddersfield CCG



2.1.2 Stakeholder engagement

Briefings were sent to a wide range of stakeholders, asking them to support the promotion of the consultation on their websites and social media channels. Information was sent to all stakeholders at the start of the consultation in August, with reminders about the deadline extensions being issued at the close of December and mid-January.

Stakeholders included:

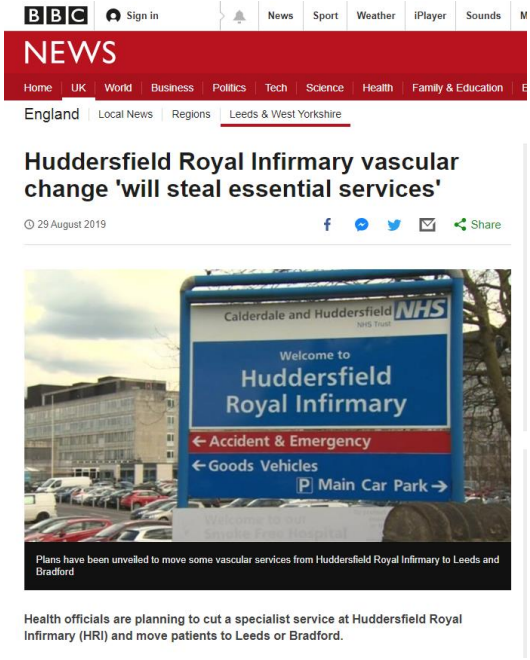
- Local Authorities – Calderdale Borough Council, City of Bradford Metropolitan District Council, Kirkless Metropolitan Council, Leeds City Council and Wakefield Metropolitan District Council
- Healthwatch; Wakefield, Leeds and Bradford – telephone briefings were additionally made with Huddersfield and Bradford leads to request further support in promotion of the consultation
- NHS England national vascular programme leads and supporting clinical reference group members
- The Royal College of Surgeons
- The Vascular Society of Great Britain and Northern Ireland
- Yorkshire Cancer Community.

2.1.3 Press release media activity

An initial press release was issued at the start of the consultation, promoting its purpose and how individuals can have their say. This achieved:

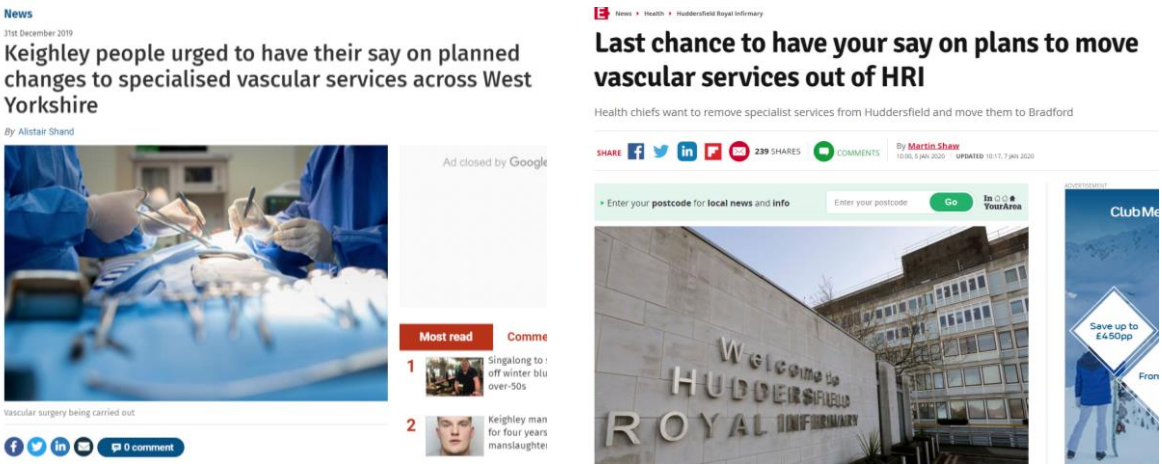
- Two news features on regional BBC North (29th August & 3rd October 2019)
- Publicity in local Huddersfield and Bradford papers; The Examiner and The Telegraph and Argus.

Figure 3: Screenshot – regional media coverage (29th August 2019)



A further press release was issued on the 30th December 2019 reminding people to have their say and providing details of the extended deadline, this achieved local coverage.

Figure 4: Screenshot – local media coverage (30th December 2019)



In addition, Hands Off HRI issued their own press release encouraging public to attend events.

Figure 5: Media coverage – The Examiner (2nd October 2019)

Updates and reminders on the consultation were also included in the monthly West Yorkshire and Harrogate Integrated Care System briefing which is sent out to a wide range of stakeholders including MPs, Councillors, Local Authority staff, CCGs, voluntary sector and provider organisations.

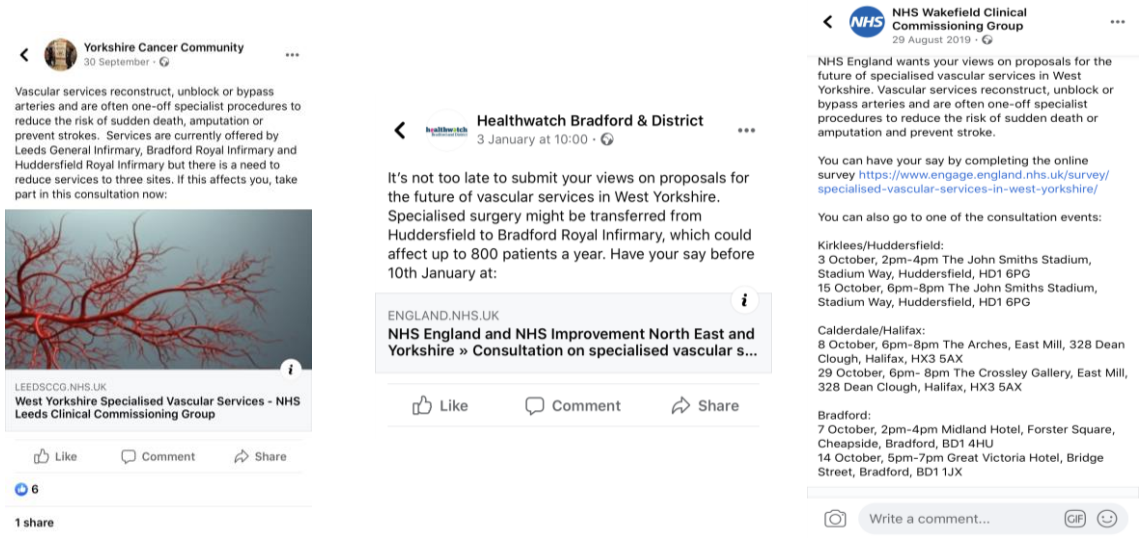
2.1.4 Social media activity

A series of scheduled tweets promoting the consultation events was undertaken by NHS England's regional Twitter @NHSNEY, which has more than 2,000 followers. The communications also directed people to the consultation survey.

Figure 6: Screenshot – promotion on Twitter (NHS England)

In addition, all the WYAAT and CCGs (with the exception of Harrogate) did their own social media promotion of the consultation as well as re-tweets / onward circulation of the social media run by NHS England. Local Authorities in Calderdale and Kirklees also ran materials, as well as Yorkshire Cancer Community and Healthwatch.

Figure 7: Screenshot – social media promotion



2.1.5 Engagement with past and current vascular patients

Letters were sent to individuals who have accessed vascular services, as an inpatient, in the last six months. The letter advised them of the consultation that was taking place and how they could provide their feedback. A total of 838 letters were sent at the start of the consultation.

In early January 2020, it was recognised that there was a great bias in those that had responded to the survey in the Huddersfield area. This was inevitably due to the heightened anxiety among these individuals about the potential negative impact of the proposal. In light of this, and to give those from other areas an equal opportunity to respond, reminder letters were sent to past service users in Bradford, with a paper copy of the survey.

Posters and hard copies of the consultation document were additionally circulated by WYAAT communication leads, with surveys available in vascular outpatient clinics for individuals to complete and return.

2.2 Engagement activity

Individuals were invited to express their views on the proposed changes through attendance at an event, by completing a survey (online or in paper) and/or through responding directly to the consultation.

2.2.1 Consultation events

Individuals were given the opportunity to hear first-hand from clinical leaders about the consultation at a series of events. The events were attended by:

- Dr. David Black - Medical Director (Commissioning) NHS England and NHS Improvement, North East and Yorkshire region
- Mr Neeraj Bhasin – Vascular Surgeon and Regional Clinical Director for Vascular Services across West Yorkshire
- Matthew Groom, Assistant Director of Specialised Commissioning, Yorkshire and Humber (for event on 7th October 2019 only).

In total, 38 individuals attended the consultation events that were held during the month of October 2019. Although six events were arranged, no individuals attended the event on the 8th October in Calderdale/Halifax and the event on the 14th October in Bradford.

Table 1: Planned consultation events and attendance

Location	Date	Time	Venue	Number of attendees
Kirklees / Huddersfield	3rd October	2pm – 4pm	The John Smith Stadium, Stadium Way, Huddersfield	22
	15th October	6pm – 8pm		11
Calderdale / Halifax	8th October	6pm – 8pm	The Arches, East Mill, 328 Dean Clough, Halifax	0
	29th October	6pm – 8pm	Crossley Gallery, Dean Clough, Halifax	2
Bradford	7th October	2pm – 4pm	The Midland Hotel, Forster Square, Cheapside, Bradford	3
	14th October	5pm – 7pm	The Great Victoria Hotel, Bridge Street, Bradford	0
			TOTAL	**38**

2.2.2 Consultation survey

There were a number of ways in which individuals could complete the consultation survey:

- Online
- Requesting a paper copy of the consultation document, by telephone or email
- Completing a paper copy of the survey which was available in vascular outpatient clinics or was sent out to past vascular service inpatients.

Note: all paper surveys could be returned to a freepost address.

During the last few weeks of the consultation, it was recognised that there was a limited number of responses from individuals from Bradford and Wakefield (both to the survey and through attendance at the consultation events), with a dominance in responses from individuals in Huddersfield. This was inevitably due to the heightened anxiety among these individuals about the potential negative impact of the proposal.

In light of this and to make sure individuals from other areas had the opportunity to have their say, Communications Officers from the NHS England Specialised Commissioning Team spent two days in the outpatient clinics at BRI and Pinderfields General Hospital, engaging with patients and encouraging them to complete the survey.

In total, 295 individuals completed the survey; 42% (124 responses) online and 58% (171 responses) in paper.

2.2.3 Engagement with renal dialysis patients

Given the interdependency with vascular and renal care, the NHS England Specialised Commissioning Team felt it was important that patients who are currently undergoing renal dialysis had the opportunity to provide their views.

To facilitate this engagement, Communications Officers from the team engaged with eleven patients currently undergoing renal dialysis or receiving renal inpatient care at BRI.

Due to the focus of this activity, the views of these individuals were kept separate from the more general sample who responded to the survey online or in paper.

2.2.4 Stakeholder and other submissions

To ensure as fair an opportunity as possible was given for all to provide a contribution to the consultation, direct communications were actively encouraged and included in the process.

In total, 41 submissions to the consultation were received, these were from members of the public (through direct submissions or social media activity) and stakeholders.

2.3 Total responses

In total, 385 people or organisations participated during the consultation period as members of the public, past or current patients, carers, NHS staff and/or stakeholders.

Table 2: The response to the consultation

Response method	Number of responses / participants
Events	38
Paper and online survey responses	295
Renal dialysis patients	11
Other submissions	41
Total responses	**385**

2.4 Analysis and reporting

The North of England Commissioning Support Unit were commissioned to provide an independent analysis of the consultation. The specific methods applied to analyse the findings were:

- **Qualitative analysis**: the findings from the consultation events are constructed on an approach where the data from the session notes is analysed and responses grouped into themes that most closely represent the views expressed. This allows us to report the findings based on an accurate reflection of the sentiments expressed. Qualitative data does not allow for commentary on the specific number of times comments are made within these themes.

- **Quantitative analysis**: the survey was structured to provide respondents with the opportunity to indicate their level of support for the proposed change to specialised vascular services as well as seeking their views as to why they do or do not support the proposed change and whether that have any other suggestions for the future of specialised vascular services. All free text responses were assigned a code, and codes grouped into categories to allow a quantitative representation of the feedback. For all questions, responses have been presented as a proportion of the number of individuals who responded to each question.

  It is important to note, that respondents to the survey (online & paper) are self-selecting, generally representing the views of those who are aware of and engaged in the topic area. This is more likely to include the views of service users, carers, staff, and others with a direct interest in the services, but cannot

be said to represent opinion from the entire population. This is very important opinion but cannot be treated as being statistically reliable.

This report presents the result of that independent analysis and is intended to inform decision makers of the views of consultees and to provide them with a summary of any additional information which they wish them to take into conscientious consideration.

3 Consultation events feedback

In total, 38 individuals attended the consultation events that were held during the month of October 2019.

The consultation events followed a format whereby a presentation on the proposed changes for specialised vascular services was provided by the Medical Director (Commissioning) for NHS England and NHS Improvement (North East and Yorkshire region) and the Regional Clinical Director (and Vascular Surgeon) for vascular services across West Yorkshire. Attendees were then given the opportunity to ask any questions they had, with the clinician and service lead able to provide responses.

The two consultation events that took place in Huddersfield saw attendance from Hands Off HRI representatives. The clinical leads from NHS England and WYAAT advised campaigners that this consultation related to regional specialised services and was a separate matter and process to the review of acute services in the local area.

A summary of the key themes that were raised during the consultation events is presented below.

3.1 Thoughts on the proposal

Concern about the closure of the specialised vascular service at HRI

Those who attended the events in Huddersfield raised significant concern about the closure of the specialised vascular service at Huddersfield. These individuals did not object to the proposal of a more centralised model of care, but instead wanted one of the centres to be located at HRI.

There was a strong feeling among those who attended the events in Huddersfield that they have been particularly 'hard done to' in recent years due to other specialised services being moved from HRI. Attendees were concerned that the continual removal of specialised services will cause the future of the hospital to become more uncertain, creating a knock on effect with more specialised services being moved due to difficulties in attracting staff.

"We can look at it in isolation, but when you look at loss of different aspects, people feel quality is diminishing. There are dis-benefits from heavy centralisation"

"You aren't going to attract staff to Huddersfield in general – no one will want to come when the future of the hospital is uncertain"

Those who attended the Huddersfield events felt that the proposed changes would not be in the best interests of the Huddersfield population - moving away from the priority of delivering care closer to home.

"I understand about centralisation, there is nowhere in this country that will be like this area (Huddersfield) 350 square miles with a population of 650,000 and we want a proper hospital. Nobody is thinking about this area"

Some individuals questioned why the renal service was moved from HRI in the first place and furthermore why it couldn't be moved back, so the specialised vascular centre could be co-located with the renal service at HRI.

"Why can't renal services come back here (Huddersfield)? The first thought is to remove a service from Huddersfield. What is going to be next? Why can't renal move here? Let Huddersfield have a crack"

"Why did you take the kidney unit from Huddersfield in the first place? The operating theatre, we have it in Huddersfield, why do we have to change it?"

"Why do you want to move to Bradford? You've said the kidney services are over there. Why can't that unit come over here? This feels like a whitewash. You have already said you would prefer the second centre is Bradford. Why not move it (renal) back?"

A small number of attendees from across the localities questioned the inter-dependency of specialised vascular and renal services, with one individual who attended an event in Bradford requesting the exact figures on how many vascular patients require renal care and whether this figure is significant.

"How many a year? Is it significant? Do you have dialysis at Huddersfield?"

It was suggested in the events in Huddersfield that NHS provision should be looked at as a whole across the region, as opposed to decisions being made about individual services.

"I feel for 20 years in the region, the NHS has not been looked at as a whole, these changes are being made piecemeal. It would be nice if the region could be looked at as a whole. Bit by bit services are being taken away. We will have a second class service"

Travel and accessibility

Individuals who attended the events in Huddersfield were concerned about the further distance that individuals from Huddersfield will be required to travel with the closure of the service at HRI, and the significant impact that this would have on patients, in terms of patient outcomes e.g. mortality rates, as well as their family and friends, who are recognised to play a pivotal role in the patient's recovery process.

"I had a friend admitted to Bradford, it was difficult for me to see him and took me an hour and a half each way. A big part of the care, is the people who come to visit you"

"The fundamental issue is that you are making patients travel. Travel to Leeds is appalling. 85-year olds are driven to hospital by other 85-year olds. You have a lot of people travelling to Bradford Royal Infirmary, it is appalling to get to"

One individual questioned whether the travel impact assessment had taken into account when 'accidents occur on the M62 corridor', with this individual noting that when this does, Huddersfield and Halifax 'grinds to a halt'.

Additionally, these attendees were concerned about the cost family and friends would incur, through increased travel, with a suggestion that these individuals should be offered some form of re-imbursement

"The seven days you are recovering, you are seeing a 90-year old husband / wife being charged to get to Bradford Royal Infirmary. Can you make the parking or travel free? It does matter for patients. It is formidably difficult"

"Things like travel and getting to and from Bradford if you live in Marsden it is costly, not easy and the M62 is a problem"

In addition, event attendees from all locations questioned whether parking at BRI has been taken into account, with some acknowledging that it can be quite difficult.

"What about parking in Bradford?"

"We have heard parking is not good, are there any ways you can consider the difficulties for people getting there?"

Impact on ambulance services

Concern was raised about the impact that the proposed changes will have on ambulance services with ambulances having to transport critically ill patients further distances. Questions were asked as to whether paramedics would require additional training for this.

"It is unfair on the ambulance services as well, making extra travelling time"

Increased demand at BRI

It was questioned at most events whether BRI would be able to cope with the increased demand, given that they already have a shortage of beds, and whether this would impact on patient waiting times.

One individual who attended the event in Bradford suggested whether moving other vascular services out of Bradford would help ease this pressure.

"They haven't got extra beds now (at Bradford) will they be available?"

"When you put pressure on Bradford Royal Infirmary, we will be anxious that capacity matches"

"What would the impact of this be on Bradford – are they not full or will people wait longer?"

Repatriation of patients and continuity of care

Attendees sought clarity on how the repatriation of patients would work and how this would impact on the continuity of care with some patients being operated on at one hospital and then receiving post-operative care / rehabilitation at another, or within their home. Based on past experiences of stroke services, there was concern that patients would face lengthy delays when waiting to be transferred.

"Would there be dedicated wards / areas for the vascular patients?"

"Transport to transfer from Bradford Royal Infirmary, patients stuck for three days"

Negative patient experiences of past mergers

A small number of attendees at the Bradford event discussed the past merging of stroke services and the negative impact that this had on the service at Bradford. One individual noted that the merger had led to a drop in quality due to issues with team working and shortages of specialist nurses. These individuals were concerned that the same issues might be faced by vascular services.

"One of the things we have done is scrutinise stroke after stroke changes at Airedale. It moved to Bradford and the quality dropped for everyone. It has taken years not months, there have been some improvements, but might this come up? This is an example of it had to happen but everyone got a poor quality service"

Consultation detail

A number of issues with the consultation were raised by individuals who attended the events, specifically these focused around the perception that decisions have already been made, the accuracy of and absent figures in the consultation documents, the long-term suitability of the proposed changes and whether the changes are being proposed for financial rather than clinical reasons.

There was a perception among some that the decision on the location of the specialised vascular centres has already been made, making the findings from the consultation irrelevant. It was suggested by some during one of the events in Huddersfield that decisions should not be made until the HRI position is resolved (i.e. the urgent and emergency care reconfiguration).

"You've said you can't wait two and a half years until this is done. All this is irrelevant. You've made the decision"

"Page 6 of the consultation booklet references the outcome of the acute services review with 'will' it is 'if'. You have stated it takes into account the move of services. The statement is wrong. You've based your plans on this, it is pre-determined"

Throughout the events, statistics used in the consultation document were called into question as well as individuals requesting specific figures to provide evidence for the proposed changes.

"Aren't the numbers are arbitrary? Not well thought through"

"You aren't coming up with a single number (in relation to how many people from trauma / renal need the vascular service). I think the answer to your question is quite small)"

"How has the magic figure of an 800,000 minimum catchment population been arrived at / measured?"

"You haven't given evidence that mortality rates will decrease"

A small number of attendees questioned the time-scale for the proposed solution to specialised vascular services and whether the changes would be appropriate given the rising population in Bradford.

"How long are these plans for given that the Bradford population is growing?"

"When I hear the word sustainability I worry as it reminds us of STPs. If this goes ahead we will fight it not stand for it"

There was concern among a few that the proposed changes are intended for financial reasons rather than clinical reasons.

"This is all about cost, about cutting and slashing services"

"As a vascular patient I am very worried, as someone who wants to move the service forward this is not about reducing the service, this is about drawing more people into the service, investing in technology, improving care"

3.2 Additional comments

A small number of additional comments were made which are summarised here:

- Individuals at the Calderdale event questioned whether a better financial package could be developed to help address the staffing shortages.

- Similarly, an individual who attended the event at Bradford emphasised the need for the NHS to tackle the issue of manpower, rather than just employing strategies to cope with it, specifically the uneven distribution across the country and why EU doctors don't want to work in England.

- It was noted that the existing public perception that care close to home is more advantageous than having to travel for specialised care needs to change in order for people to support more-centralised models of care.

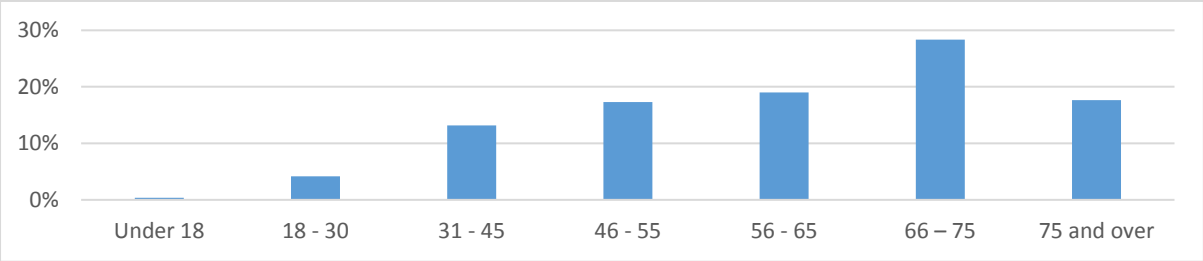
4 Survey feedback

4.1 Demographics

A total of 295 individuals completed the survey; 42% (124 respondents) responded online and 58% (171 respondents) on paper.

The most respondents were aged 66 – 75 years (28%; 82 respondents), with slightly smaller proportions aged 55 – 65 years (19%; 55 respondents), 75 and over (18%; 51 respondents) and 46 - 55 years (17%; 50 respondents).

Figure 8: Age profile of respondents



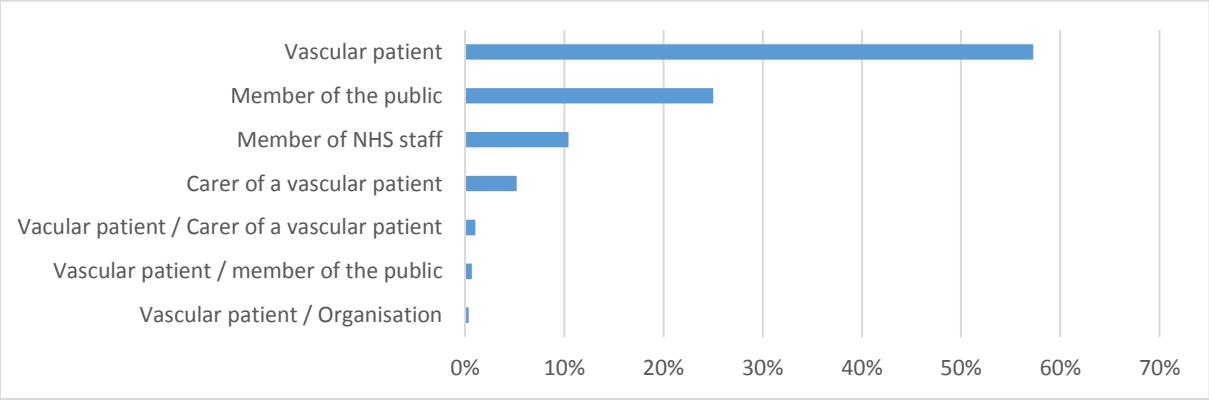
The majority of the sample were White British (83%; 235 respondents) and 35% (98 respondents) indicated that they had a disability.

Table 3: Ethnicity of respondents

Ethnic group	No.	%
White British	235	83%
Asian or Asian British	11	4%
Black / African / Caribbean / Black British	7	3%
Other	6	2%
White Irish or White Other	6	2%
Multiple / Mixed Ethnic Group	4	1%
Total	**269**	**100%**

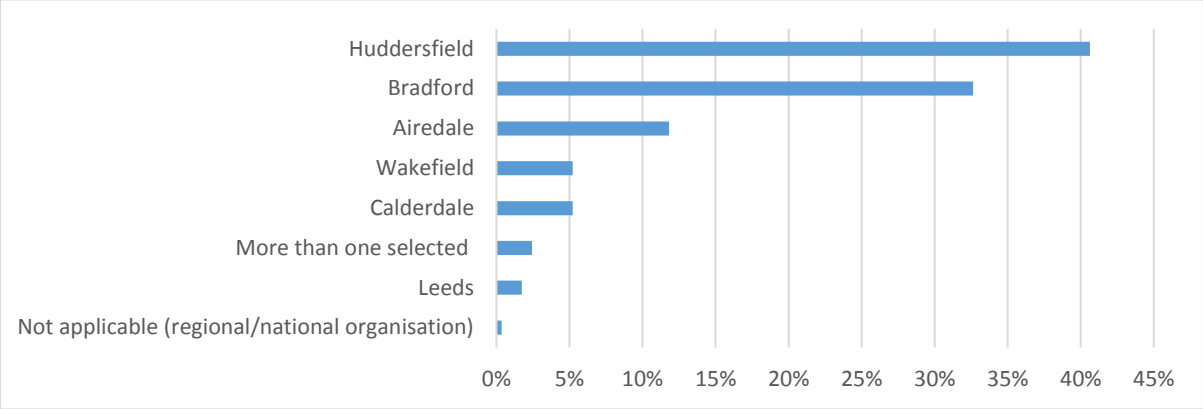
Over half responded as a vascular patient (57%; 165 respondents), with smaller proportions responding as a member of the public (25%; 72 respondents), a member of NHS staff (10%; 30 respondents) or a carer of a vascular patient (5%; 15 respondents).

Figure 9: How individuals responded to the survey



The most respondents indicated that their nearest hospital was Huddersfield (41%; 117 respondents), whilst 33% (94 respondents) stated that this was Bradford and 12% (34 respondents) Airedale. Much smaller proportions were from Wakefield and Calderdale (5%; 15 respondents for each area).

Figure 10: Respondents' nearest hospital



4.2 Specialised vascular services

Respondents were asked to prioritise a number of factors on a scale of 1 to 6 with 1 being the most important and 6 the least.

Unfortunately, some respondents who completed the survey on paper ranked the factors incorrectly, assigning the same number to two or more factors. The responses from these individuals were therefore discarded (61 respondents). However, in cases were all six factors were ranked equally (i.e. all six factors ranked as a '1'), responses from these individuals were permitted with the calculations below allowing for this.

The responses from the 233 individuals who responded to the question correctly or ranked all six factors equally are shown in Table 4. The Table shows the proportion who selected each number on the scale, for each factor, as well as the average rating score (the lower the average rating score, the more important the factor).

The most important factor for respondents is 'being seen by a specialist team, available 24 hours a day, 7 days a week', with this factor scoring an average of 2.5.

This was closely followed by 'knowing the place you are being treated has good patient outcomes / success rates' (average score 2.9) and 'the level of expertise of people treating you is of a high standard due to the large number of patients they see each year' (average score 3.0).

The remaining three factors which related to being treated close to home, ease of getting to and from appointments and links with other specialist doctors (i.e. renal care) were ranked equally as the least important.

Table 4: Factors that are most important when thinking about specialised vascular care (1 being most important and 6 least important)

Factor	1	2	3	4	5	6	Average rating
Being seen by a specialist team, available 24/7	28%	13%	20%	16%	7%	9%	**2.5**
Knowing the place you are being treated has good patient outcomes / success rates	15%	25%	21%	21%	13%	8%	**2.9**
The level of expertise of people treating you is of a high standard due to the large number of patients they see each year	15%	21%	21%	18%	16%	10%	**3.0**
Being treated in a place that is close to where you live so people can visit	17%	14%	10%	7%	16%	35%	**3.6**
Ease of getting to and from your hospital appointment	15%	17%	7%	7%	34%	20%	**3.6**
Knowing that your vascular specialist is able to work closely with other relevant specialist doctors	9%	10%	21%	30%	15%	19%	**3.6**

In response to the above question, a number of additional comments were made which were coded and categorised into the themes below. As with all questions, percentages were calculated as a proportion of those that responded to the question.

The most individuals expressed their dissatisfaction of being asked to rank the factors, with many noting that they are all equally important (36%).

"All of these answers are as important as each other. The hospital should be easy to get to for patients, family and friends, whilst providing the best service with highly qualified practitioners and good patient outcomes"

Furthermore, respondents expressed concern about the impact that the proposal would have on patients who would normally access HRI, and their visitors, who would have to travel further to access specialised vascular care (19%). This included concerns about the distance and time it would take, the cost, the poor public transport routes as well as parking issues.

"Bradford Hospital is difficult to access as is LGI, HRI is straight of the M62 and on at least three major bus routes from Huddersfield Town Centre"

"Huddersfield is my nearest hospital the other hospitals are too far for me to get there"

A slightly smaller proportion (14%) raised concern about the specialised vascular service being removed from HRI and the negative impact that this would have on the hospital and the local community.

"This is why you should not shut this unit down because Huddersfield is one of biggest towns so moving it to Leeds or Bradford will massively impact people who live in Huddersfield"

Other themes included the importance of providing good services locally (12%) and patients having past negative experiences at BRI (5%).

In contrast, a very small number (5%) supported the proposal explaining that receiving specialised care is more important than the location of that service.

Response theme	No.	%
Not fair to make people prioritise factors / all equally important	15	36%
Travel implications for patients and visitors	8	19%
Retain specialised vascular services at HRI	6	14%
Provision of good services locally is important	5	12%
Past negative experience at BRI	2	5%
Receiving specialised treatment is more important than location	2	5%
Other including; • Decision has already been made • Nursing and rehabilitation services for vascular patients' needs to be explored/invested in • Survey requires extensive knowledge of system • Capacity issues at BRI due to increased demand.	10	24%

4.3 Thoughts on the proposal

In terms of support for the proposal of having specialised vascular services delivered at two centres across West Yorkshire, 36% strongly supported it, with a further 8% tending to support it.

In contrast however, an equal proportion objected to the proposal with 35% strongly opposing it and 9% tending to oppose it. Furthermore, 12% neither supported nor opposed the proposal.

Table 5: Level of support for the proposal

Level of support	No.	%
Strongly support	104	36%
Tend to support	24	8%
Neither support nor oppose	35	12%
Tend to oppose	25	9%
Strongly oppose	102	35%
Total	290	100%

The following provides an overview of the sub-groups that were more / least likely to support the proposal.

Note: Caution must be applied to the results for some of the sub-groups due to the low number of respondents within these categories.

Overall support for the proposal was greatest among those who indicated that their closest hospital was Bradford or Airedale (79% & 71% supporting the proposal, respectively) compared to those whose closest hospital was Huddersfield (14% supporting the proposal & 82% opposing it).

Table 6: Level of support for the proposal by respondents' closest hospital

Level of support	Calderdale (n=15)*	Wakefield (n=15)*	Airedale (n=34)	Bradford (n=91)	Huddersfield (n=117)
Support	27%	7%	71%	79%	14%
Neither support nor oppose	7%	80%	12%	11%	4%
Oppose	67%	13%	18%	10%	82%

**Caution must be applied to the results from these sub-groups due to the small number of respondents*

A much greater proportion of members of the public opposed the proposal (85%), compared to NHS staff and vascular patients (47% & 25%, respectively). In contrast, support for the proposal was highest among vascular patients – 57% supporting the proposal compared to 50% of NHS staff and 14% of members of the public.

Table 7: Level of support for the proposal by respondent type

Level of support	Carer of a vascular patient (n=15)*	NHS staff (n=30)	Member of public (n=72)	Vascular patient (n=162)
Support	33%	50%	14%	57%
Neither support nor oppose	7%	3%	1%	18%
Oppose	60%	47%	85%	25%

**Caution must be applied to the results from this sub-group due to the small number of respondents*

Support for the proposal was slightly higher among older age groups, with those aged 75 and over showing the greatest support (51%) and those aged 31-45 years the least support (26%).

Table 8: Level of support for the proposal by respondents' age

Level of support	31-45 (n=38)	46-55 (n=48)	56-65 (n=55)	66-75 (n=82)	75+ (n=51)
Support	26%	40%	44%	52%	51%
Neither support nor oppose	8%	6%	9%	7%	27%
Oppose	66%	54%	47%	40%	22%

Support for the proposal was also slightly higher among those who had a disability, compared to those who didn't (50% & 42%, respectively).

Table 9: Level of support for the proposal by respondents' disability status

Level of support	Disability (n=98)	No disability (n=175)
Support	50%	42%
Neither support nor oppose	18%	9%
Oppose	32%	50%

4.4 Reasons to support / oppose

The main reasons given by respondents who supported the proposal related to the advantages of a more centralised model of care (19%). These included 24/7 care provision, improved staffing and expertise, more effective use of resources with potential cost-savings, better outcomes for patients and developing a more sustainable model of care.

"Should allow staffing levels/expertise/support to be maintained and will increase patient turnover"

"More experts in one place and easier to get appointments"

Other key reasons provided in support of the proposal included BRI and LGI being accessible and/or close to where the respondent lived (14%) and both hospitals having a good reputation / providing good patient care (9%).

"The care in Bradford is superb and I have also needed renal care"

"Nearest hospital to me, BRI also had excellent treatment care"

"Because it provides good care during operation and great aftercare"

In contrast, two main reasons were provided in objection to the proposal - the travel implications for patients, and visitors, who would normally access the specialised vascular service at HRI (19%) and the negative impact that removal of the service will have on HRI, and its local community (15%).

Respondents were concerned about the travel implications that they, or others who currently rely on the service at HRI, would have in accessing the specialised service at BRI or LGI. This included concern about the distance and time it would take to travel, the cost, the poor public transport routes as well as parking at the hospitals. Furthermore, great concern was raised with regard to the elderly population who were felt to be the most frequent users of this service and are less able to travel, and the fact that visitors may be unable to travel resulting in less frequent visits for the patient.

"I live in Huddersfield and should the need arise I want to be treated in Huddersfield not some hospital miles and miles from where I and my family and friends live"

"At 75 years old going to Bradford or Leeds is very difficult without transport, not everybody has a car and find it very hard to travel that far from Huddersfield - a totally stupid idea, just think about the old for a change"

The other key objection related to the impact that the proposal will have on HRI and the local community. These individuals felt strongly that the specialised vascular service should remain at HRI, given Huddersfield's large and increasing population, and that removing this service will be detrimental to the health of local people that need the service. Additionally, respondents raised concern about the future of HRI given that other specialised services have been moved to other hospitals.

"STOP stripping our services in Huddersfield, ALL you so called managers with good wages seem to forget, "normal" working households cannot afford all this extra travel and time involved in getting to different towns. Serve the people not your own vested interests"

"Huddersfield like many services becomes a forgotten town by NHS and other Government agencies"

"A borough as big as Kirklees and Calderdale should retain its essential services"

Other objections included increased demand at BRI and LGI and the impact this will have on patient waiting times (5%) as well as confusion as to why change is needed when HRI is currently providing a good service (4%).

Table 10: Reason for level of support

Response theme		No.	%
Reasons to support	Benefits of a more centralised model of care	48	19%
	Accessible locations / close to home	35	14%
	BRI and LGI are good hospitals	24	9%
	Vascular services should be expanded / extended	5	2%
	Strong support / proposal needed	4	2%
	Other, including: • LGI & BRI close to each other and can provide support • Link with renal care • Outpatient appointments should be provided locally • Two centres are better than one.	11	4%
Reasons to oppose	Travel implications	64	25%
	Negative impact on HRI and local community	39	15%
	Increased demand at BRI and LGI	13	5%
	Why is change needed?	9	4%
	Preference to receive local care	8	3%
	Increased patient risk (further travel)	8	3%
	BRI and LGI are close in location compared to HRI	7	3%
	Poor reputation / patient experience at LGI and BRI	5	2%
	Patients' needs must be priority	2	1%
	Three vascular centres are better than two	2	1%
	Flawed renal argument	2	1%
	Other, including: • Cost saving initiative • Impact on ambulance service • Coronary & vascular care are connected	7	3%

Reasons to neither support nor oppose	Doesn't affect individual	10	4%
	Individual unable to make decision	3	1%
	Both locations quite a distance away	3	1%

4.5 Alternative options

Respondents put forth a variety of alternative suggestions that they would like to be considered by NHS England. The most frequent of which related to the need to keep the specialised vascular service as well as other specialised services at HRI (33%). It was uncertain whether these individuals were suggesting that HRI should be one of the two specialised centres instead of BRI or LGI, or that they wanted a three-centre model of care.

"Invest in Huddersfield Royal Infirmary, we are a large town and need a well-funded and well run hospital for the town without having to travel elsewhere for treatment"

"Keep this service, and as many others as possible, available at HRI"

Furthermore, 15% felt HRI should be one of the two specialised centres instead of BRI or LGI, whilst 13% felt that the services should continue as they are delivering specialised vascular services from all three sites with a recruitment drive and better staff training to help address staff shortages.

"Staff the 3 sites and provide high quality training to staff to maintain services where they are"

"Yes leave well alone, if it's not broke don't fix it"

In addition, 13% also suggested that other locations for the specialised vascular centre should be considered such as Calderdale Royal Hospital, Airedale General Hospital, and Dewsbury Hospital.

Response theme	No.	%
Improve / invest in services at HRI	43	33%
Keep specialised vascular service at HRI and close the service at either BRI or LGI	19	15%
Keep services as they are / continue to deliver vascular surgery at all three sites	17	13%
Consider locating one of the centres at another hospital	17	13%
None – good proposal	10	8%
Provide free, efficient transport for family, friends and carers to travel to other hospitals	2	2%
Continue to provide outpatient appointments at local hospitals	2	2%
Other comment / suggestion, including: • Patients' priorities must come first • Train more surgeons and specialised doctors and nurses • Consider a 4-centre option • Greater understanding of what is available on the other side of Yorkshire • Always give patients the choice between BRI and LGI • Keep Mr Bhasin's team together under his leadership	18	14%

• Create one centre that is central in distance to all three hospitals.		

4.6 Additional comments

Respondents were asked if they required any further information or clarification about the proposal, these are presented in Table 11. In addition, respondents gave a number of other comments which were categorised in the table below as negative, positive and neutral.

Table 11: Further information or clarifications

Response theme		No.	%
Further information required	How do you expect people to travel to the proposed locations? (particularly those who don't drive and the elderly)	8	16%
	Why are specialised vascular services not being retained at HRI? Why Leeds and Bradford?	6	12%
	Why have the negative impact on patients not been considered?	2	4%
	Why have other locations not been considered to provide a better geographical spread / better access to the centres?	2	4%
	Make it clearer that rehabilitation and outpatient appointments could be provided closer to home	2	4%
	Will additional staff be employed to cater for increased demand?	2	4%
	Why have decisions already been made?	1	2%
	Consultation to be explained and disseminated to a greater audience	1	2%
	Given the amount of work that gets transferred out of BRI to Yorkshire clinics, would there be any stipulation to prevent patients being forced there due to capacity issues?	1	2%
	Clarification on the link with renal care – renal patients in Calderdale and Huddersfield come under LTHT, with intervention being undertaken at LGI or HRI and if required transferred to the mother unit	1	2%
	Travel impact assessment needs to allow for disruption caused by incidents on the motorway	1	2%
	Is there sufficient beds available at BRI?	1	2%
	What improvements will the proposal bring?	1	2%
	Will there be adequate support available in local hospitals for patients following surgery, as well as community support services?	1	2%
Other comments	Other negative comments, including: • HRI to improve / expand / retain services • Retain and invest in all three centres • Putting money before patient care	14	27%

	• More services should be located in Bradford (easier to access than Leeds) • Centre at Leeds should remain • Listen to service users and staff – people want local services • There must be sufficient beds/theatre time on the BRI site and problems with delayed image transfer must be resolved.		
	Other positive comments, including: • Aid repatriation to local hospitals and ensure a good process for this • The general public need to understand that competency is more important than having relatives and friends able to visit • Sell the service as an outstanding facility.	4	8%
	Other neutral comments	5	10%

5 Engagement with renal dialysis patients

Given the interdependency with vascular and renal care, the team at NHS England Specialised Commissioning felt it was important that patients who are currently undergoing renal dialysis had the opportunity to provide their views.

Due to the focus of this activity, the views of these individuals were kept separate from the more general sample who responded to the survey online or on paper.

To facilitate this engagement, Communications Officers from the team engaged with eleven patients currently undergoing renal dialysis at BRI.

5.1 Demographics

The demographics of the patients engaged with are as follows:

- Four were aged 31-45 years, three aged 46-55 years, one aged 56-65 years, one aged 66-75 years and two aged 75 years or more
- Eight were White British and three Asian or Asian British
- All but two had a disability.

5.2 Specialised vascular services

Table 12 shows the factors that are most important to these patients when thinking about specialised vascular services. Individuals ranked these on a scale of 1 to 6, 1 being the most important and 6 the least, therefore the lower the average rating scores the more important the factor.

It is important to note that of the eleven individuals who took part in this engagement, three rated all of these factors as equally important (this has been reflected in the rating scores below).

Having access to a specialist team that are available 24 hours a day, 7 days a week was felt to be the most important (average rating 1.9), with ease of getting to and from your hospital appointment, the least important (average rating 3.7).

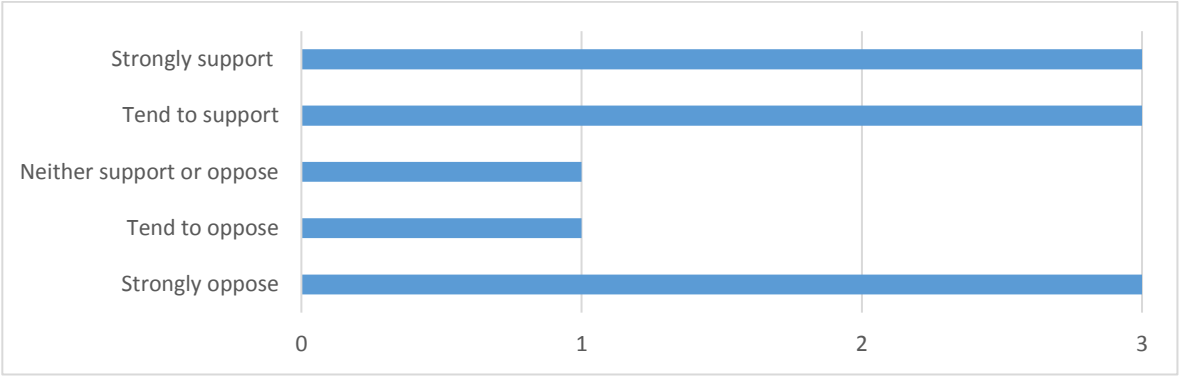
Table 12: Factors that are most important when thinking about specialised vascular services (1 being most important and 6 least important)

Factor	Average rating
Being seen by a specialist, available 24/7	**1.9**
The level of expertise of people treating you is of a high standard due to the large number of patients they see each year	**2.4**
Knowing that your vascular specialist is able to work closely with other relevant specialist doctors	**2.6**
Knowing the place you are being treated has good patient outcomes / success rates	**2.8**
Being treated in a place that is close to where you live so people can visit	**2.9**
Ease of getting to and from your hospital appointment	**3.7**

5.3 Thoughts on the proposal

Although a very small sample, a slightly higher number supported the proposal (3 strongly supporting & three tending to support) compared to those who opposed it (3 strongly opposing and 1 tending to oppose) (see Figure 11).

Figure 11: Level of support for the proposal



5.4 Reasons to support / oppose

The reasons given by these patients for their support are summarised in Table 13.

Table 13: Reasons to support / oppose the proposal

Reasons to support	Reasons to oppose

• BRI is patient's local hospital / good access
• Good standard of care provided at LGI
• Benefits of a more specialised model providing 24/7 care and helping staff to develop and maximise their expertise
• Importance of co-location of vascular and renal services;
  ○ To assist in an emergency which requires specialist input
  ○ Access to doctors who have specialist knowledge; benefits in terms of communication with patient (i.e. explanations of procedures) and ensuring needles are inserted in the right place, the first time.
	• Longer waiting times at BRI and LGI
	• Impact on HRI, and local community, from losing a specialist service
	• Huddersfield / Calderdale patients will be required to travel long distances

Specific comments made by patients included:

"With 2 rather than 3 centres the specialist staff could have the opportunity to treat a larger number of patients which would help them to develop and maximise their expertise. It is very important that vascular and renal services are available on the same site"

"Needles going in arms is not nice but someone with vascular knowledge gets it in the right place so it's not attempted several times. Sometimes / I have had experience of constant stabbing of needles and it is not nice"

"Affect the Calderdale community as patient will have to travel. Will affect Bradford patients as it will be longer waiting times"

"It is £2 in taxi to Bradford from where I live, if going to Huddersfield it will be £25. Some people cannot afford this"

The only alternative suggestion that was made by two individuals was to keep all three centres open. Furthermore, one individual commented that proposal was vague.

6 Stakeholder feedback

To ensure as fair an opportunity as possible was given for all to provide a contribution to the consultation, direct communications were actively encouraged and included in the process.

In total, 41 submissions to the consultation were received from:

- The Royal College of Radiologists
- The British Society of Interventional Radiology
- Members of the public
- Social media.

6.1 The Royal College of Radiologists

A response was received on the 24th December 2019 from the Royal College of Radiologists.

The response emphasised the importance of ensuring that the reconfiguration does not negatively impact on the delivery of non-vascular interventional (NVI) services and that a robust plan is developed to ensure the sustainability of these services during and after the reconfiguration.

'Interventional radiologists carry out a range of other services and procedures in addition to vascular interventions, and failure to keep this in mind during the reorganisation could result in significant threats to patient care. A robust plan must be developed to ensure the sustainable provision of NVI services during and after the reconfiguration'

6.2 The British Society of Interventional Radiology

A response was received from the President of the British Society of Interventional Radiology (BSIR) on the 8th January 2020.

In their response it was stated that they 'fully understand the need for reconfiguration form the vascular surgical perspective and to a degree to align with interventional radiology 24/7 cover in the hubs'.

Furthermore, the BSIR made the following comments:

- The hubs should ensure that they have a robust, sustainable and reasonable IR service; whilst we recommend 1 in 6 or above with internal cover this is really 1 in 7 to a 1 in 8 rota.

- The 24/7 IR services includes vascular (EVAR / TEVAR) as well as trauma and bleeding vascular (GIB & embolisation) as well as non-vascular (nephrostomy, PTC and drainage of sepsis). In fact, the most common IR intervention is nephrostomy insertion for urosepsis / image guided drainage of abscess. Any change to the spoke hospitals should take into account the potential consequences of leaving these centres without cover for these lifesaving non-vascular interventions. In fact, one needs to be very sensitive to the fact that taking IRs away from these spoke centres has a significant risk of destabilisation of the whole IR service and concomitant risk to patient safety.

- With any spoke and hub arrangement it is essential that there are mandatory, written, clear transfer policies and capacity to allow for the treatment for acute bleeding (GIB, obstetric, trauma etc.) and other sepsis related procedures. The transfer policy should be guaranteed e.g. as it is with trauma to MTCs (one does not need a bed) and have clear lines of clinical responsibility including the requirement to transfer to CCU or ITU.

- Centres should also be able to continue to provide training for the registrars in IR with enough work maintained at the spoke hospitals as training opportunities at the hubs will always be limited due to room space.

6.3 Members of the public

Five direct submissions were received from members of the public. These responses provide real life experience and add valuable insight to the consultation.

All individuals expressed concerns over the proposal; their submissions have been reviewed and are thematically summarised below:

- **Constant undermining of the facilities at HRI**

  These individuals felt strongly that the people of Huddersfield have been constantly disadvantaged due to past service reconfiguration and that HRI should be offering all services that serve its population. This was particularly the case for vascular services in recognition of the demographic profile of Huddersfield.

  One individual felt that there was a constant message to the people of Huddersfield that they ‘do not deserve good, accessible medical care’.

  Another noted how the NHS is the largest employer in Huddersfield and as services are moved elsewhere, there is a knock on effect on the town and its surrounding areas.

- **Location of the two specialised vascular centres**

  Individuals raised concern about the location of the proposed specialised vascular centres, in particular with BRI and LGI being relatively close to each other, in comparison to HRI. For this reason, it was suggested that having a centre at HRI would increase accessibility for all.

- **Detrimental impact on the people from Huddersfield who require this service**

  Concern was raised about the impact that traveling the further distance to Bradford or Leeds to access specialised vascular care will have on Huddersfield patients.

  This was a particularly emotional issue for one individual who had lost their mother when she was transferred by ambulance to a hospital further afield, rather than her local one.

- **Travel implications**

  It was noted that some individuals from Huddersfield would face great difficulty in accessing the specialised vascular centres in BRI or LGI, particularly those on a low income, the elderly, those who rely on public transport as well as those with disabilities. The pivotal role that visitors play in a patient's recovery was also recognised.

- Other concerns related to the cost-cutting nature of the proposal and the increased demand on other hospitals.

- Alternative suggestions were made with regard to the centres being distributed evenly across West Yorkshire or aligned with population distribution.

6.4 Social media

A total of 34 comments were made in response to the promotion of the campaign on social media, all of which were on Facebook. As posts are directly identifiable, these were anonymised within the following themes - categorised as positive, negative and other:

Positive (4 comments)

- Preference to travel further to receive the right care

  "Traveling to consultant led state of the art hospitals is the future for critical care"

- Poor perceptions and lack of confidence in HRI

  "Over the last 2 years HRI has got worse, they don't care like they used to"

Negative (18 comments)

- Continual removal of specialised services at HRI / concern about the future of HRI

  "The powers that be do not want Huddersfield to have anything it is getting out of hand Huddersfield is a large town with nothing left, ridiculous situation"

  "They did this with Dewsbury….bit by bit everything has gone and Dewsbury is little more than a nursing home. They WILL do this to Huddersfield"

- Decisions have already been made, regardless of the feedback from the public

  "Last chance to have our say?! When have they listened to what people have to say! They made their minds up a long time ago! We, the people have no say in the matter - all done and dusted!! They don't care about health anymore"

- Travel implications for visitors; distance, cost and public transport access

  "I have to travel to Leeds every day for my radiation therapy, nowhere nearer, ridiculous just trying to get there between traffic, accidents and idiots plus the expense totally unfair"

- Increased demand on other hospitals which are already full to capacity

  "Barnsley hospital get ready for influx of west Yorkshire patients, as if you're not full now"

  "Both of which are on their knees with the volume of their own patients"

- Increased risk for patients travelling further distances

  "They are putting people's lives at risks. People are too ill to be travelling these distances"

- Negative patient experience of waiting hours for hospital transfer

  "I had a heart attack in June and was taken to HRI for assessment and treatment, then waited 8 hours for an ambulance to take me to Halifax"

Other comments (12 comments)

A number of individuals made comments unrelated to the consultation, this included comments relating to NHS funding, government leadership and healthcare provision for those from other countries.

"Not council decisions but central govt. People voted Tory this is just the beginning. The people of Huddersfield getting their just deserves. Won't see Boris around the place any time soon"

One individual raised concern about the motives for the proposal and the lack of responses that could be provided at the consultation event:

"NHS England stated that they felt recruitment would be made easier by centralising the service, but admitted that a national shortage of 200 surgeons was proving an issue nationally. A number of other questions raised were not answered such as visitor parking, travel costs and what seemed a sensible request to return the renal unit to Huddersfield"

7 Summary of findings

In terms of support for the proposal of having specialised vascular services delivered at two centres across West Yorkshire; one at LGI and the other at BRI, 36% of survey respondents strongly supported it, with a further 8% tending to support it.

In contrast however, an equal proportion objected to the proposal with 35% strongly opposing it and 9% tending to oppose it. Furthermore, 12% neither supported nor objected to the proposal.

Support for the proposal was found to be higher among:

- Those who indicated that their closest hospital was Bradford or Airedale (79% & 71% supporting the proposal, respectively) compared to those whose closest hospital was Huddersfield (14% supporting the proposal & 82% opposing it).

- Vascular patients, with 57% supporting the proposal compared to 50% of NHS staff and 14% of members of the public (a much greater proportion of members of the public objected to the proposal - 85%, compared to 47% of NHS staff and 25% of vascular patients).

- Older age groups, with those aged 75 and over showing the greatest support for the proposal (51%) and those aged 31-45 years the least (26%).

- Those who had a disability, with 50% supporting the proposal compared to 42% of those who don't have a disability.

Among the renal dialysis patients engaged with, a slightly higher number supported the proposal (3 strongly supporting & 3 tending to support) compared to those who opposed it (3 strongly opposing and 1 tending to oppose).

Some survey respondents recognised that the proposal does have some positive aspects, with themes relating to:

- Benefits of a more centralised model of care i.e. 24/7 care provision, improved staffing and expertise, more effective use of resources with potential cost-savings, better outcomes for patients and developing a more sustainable model of care

- BRI and LGI being accessible for some

- BRI and LGI both having good reputations and/or providing good patient care.

The aforementioned points were also cited by some of the renal patients who supported the proposal. These individuals also recognised the importance of the co-location of vascular and renal services.

However, these were counter-balanced by strong overarching concerns emerging from all consultation methods. In summary these were:

- The negative impact that the removal of the specialised vascular service will have on HRI and its local community

- The travel implications that individuals who rely on the service at HRI, would have in accessing the specialised service at BRI or LGI. This included concern about the distance and time it would take to travel, the cost, the poor public transport routes as well as parking at these hospitals

- Impact on the health of the patient who will be required to travel a further distance when critically ill, as well as having potentially less frequent visits from family and friends during their hospital stay

- Increased demand at BRI and LGI and the impact this will have on patient waiting times

- The impact on ambulance services who will be required to transport critically ill patients, further distances

- The relatively close distance between BRI and LGI, in comparison to HRI creating an unfair geographical distribution of service provision

- Confusion as to why change is needed when HRI is currently providing a good service

- Concern about continuity of care with some patients being operated on at one hospital and then receiving post-operative care / rehabilitation at another, or within their home.

Alternative options / points for consideration

A number of alternative options were suggested by consultees, these included:

- Moving the renal service back to HRI, so the specialised vascular centre could be located at HRI

- Making HRI one of the two specialised centres instead of BRI or LGI

- Continuing to operate from all three centres with a recruitment drive and greater staff training to help address staff shortages

- Considering other locations for the specialised vascular centre such as Calderdale Royal Hospital, Airedale General Hospital or Dewsbury Hospital

- Aligning the centres with population distribution

- Creating a fair geographical distribution of services.

Submissions by the Royal College of Radiologists and the British Society of Interventional Radiology emphasised the importance of ensuring that the reconfiguration does not negatively impact on the delivery of non-vascular interventional services and that a robust plan is developed to ensure the sustainability of these services during and after the reconfiguration.

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APPENDIX B:
Points raised in consultation feedback for additional information or explanation from NHS England

Why are specialised vascular services not being retained at Huddersfield Royal Infirmary? Why Leeds and Bradford?
Currently the specialised vascular services in West Yorkshire are delivered from three centres – Leeds General Infirmary, Bradford Royal Infirmary and Huddersfield Royal Infirmary. Based on a need to reduce the number of specialised vascular centres from three to two, identified by Yorkshire and The Humber Clinical Senate, the proposed recommendation consulted on is that those centres should be at Leeds General Infirmary (due to its status as a major trauma centre) and Bradford Royal Infirmary (due to its co-location with renal care).
What improvements will the proposal bring?
Throughout the consultation process and at the public engagement events, clinical leaders have set out that the proposal will deliver the following improvements: • Easing pressure on all vascular services including emergency and routine procedures. • Improving recruitment and retention by having a single shared out-of-hours workforce. • Offering clarity on future service arrangements would make the service more sustainable. • Creating a clear pathway for emergency transfer of patients rather than a weekly rotation of the unit covering emergencies. • Enabling clinicians to develop their expertise working as part of a larger specialist vascular team. • Enabling routine vascular services, outpatients (e.g. pre and post operation appointments) to continue to be available in local hospital.

Consultation to be explained and disseminated to a greater audience

A wide range of communication and engagement approaches were used to ensure as many opportunities as possible for patients, staff and members of the public to be aware of the planned changes and contribute to providing feedback. This included:

- Online presence of the consultation on NHS England regional website, NHS England national involvement hub, all West Yorkshire Association of Acute Trust and CCG websites (with the exception of the West Yorkshire and Harrogate Integrated Care System website).
- Six public engagement events, across Huddersfield, Bradford and Halifax to provide an opportunity for members of the public to find out more about the proposals and ask questions of clinical leaders.
- A targeted mail out to patients with experience of using specialised vascular services in Huddersfield and Bradford hospitals, advising of the consultation and the public engagement events.
- A targeted mail out to a wide range of stakeholders including local authority partners, MPs, Healthwatch organisations and professional bodies with an interest in vascular services – issued both at the start of the consultation and as a reminder ahead of the consultation closing.
- Press release activity at the launch of the consultation, participation in media interviews to promote public engagement events and further media promotion ahead of the consultation closing resulting in two high profile regional BBC television news features, as well as local media coverage across Halifax, Huddersfield and Bradford.
- A schedule of social media activity using NHS England's regional Twitter account to promote the consultation and public engagement events.
- Surveys being available in vascular inpatient and outpatient clinical areas for the duration of the consultation.
- Regular reminders on the consultation featuring in hospital staff briefings/bulletins as well as in the West Yorkshire and Harrogate Integrated Care System bulletin distributed to a wider range of stakeholders
- Targeted face-to-face engagement with renal inpatients and dialysis patients to explain the consultation and encourage feedback

Why have the negative impacts on patients not been considered?
The consultation document sets out and recognises the impact for patients. At Calderdale and Huddersfield NHS Foundation Trust, there are approximately 2,100 in-patient episodes (a stay or attendance in hospital which is not a clinic appointment) under vascular surgery or interventional radiology in one year. This includes both planned lower risk day case surgery, such as varicose vein treatment, and the more complex emergency vascular treatments with a long stay in hospital. This proposal would be a change for only those patients requiring the more complex and higher risk planned and emergency vascular procedures. Therefore, this will affect approximately 800 patients per year (38%) out of the 2,100. The remaining 1,300 (62%) surgical and interventional radiology treatments would remain locally at the hospital, alongside all the existing diagnostic tests and outpatient/follow up care which will also continue at the local hospital (this equates to approximately 4,800 vascular outpatient appointments at Calderdale and Huddersfield NHS Foundation Trust per year). This change represents 7% of the total vascular activity across West Yorkshire who currently receive this level of care at Calderdale and Huddersfield Foundation Trust.
Why have decisions already been made?
No decision will be made until late March 2020. At this stage, the focus has been on reviewing the consultation feedback and responses. NHS England will then be presenting the consultation feedback report to the West Yorkshire JHOSC, for their consideration and further feedback, ahead of a final decision being reached.
Why have other locations not been considered to provide a better geographical spread/better access to the centres?
NHS England commission services from centres such as large teaching hospitals that provide a wide variety of quality services, usually in central locations to attract sufficient skilled staff. Other smaller hospital locations are less likely to have the supporting infrastructure needed for specialised services such as vascular. The consultation document does set out details of all the locations considered and takes account of population catchment areas. The larger populations are resident in the compact areas around Bradford and Leeds.

How do you expect people to travel to the proposed locations? (particularly those who don't drive and the elderly)
This change will impact on inpatient vascular care for those that require the most complex interventions. Consolidating from three to two centres will always mean travel implications for those populations living furthest from the centre. To reduce the need to travel to the centre, local hospitals will provide the majority of vascular care whenever possible, avoiding the need for admission by increasing day surgery and outpatient appointments. Transport services will be available for planned admissions and emergency ambulances will take all urgent and emergency cases.
Travel impact assessment needs to allow for disruption caused by incidents on the motorway
Travel impact assessment work to date has taken account of public transport routes, as well as travel by car. Emergency admissions are likely to be managed by the ambulance service, who will have arrangements in place to manage any disruption to services caused by incidents on the motorway.
Make it clearer that rehabilitation and outpatient appointments could be provided closer to home
Under the proposal set out on the consultation, it is the intention for outpatient appointments and rehabilitation to continue to be provided in local hospitals, close to home.
Will additional staff be employed to cater for increased demand?
There will be investment in more staff to make the service more resilient and designing different models of working to provide quicker care.
Given the amount of work that gets transferred out of Bradford Royal Infirmary to Yorkshire clinics, would there be any stipulation to prevent patients being forced there due to capacity issues? Are there sufficient beds available at Bradford Royal Infirmary?
There has been some modelling for the number of extra beds, theatre and Interventional Radiology capacity that would be required at either site. As we progress to any implementation phase work would begin to create this capacity. Performance would be monitored through cancelled procedures. New models of working will reduce the bed capacity requirement and sharing of waiting list may well be beneficial to the wait times.

Clarification on the link with renal care – renal patients in Calderdale and Huddersfield come under Leeds Teaching Hospitals NHS Trust (LTHT), with intervention being undertaken at Leeds General Infirmary or Huddersfield Royal Infirmary and if required transferred to the mother unit
Renal patients can have vascular complexities which requires inpatient renal daily dialysis and inpatient vascular care. Bradford has over 300 renal dialysis patients per year who are potentially at risk of vascular complexities. Bradford also has the fastest renal population growth and the second highest deprivation levels in England. As we progress to any implementation phase the operations team at Calderdale and Huddersfield would work with both Leeds and Bradford vascular and renal clinicians to clarify the pathway arrangements specific to this small group of patients.
Will there be adequate support available in local hospitals for patients following surgery, as well as community support services?
The aim is to have an agreed Memorandum of Understanding across the trusts to replicate that in the Major Trauma Care model to ensure repatriation is timely. The clinical view is that only those patients who need rehabilitation on ongoing medical (not surgical) issues will be repatriated. If they need ongoing surgical care they will remain in the arterial centre. There will be a clinically agreed protocol around who can and who cannot be repatriated following senior surgeon review and there is work with the non-arterial sites to determine the safest way, site, bed base and specialty to care for repatriated patients

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