Yorkshire and the Humber review of specialised vascular services: report of patient and public engagement events, July–August 2016

Prepared by the School of Health and Related Research (ScHARR), University of Sheffield for NHS England Specialised Commissioning North

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Summary

Background

Specialised vascular services commissioned by NHS England are currently provided by seven NHS Trusts in Yorkshire and the Humber region. An independent review found that none of these services meets all of the standards in NHS England's national service specification. Although clinical outcomes are currently within the accepted range, the report recommended NHS England to develop a commissioning framework that ensures the service specification is met. The report noted that consolidation of services (on fewer sites) will be required to achieve this.

NHS England is currently working with stakeholders, including patient representatives, to produce a detailed options appraisal and identify a preferred option for future configuration of specialised vascular services. NHS England commissioned ScHARR to provide independent facilitation, analysis and reporting of patient engagement events to inform development of the options appraisal.

Methods and recruitment

ScHARR organised patient discussion group meetings at five locations (Doncaster, Leeds, Sheffield, York and Huddersfield). Patients were recruited using NHS Trusts and clinicians as intermediaries. A total of 41 patients and family members attended. Two of the NHS Trusts we approached did not recruit any patients. A similar format was used for all the meetings: a brief presentation followed by discussion in small groups and concluding with a brief summary of the issues raised. Comments made by patients were grouped to identify recurring themes.

Patients' experience of services

The specific questions discussed were 'what is good about your current service?' and 'what could be improved?'

It was apparent that patients at every site valued the service provided by their local hospital Trust. **Professionalism** and **friendliness** of staff (including both surgeons and support staff) and rapid and convenient **access** to treatment were the positive factors most frequently mentioned. Patients valued what they saw as the **personal nature** of the service,

particularly those at Doncaster and Huddersfield. The importance of integrated **specialist teams** was mentioned at three meetings and the value of a **specialist ward** was identified in Sheffield. Participants at York and Huddersfield mentioned that they had been involved in **shared decision-making** about their treatment.

In terms of access, participants reported **short waiting times** from diagnosis to surgery; convenient **timing and location** of appointments; and availability of staff to answer questions over the phone.

Areas where patients reported that the service could be improved included **communication:** in particular, poor communication after discharge was mentioned at four meetings. There was also a feeling that there could be better **integration** of services to meet people's multiple health and care needs. One suggestion from the meeting in Leeds was for **case workers** to be available for patients with complex needs. Patients in York mentioned that **access** to services varies with place of residence and patients have to 'push' to obtain services that they are entitled to.

Participants had differing views about the quantity and quality of **information** they received about their condition and treatment. Some people in both Leeds and York said that they felt 'lost' after being discharged from hospital.

Physical access to treatment (e.g. travel and parking) was not widely mentioned as an issue although some patients did want to see improvements. There were contradictory views at some meetings, reflecting differences in patients' individual experiences.

Advantages and disadvantages of different service models

The discussion was limited by the complexity of the question being asked, with some participants struggling to understand the detail and implications of the different models.

The introductory presentation explained the importance of the national standards and the reasons why the current model of service is not thought to be sustainable. However, **resistance to any change** was expressed at some meetings, particularly Doncaster and Huddersfield. The **disruptive** effects of any change to services were emphasised by several participants. This view was summed up by the comment, 'If it ain't broke, don't try to fix it'. Few disadvantages of the current set-up were mentioned apart from **access difficulties**.

Turning to a model based on three centres aligned with major trauma centres, some participants accepted that this model could provide **better access** to specialist expertise and equipment. The major disadvantages of this model were perceived to be the extra time required to reach a specialist centre (for emergencies) and the extra **travelling time** and **expense imposed** on patients and family members/visitors (for elective surgery). The **capacity** of already busy large hospitals to expand to meet extra demand was also mentioned but less frequently.

Participants also perceived some advantages for a network model, including possibly **less busy clinics**, **better access** to **specialised equipment**, and patients going to the centre that **best meets their needs**. Having **rapid access** in emergencies and **convenience** for visitors were again mentioned as concerns, together with **loss of time** when staff had to travel between centres.

Participants' evaluation of events

Participants' evaluations of the engagement events were generally positive, with most reporting that the event met their expectations and they would recommend this type of event to others. The main area which could have been improved was variation in the amount of information provided to participants in advance, which reflected the different ways people were approached and recruited.

Lessons learned

We were successful in gaining involvement from a sizeable number of patients and family members over a short time period, and also at a time of peak holiday season. We achieved representation from a spread of participants who had undergone different types of surgery, and who had experience of services at different centres, both larger and smaller.

The inability to approach patients directly was a key challenge for recruitment: the ScHARR team were dependent on hospitals to recruit participants and organise events and their willingness to engage was influenced by the local context. With more time/resources, other methods could have been used to engage a wider sample of patients and their families, e.g. inviting comments online or using social media. Participants might also have been offered the opportunity of completing a confidential questionnaire in case they felt constrained in speaking in front of a group or expressing a minority view. However, the ScHARR team tried hard to encourage all participants to express their views and opportunities were available for people to approach us informally during the breaks as well as by phone or email.

Implications for NHS England

In developing the options appraisal and identifying a preferred option, NHS England will need to work with other stakeholders (e.g. clinicians and commissioners) to develop clear patient pathways.

It will be important to emphasise both to patients and the general public that most patients with vascular problems will not be affected by any changes to specialised services

The options appraisal will need to explain clearly how the network model will work (if that is the preferred option) and what this will mean for staff and patients, especially those that will perceive themselves to be at risk of losing their current services. NHS England need to acknowledge patient concerns about the possible impact of changing services and explain how these will be addressed. It will be important for the options appraisal to recognise the differences in population density and geography in different parts of the region. NHS England will also benefit from the continuing advice of independent clinical experts and the Yorkshire and the Humber Clinical Senate.

An area of particular concern for patients was the possible risk of having to travel further for treatment in the event of an emergency. The development of clear evidence-based protocols for dealing with emergencies in collaboration with the Ambulance Service could mitigate this concern.

NHS England could consider providing more detailed information on workforce to explain why sustainability of services is a concern and over what timescale. Most participants at the engagement meetings accepted that patient outcomes were similar between hospitals but it would potentially be helpful to provide data as part of the options appraisal.

The options appraisal should acknowledge the contribution of patient engagement undertaken to date and highlight any changes made as a result. It will be important to follow up on the commitment to disseminate this report via NHS organisations (including those that did not contribute) and to individuals (summary with full report available on request).

Recruitment was made more complex by a shortage of independent patient support groups for vascular patients. NHS England's processes for engaging with patients and carers could benefit from the existence of more such groups. NHS England and other stakeholders could consider encouraging the formation of support groups where these do not currently exist, although it is acknowledged that this may be easier for patients with long-term conditions.

Contents

Background

NHS England is responsible for the commissioning of specialised vascular services on a regional basis. The definition of specialised vascular services covers primarily surgery for aortic aneurysm repair, carotid artery disease (carotid endarterectomy) and amputations related to vascular complications. Other vascular services such as treatment of varicose veins and diabetic foot problems are commissioned locally by clinical commissioning groups (CCGs).

NHS England's commissioning of specialised vascular services is covered by a national service specification. The specification is informed by recommendations and published evidence from the Department of Health, the Vascular Society of Great Britain and Ireland (VSGBI), the Royal College of Radiologists (RCR), the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), and relevant guidance from the National Institute for Health and Care Excellence (NICE). Hospital Trusts providing specialised vascular services should:

- serve a minimum population size of 800,000
- ensure that surgeons carry out sufficient procedures to maintain their skill levels (for example at least 10 abdominal aortic aneurysm repairs per year)
- employ sufficient surgeons to run a sustainable on-call rota to cover emergencies
- provide an adequate infrastructure in terms of operating theatre provision, particularly the availability of 'hybrid' theatres that can cater for both minimally invasive (endovascular) and conventional surgery.

Specialised vascular services in Yorkshire and the Humber are currently provided by seven Hospital Trusts: Doncaster and Bassetlaw (Doncaster Royal Infirmary); Sheffield Teaching Hospitals (Northern General Hospital); Bradford Teaching Hospitals (Bradford Royal Infirmary); Calderdale and Huddersfield (Huddersfield Royal Infirmary); Leeds Teaching Hospitals (Leeds General Infirmary); York Teaching Hospitals; and Hull and East Yorkshire. The Leeds Teaching Hospitals Trust operates a network arrangement with Pinderfields General Hospital (mid-Yorkshire NHS Trust).

A review (Independent Regional Stocktake 2014–15) carried out for NHS England found that none of the hospitals currently meet the service specification in full. Despite this, outcomes for patients in terms of mortality and complications were within the nationally expected range and the smaller hospitals (Calderdale, Bradford, Doncaster) were found to 'demonstrate excellent outcomes'. The stocktake report recommended that NHS England should work to develop a commissioning framework that ensures the service specification is met. The report noted that consolidation of services (on fewer sites) will be required to achieve this.

A review by the Yorkshire and the Humber Clinical Senate (April 2016) considered the position of specialised vascular services in relation to wider patient pathways, including primary care and ambulance services. The Senate emphasised the importance of engaging with patients and the public at an early stage in the development of options for future provision of services. Three broad options were identified:

- continue with current arrangements
- locate specialised vascular services alongside major trauma centres (Leeds, Sheffield, Hull)
- develop a network model with three to five centres providing specialised vascular services and teams working across centres (sometimes called a 'hub and spoke' model and similar to the arrangement already operating in Leeds and mid-Yorkshire).

NHS England is currently working with stakeholders, including patient representatives, to produce a detailed options appraisal and identify a preferred option for future configuration of specialised vascular services with a view to making a decision (subject to further consultation as required) in 2016/17 and implementing any changes from 2017/18.

NHS England commissioned ScHARR to provide independent facilitation, analysis and reporting of patient engagement events to inform development of the options appraisal. Representatives of NHS England attended some of the meetings to answer questions and provide clarification but were not involved in running or reporting the meetings. NHS Trust staff gave indispensable support in recruiting patients and providing venues for the meetings but were not present during the meetings themselves. This helped ensure patients did not feel obliged in any way and were free to provide their perspectives to an independent group.

Patient engagement events

Recruitment

We approached all seven NHS Trusts currently providing specialised vascular services in Yorkshire and the Humber for help in recruiting patients and carers/family members. Using NHS Trusts as intermediaries was necessary because of the absence of patient groups we could have approached directly. The Trusts varied in their response and approach to recruitment. Two Trusts did not recruit any patients within the timescale of the project. On the other hand, two of the smaller Trusts were particularly helpful in recruiting patients (Table 1).

Attendance

We were able to organise five meetings in total between June and August 2016, with a total of 41 participants. Four meetings were held on hospital premises and one at ScHARR, University of Sheffield. Of those participants who provided details about themselves, 29 were patients and four were carers or family members (Table 2). Equal numbers of participants (15) were in their 60s and 70s, with only one aged under 60. Aneurysm repair was the most common type of surgery undergone by participants, followed by carotid surgery and then amputation. However, not all participants provided clear answers as to which type of surgery they had undergone. The patients who attended the York meeting had all undergone amputations.

Table 1: Summary of recruitment and attendance

Location	Method of recruitment	Number attending
Doncaster	Active promotion by NHS Trust	12
Leeds	Active promotion by NHS Trust plus circulation of fliers to mid-Yorkshire patients	6
Sheffield	Ad hoc promotion by one consultant	2
York	NHS Trust invited members of an amputee support group but declined to contact surgical patients	4
Huddersfield	Active promotion by NHS Trust	17
Bradford	N/A: no patients recruited	–

Hull	N/A; no patients recruited	–

Table 2: Summary of participant characteristics

Location	Number attending	Patient	Carer or family member	<60	60-70	>70	AA repair	CE	Amputation
Doncaster	12	8			6	2	3	3	1
Leeds	6	4	1		2	3	3	1	
Sheffield	2	1				1			
York	4	3	1		1	3			3
Huddersfield	17	13	2	1	6	6	11	2	

Note: some participants did not complete feedback forms or did not complete all questions.

Meeting format

A similar format was used for all the meetings: a brief presentation (Appendix 1) followed by discussion in small groups. The number of groups varied from one to three depending on the number of participants. Groups discussed patients' and family members' experience of services and their views of the advantages and disadvantages of the three options for future service models. Members of the ScHARR team facilitated the discussion, recorded the points raised in writing and summarised key themes at the end of the meeting. This allowed participants to add points or clarify any misunderstandings. Some participants also provided written feedback and this has been incorporated into the report below.

Patient experience of services

The specific questions for discussion were:

- What is good about your current service?
- What could be improved?

The comments made by participants were grouped within recurring themes. These themes are summarised in Table 3 (page 19). It was apparent that patients at every site valued the service provided by their local hospital Trust.

What is good about current services?

Professionalism and **friendliness** of staff, and rapid and convenient **access** to treatment were the positive factors most frequently mentioned. Patients valued what they saw as the **personal nature** of the service, particularly those at Doncaster and Huddersfield. Participants at Leeds mentioned the availability of '**world-class' surgeons**, while those at Huddersfield referred both to the skills of the surgeons and the role of 'phenomenal' **support staff**. The importance of integrated **specialist teams** was mentioned at Leeds, York and Huddersfield and the value of a **specialist ward** and recovery area was identified in Sheffield. Participants at York and Huddersfield mentioned that they had been involved in **shared decision-making** about their treatment.

In terms of access, patients in Leeds, Sheffield and Huddersfield mentioned **short waiting times** from diagnosis to surgery. Convenient **timing and location** of appointments were seen as valuable by participants in Doncaster and Sheffield, while those in Leeds valued the availability of staff to answer questions over the phone. Some but not all participants in Huddersfield stated that **access to the hospital** by car and public transport (including for visitors) currently works well.

Participants in the York meeting mentioned other services that had worked well for them, including physiotherapy, occupational therapy, anticoagulant services and NHS 111. The aortic aneurysm screening programme was considered to work well by participants in Huddersfield.

What could be improved?

Areas where patients reported that the service could be improved sometimes reflected **pressures on the NHS** in general, e.g. staff seeming under stress (Doncaster) and pressure on beds delaying planned surgery (Leeds). Specific areas for improvement included **communication:** patients in Doncaster reported being sometimes asked to attend for appointments that their doctors did not consider necessary and poor communication after discharge was mentioned in Leeds, York, Sheffield and Huddersfield. There was also a feeling that there could be better **integration** of services, given that many patients with vascular disease are elderly and may have multiple health and care needs. Patients in York mentioned that **access** to services varies with place of residence and patients have to 'push'

to obtain services that they are entitled to. One suggestion from the meeting in Leeds was for **case workers** to be available to co-ordinate care for patients with complex needs.

Participants had differing views about the quantity and quality of **information** they received about their condition and treatment. Some people in both Leeds and York said that they felt 'lost' after being discharged from hospital.

Physical access to treatment (e.g. travel and parking) was not widely mentioned as an issue although some patients did want to see improvements. There were contradictory views at some meetings (e.g. Doncaster), reflecting differences in patients' individual experiences.

Advantages and disadvantages of different service models

Participants were also asked what they considered to be the "pros and cons" of the different possible service models (including 'no change'). The discussion was limited by the complexity of the question being asked, with some participants struggling to understand the detail and implications of the different models. Nevertheless, some interesting comments were received (Table 4 on page 21).

Current service model

The introductory presentation explained the importance of the national standards and the reasons why the current model of service is not thought to be sustainable. However, it was important to explore people's views of the current model of service generally (as distinct from services at their local hospital). Participants generally reported that current services were **working well** and **resistance to any change** was expressed at some meetings, particularly Doncaster and Huddersfield. The **disruptive** effects of any change to services were emphasised by several participants. This view was summed up by the comment, 'If it ain't broke, don't try to fix it'. Few disadvantages of the current set-up were mentioned apart from **access difficulties**. One participant acknowledged the importance of the national standards and suggested that the current service model may be less cost-effective than alternatives (despite the fact that costs and cost-effectiveness were not covered in the presentation).

Three centres aligned with major trauma centres

Turning to a model based on three centres aligned with major trauma centres, some participants accepted that this model could provide **better access** to specialist expertise and equipment. Opinion was divided as to whether this was more important for planned or emergency surgery. The major disadvantages of this model were perceived to be the extra time required to reach a specialist centre (for emergencies) and the extra **travelling time** and **expense imposed** on patients and family members/visitors (for elective surgery). The **capacity** of already busy large hospitals to expand to meet extra demand was also mentioned but less frequently. One participant questioned whether centralisation of services on fewer sites would have implications for associated activities such as screening older men for asymptomatic aortic aneurysms.

Network model

Participants also perceived some advantages for a network model, including possibly **less busy clinics**, **better access** to **specialised equipment**, and patients going to the centre that **best meets their needs**. Having **rapid access** in emergencies and **convenience** for visitors were again mentioned as concerns, together with **loss of time** when staff had to travel between centres.

As this engagement was undertaken at a relatively early stage of the decision-making process, ScHARR and NHS England were unable to provide full details of the implications of this model for existing services, especially those in smaller hospitals. For example, it was unclear how many hospitals would be providing specialised vascular services under this model and which hospitals these would be. Participants at meetings organised by two of the smaller hospitals (Doncaster and Huddersfield) emphasised the finding of the Independent Regional Stocktake that smaller hospitals provide ‘excellent’ outcomes as a justification for maintaining specialised services at these hospitals.

Additional comments

A number of other points were made during the discussion and these are briefly summarised below:

- ‘Loudest voices get heard’, i.e. some participants perceived that the decision-making process was biased towards larger hospitals and population centres

- Worry about hospitals taking over others

- Changes may be motivated by money rather than clinical care

- One participant mentioned that some experts consider that the current national standards may be too high: and any change to the standards would have implications for the debate around service provision

- Importance of prevention/screening: AAA screening programme not as well known or publicised as it should be.

Implications for NHS England

In developing the options appraisal and identifying a preferred option, NHS England will need to work with other stakeholders (i.e. clinicians) to develop clear patient pathways. This process may provide an opportunity to show the potential benefits of the new service for patients, e.g. better after-care and follow-up.

It will be important to emphasise both to patients and the general public that most patients with vascular problems will not be affected by any changes to specialised services (because services for common vascular problems like varicose veins will be unaffected). It is also the case that wherever they have surgery, patients will remain the responsibility of their local hospital.

The options appraisal will need to explain clearly how the network model will work (if that is the preferred option) and what this will mean for staff and patients, especially those that will perceive themselves to be at risk of losing their current services. NHS England need to acknowledge patient concerns about the possible impact of changing services and explain how these will be addressed (for example, through audit and evaluation). It will be important for the options appraisal to recognise the differences in population density and geography in different parts of the region. Support for the process from local clinicians will be essential, but will not be sufficient if patient concerns are not acknowledged and addressed. In

developing the options appraisal, NHS England will also benefit from the continuing advice of independent clinical experts and the Yorkshire and the Humber clinical Senate.

An area of particular concern for patients was the possible risk of patients having to travel further for treatment in the event of an emergency. The development of clear evidence-based protocols for dealing with emergencies in collaboration with the Ambulance Service could mitigate this concern.

Comments at several meetings suggest that patients value the national aortic aneurysm screening programme and any implications for this service need to be considered.

NHS England could consider providing more detailed information on workforce to explain why sustainability of services is a concern and over what timescale, i.e. why action is needed now. Most participants at the engagement meetings accepted that patient outcomes were similar between hospitals but it would potentially be helpful to provide data (or links to appropriate sources) as part of the options appraisal.

Many participants accepted the principle of travelling for planned surgery, albeit reluctantly in some cases. Hospital trusts could be encouraged to take practical steps to alleviate patient concerns where possible, e.g. consider developing volunteer transport schemes

The options appraisal should acknowledge the contribution of patient engagement undertaken to date and highlight any changes made as a result. It will be important to follow up on the commitment to disseminate this report via NHS organisations (including those that did not contribute) and to individuals (summary with full report available on request).

As discussed below under ‘Lessons learned’, recruitment of patients was made more complex by a shortage of independent patient support groups for vascular patients. Only the Leeds Teaching Hospitals NHS Trust had such a group and this was at an early stage of development. As a result, recruitment was dependent on the support and assistance of individual NHS Trusts. NHS England’s processes for engaging with patients and carers could benefit from the existence of more such groups as they could enable easier access to a wide variety of patients. NHS England and other stakeholders could consider encouraging the formation of support groups where these do not currently exist, although it is acknowledged that this may be easier for patients with long-term conditions than those undergoing a single elective procedure such as aneurysm repair.

Participants' evaluation of events

Participants' evaluations of the engagement events were generally positive (Table 5). The main area which could have been improved was variation in the amount of information provided to participants in advance, which reflected the different ways people were approached and recruited.

Table 5: Summary of participants' evaluations of the meetings

Location	Evaluations received	Number who would recommend event	Number stating event met expectations	Number with positive text comments	Number with suggestions for improvement/ negative comments
Doncaster	8	8	8	4	1
Leeds	6	6	4 (2 blank)	1	2
Sheffield	1	1	1	0	0
York	4	4	4	4	1
Huddersfield	15	14 (1 blank)	13 (2 blank)	7	2

Examples of positive comments:

Very enjoyable, learnt a lot (Doncaster)

Enjoyed it very much (Leeds)

Very well organised and chaired (York)

The day was well-focused and individuals were given ample opportunity to present their points of view (Huddersfield)

Examples of suggestions for improvement:

If the aims… had been made clearer before the event, might have been able to think more about the issues (Doncaster)

Someone from NHS England to attend (Leeds)

Vascular services cover more than the three conditions outlined (York)

Not lead strong enough. Statistics should have been made available (Huddersfield)

Participants who were interested in receiving feedback on the outcome of this review were asked to provide their contact details and will be provided with a summary of the report. The findings will also be shared with the relevant NHS Trusts.

Lessons learned

We were successful in gaining involvement from a sizeable number of patients and family members over a short time period, and also at a time of peak holiday season. We achieved representation from a spread of participants who had undergone different types of surgery, and who had experience of services at different centres, both larger and smaller.

The inability to approach patients directly was a key challenge for recruitment: the ScHARR team were dependent on hospitals to recruit participants and organise events. For many patients, their contact with the service was for a short time scale with only a brief period of follow up.

Willingness to engage also depends on local context. Doncaster patients were clearly concerned about the possibility of having to travel to Sheffield (for example) for surgery. Huddersfield had recently been involved in patient/public consultation about reconfiguration of accident and emergency services so the topic was a live and sensitive one. These centres organised by far the best attended meetings.

A major barrier to effective engagement when there is limited time and resource available for facilitating patient consultation is the lack of existing patient groups for most types of vascular surgery patients. Where such groups already exist they can be invaluable in providing appropriate access to patients, families and informal carers although they may not include more socially isolated, less engaged or more frail patients. Participants at the York meeting were members of an amputee support group and despite the small numbers they provided valuable insight into a wide range of issues

With more time/resources, other methods, in addition to face to face meetings organised by Trusts, could have been used to engage a wider sample of patients and their families, e.g. inviting comments online or using social media. This would require the time for both developing web based materials, such as on line survey instruments tailored for specific patient groups, and (to a lesser extent) for uploading and hosting web materials. Using an online or survey method may however, have presented similar challenges in terms of patient recruitment. The limited response rate for surveys is well documented. This method of data collection would also have not been able to provide the rich discussion and interaction between participants that we gained. Participants might also have been offered the opportunity of completing a confidential questionnaire in case they felt constrained in speaking in front of a group or expressing a minority view. However, the ScHARR team tried hard to encourage all participants to express their views and opportunities were available for people to approach us informally during the breaks as well as by phone or email if they had wished to do so.

Table 3: Summary of recurring themes regarding services received at the different centres

	What is good about your current service?	What could be improved?
Doncaster	Local service Professional, friendly staff Good access Information Timing of appointments Personal relationship with service Feedback and follow-up	Accuracy of communication Sometimes given unnecessary appointments Space/staff capacity Staff sometimes stressed/rushed Waiting times Access
Leeds	Response time to see specialist and for surgery Provision of information and reassurance Contact by phone World-class surgeons Dedicated team	Issues that delay surgery, e.g. outdated scans, no beds available Communication after discharge Risks explained and consent obtained earlier Liaison with GPs Case worker to co-ordinate care
Sheffield	Excellent treatment Availability of scans and equipment Specialist ward Availability of recovery area One follow-up appointment then discharged First appointment at local hospital Rapid diagnosis and treatment (2–3 weeks from referral to	Information about what was going to happen

	discharge)	
York	In-hospital care by integrated team Physio/OT services Nursing support after amputation Shared decision-making Coagulant services 111 service	Support from social care Patients felt 'lost' after discharge, e.g. notes were not transferred Services not integrated and access depends on where you live Maintenance of equipment Need to push to get a response to needs
Huddersfield	Convenient location Efficient and friendly staff Personalised approach Availability of information and reassurance Clear patient care pathway Excellent aftercare Short time from diagnosis to surgery Skills of surgeon Effective team and 'phenomenal' support staff Accessibility by car and public transport (including for visitors) Involvement of family members and shared decision-making Screening programme (for aortic aneurysms) Continuity of care	Care in vascular ward (after ICU) felt less personal Pre-operative assessment using electronic notes less individualised Anaesthetist assessment 'daunting' Reliance on temporary staff Some find parking a problem Improve public awareness of vascular conditions and screening Make people aware of help with transport Better information on patient pathway Long wait for discharge

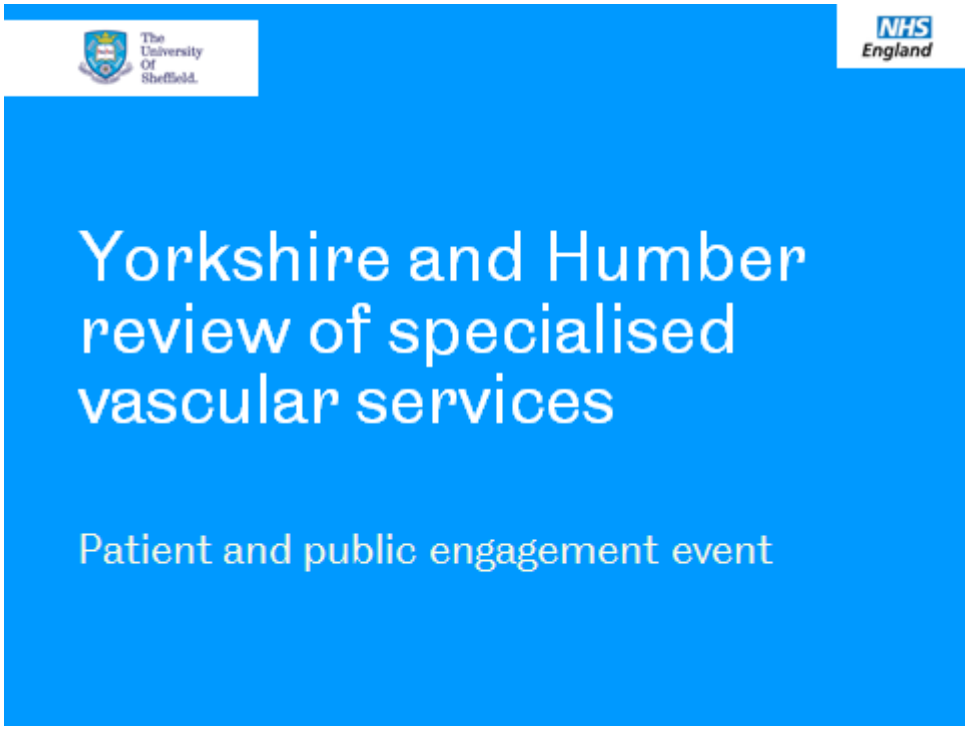
Table 4: Perceived advantages and disadvantages of different options for service delivery

	Continue with current arrangements	Services aligned with major trauma centres	Network model with 3–5 centres providing specialised surgery and teams working across centres
Doncaster	**Pros** Current high quality service; 'If it ain't broke, don't try to fix it' Appropriate size and location of hospital **Cons** Some find access a problem	**Pros** Some happy to travel for best care Large specialised centres may have better equipment May be OK if not time critical **Cons** Difficult access, especially for visitors and those using public transport Burden and costs for family members Worried about capacity Risk of taking too long to reach centre in an emergency	**Pros** May provide better access and less busy clinics (compared with major trauma centres) Could work for elective operations **Cons** Availability of equipment could vary between centres Could increase travel distance in emergency Patients further away from home Concerns about bed and surgeon availability
Leeds	Not discussed in depth	**Pros** Best care for life threatening conditions Top quality staff and expertise in	**Pros** Patients could be channelled based on their clinical needs Smaller hospitals have good outcomes and are

		one place **Cons** Issues of capacity (e.g. operating theatres) Excessive workload could increase waiting times Costs and burden for visitors	creative/innovative **Cons** Viability of model depends on geography Costs of investing in more theatres Staff might be unwilling to work in this way Risk of reduced access for patients outside major cities Condition could progress while waiting for treatment Patients would need right information (record/data sharing?) Surgeons not in right places for this model
Sheffield	**Pros** Working well **Cons** None mentioned	**Pros** Patients will go where service is available **Cons** Travel to unfamiliar city, increased costs for patients and visitors	**Pros** May provide better service **Cons** Similar issues to MTC model regarding access and transport
York	**Pros** In-hospital care working well, see Table 3 **Cons** None mentioned	**Pros** Access to best care for both elective and emergency care **Cons** None mentioned	**Pros** Close to family and friends for visits and support Retains access to experts **Cons** None mentioned

Huddersfield	**Pros** Service works well Local and accessible Quick response, operations generally performed on scheduled date High patient satisfaction Consistency of seeing the same staff **Cons** Access depends on locality May be less good value for money (how is this measured?) National standards not fully met	**Pros** Leeds is most accessible Centres may offer more specialist equipment and staff May offer better outcomes? Process could be more seamless and consistent One group saw benefits for NHS but not for patients Meet national standards **Cons** Could they cope with workload? Strain on infrastructure (beds, operating theatres etc.) Issues around relocation of staff from 'closed' centres Time to get there in emergency Issues around parking, traffic congestion and travel for visitors Unnecessary travel for follow-up appointments	**Pros** Enable staff to develop skills while maintaining patient access Could support more joined up services Could develop centres of excellence for elective surgery **Cons** Need to prove it works Not clear what it actually means. Does it include all diagnostic tests, radiology, pre-treatment tests? Needs good communication, e.g. to ensure notes are accessible Inconvenient for patients (travel etc.) Risk of losing personalised approach Reduced continuity of care Time wasted and costs for staff travelling between centres May dilute expertise Risks loss of access to specialists in emergency

Appendix 1: Introductory PowerPoint presentation




The University Of Sheffield.
Why are we here?
• To discuss why NHS England is reviewing specialised vascular services
• To introduce possible options for future development of services
• To seek your opinions and what is important to you
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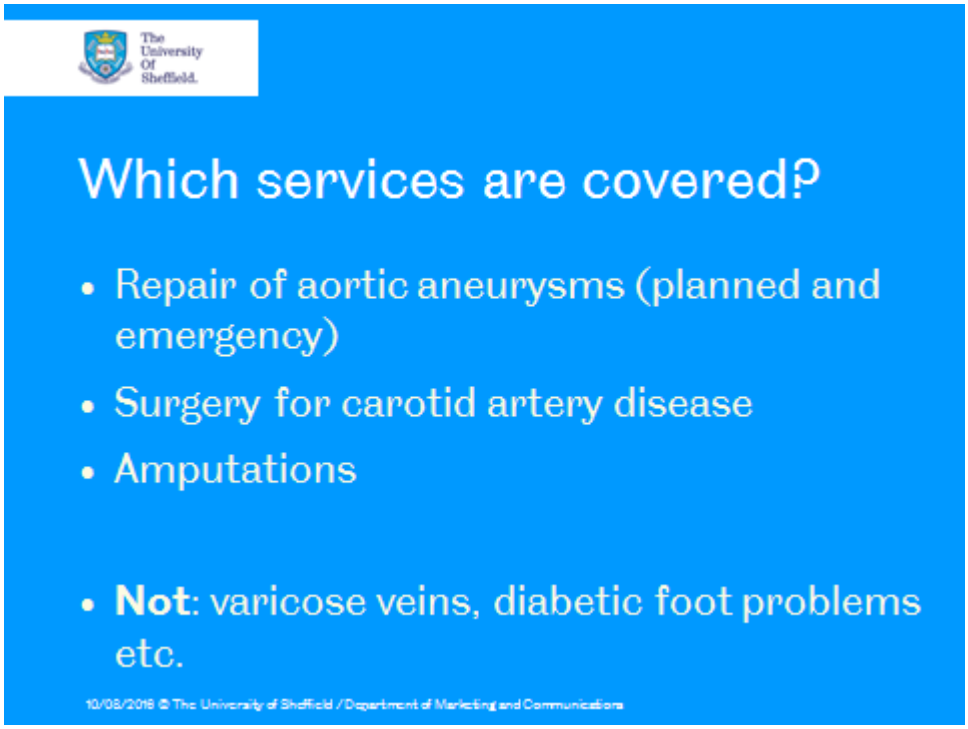
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Which services are covered?
• Repair of aortic aneurysms (planned and emergency)
• Surgery for carotid artery disease
• Amputations
• **Not**: varicose veins, diabetic foot problems etc.
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Why is NHS England carrying out this review?
• NHS England is responsible for planning and monitoring (commissioning) specialised services for Yorkshire and the Humber
• Service providers (hospitals) need to meet NHS England's national service standard
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Current services
• Seven hospitals provide specialised vascular services:
• Doncaster, Sheffield (NGH), Bradford, Calderdale (Huddersfield), Leeds, York, Hull
• Details of how the service works for patients vary from place to place
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Concerns with current service
• None of the hospitals fully meet the national standard for:
• Size of population served
• Number of specialised procedures (needed to maintain skills and clinical standards)
• Number of specialist staff (needed to maintain sustainable rota to cover emergencies)
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Independent regional stocktake 2015
• Death and complication rates are low and within nationally expected range
• Smaller hospitals (Calderdale, Bradford, Doncaster) show excellent outcomes
• Consolidation of services needed to meet service standard in full
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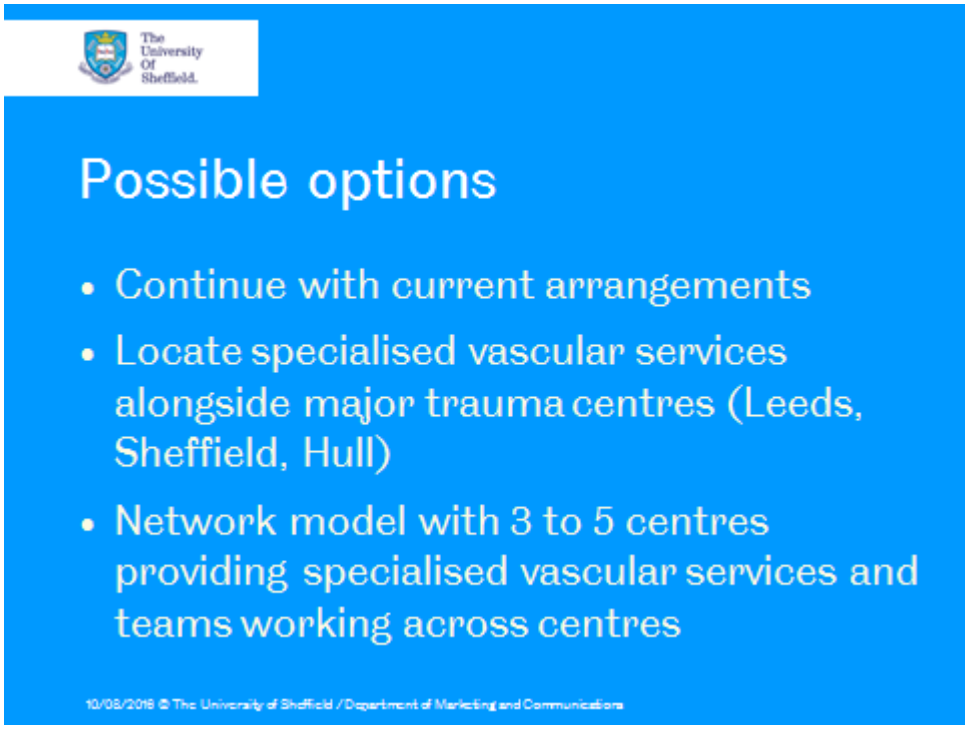
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Possible options
• Continue with current arrangements
• Locate specialised vascular services alongside major trauma centres (Leeds, Sheffield, Hull)
• Network model with 3 to 5 centres providing specialised vascular services and teams working across centres
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Questions for discussion
• What is good about your current service?
• And what could be improved?
• Pros and cons of the three models?
• What other issues should NHS England consider?
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What happens next?
• This is the first stage of engagement
• Feedback from today will inform a detailed examination of possible options
• Further engagement with patients, public, hospital clinicians, CCGs
• Development of a preferred option and timetable
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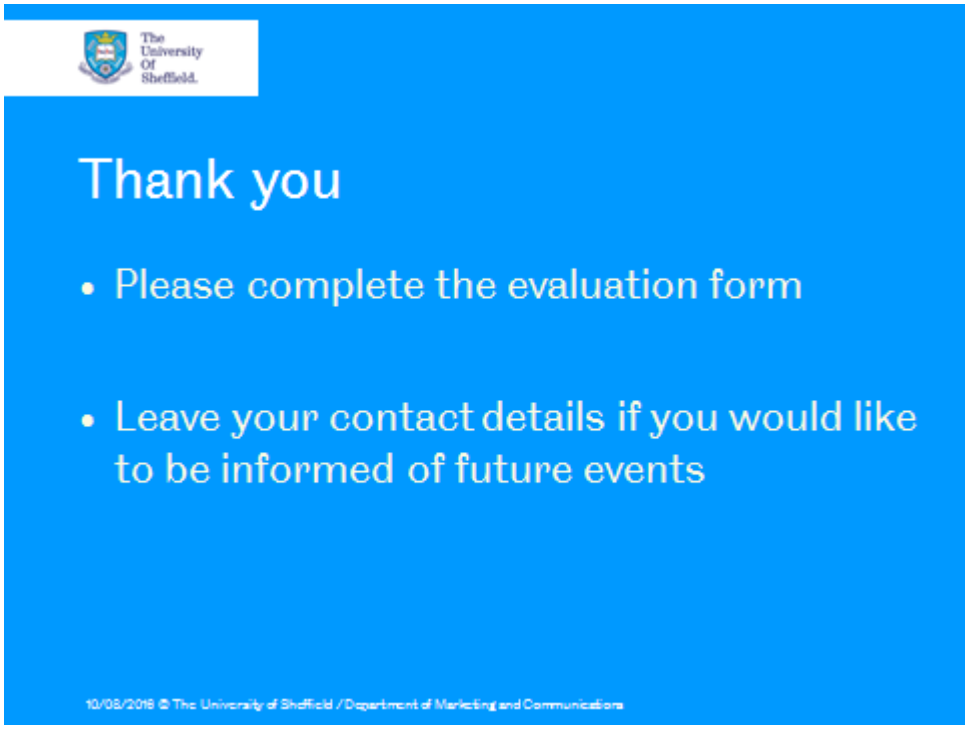
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Thank you
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