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NHS Greater Manchester Integrated Care Partnership

Engagement Team — by email: gmhscp.engagement@nhs.net

Consultation response from West Pennine LMC: proposed changes to adult cardiac surgery (Wythenshawe) and specialised arterial vascular surgery (Manchester Royal Infirmary)

Dear Colleagues,

West Pennine LMC is the statutory body for general practice across the West Pennine locality. That includes practices in the Oldham South PCN and across the Oldham footprint. We are responding for our member practices and for the patients on their lists. Both proposals affect those patients. The vascular proposal affects them most directly, because it takes arterial surgery away from Royal Oldham Hospital, which serves one of the most deprived populations in the country.

We have read the consultation summaries and the evidence behind them: the two Pre-Consultation Business Cases, the Cases for Change, the Travel Analyses, the Equality Impact Assessments, the Options Development papers, and the relevant NHS GM Board minutes. What follows is based on that evidence, not on the summaries alone.

Where we agree

We back the general idea. Bringing high-risk, low-volume surgery onto one site can be the right thing to do when it genuinely makes care safer, holds fragile rotas together, and cuts variation. Several parts of the case are sound, and we say so plainly.

On vascular surgery, Royal Oldham falls below the minimum AAA procedure volume at both unit and average-operator level, and its vascular interventional radiology on-call is being held together largely by locum cover. A service running under national volume standards on locums is not sustainable. That is a real safety problem, and it needs fixing.

The vascular PCBC also does a thorough job on service co-dependencies. Its accounts of the renal, stroke, interventional radiology, cardiac and diabetic-foot interfaces are detailed and, in most respects, reassuring, and the commitment to keep outpatient, diagnostic, day-case and diabetic-foot work local at Royal Oldham is welcome. On cardiac surgery, the workforce case is fair: losing cardiac anaesthesia cover at MRI in April 2024 was a genuine safety issue, and MRI keeps its full range of non-surgical cardiology.

We start here on purpose. What follows is a set of specific points, not a blanket objection.

The standard we are measuring against

Both consultations have to meet the common-law fairness tests set out in the Gunning case (1985) and confirmed by the Supreme Court in Moseley v Haringey (2014): the consultation must happen while the decision is still open, give people enough to respond intelligently, allow enough time, and be taken seriously afterwards. For vascular surgery, much of the supporting evidence is already published, so below we engage with what it says rather than simply asking for it. For cardiac surgery, our main point is about whether the decision was still open when the public was asked. We turn to that first.

Cardiac surgery at Wythenshawe

Was the decision still open?

The Case for Change and Options Development papers are open about the fact that all cardiac surgery has already moved to Wythenshawe: elective, TAVI and EP during the pandemic, and non-elective from 8 April 2024. Throughout, the preferred option (4a) is called the "current state." The Equality Impact Assessment says the Cardiac Integration Programme "has now been concluded and ratified as business as usual." The scoring that gave Option 4a a 98.9% positive rating was carried out after the move, on the service as it already stood.

This raises a fair question, and we put it as a question. How does NHS Greater Manchester show that this consultation is genuinely at a formative stage, as the law requires, when the model went live up to two years before the public was consulted and was scored as the existing service? A clear answer, setting out what could actually change as a result of what people say, would strengthen the eventual decision. Our issue is with the process, not the clinical destination.

The survey used to play down travel does not measure the right population

The cardiac case leans repeatedly on one survey finding: that patients ranked travel time their lowest priority. That finding cannot bear the weight placed on it, for a specific reason.

The Stakeholder Engagement Summary records that 84% of the patients surveyed were already being seen at Wythenshawe. For those patients, travel to Wythenshawe was not a hypothetical future burden. It was their existing arrangement; one they had already accepted by attending. Asking a Wythenshawe patient how much travel matters to them tells you very little about how the same journey will land on an Oldham, Rochdale or Tameside patient who has never had to make it. The survey measured the priorities of the population least affected by the change, and the result has then been applied to the population most affected by it.

Two further points compound this. First, the survey reported where patients were treated, not where they lived, and we can find no analysis anywhere in the evidence base that breaks the "travel ranked lowest" finding down by home location or deprivation. So the claim rests on a survey that cannot distinguish a patient living minutes from Wythenshawe from one travelling across Greater Manchester, and that was never analysed by residence at all. Second, the same summary concedes that satisfaction with travel arrangements was itself the lowest-scoring item. In other words, the very patients said to rank travel low were also the most dissatisfied with it, which points to travel being a settled irritation for people already at the receiving site rather than evidence that distance does not matter. The sample was also two-thirds male and 94% White British, and the summary itself states the findings "should not be assumed to reflect the entire view of cardiac surgery patients within GMEC." We note that the Equality Impact Assessment relies on the same survey to support its finding of no disproportionate impact, so this weakness runs through two parts of the case, not one. That finding should carry far less weight than it currently does, and the travel question should be tested against where patients actually live.

What this means by public transport for Oldham

The cardiac Travel Analysis is one of the better parts of the evidence base, and it is where our concern lies. By car, most journeys change little. By public transport, journeys to Wythenshawe are markedly longer from the communities we represent: roughly 32 minutes longer from Oldham town centre, 29 minutes longer from Shaw, and 42 minutes longer from Delph, with similar increases across Rochdale and Tameside. These are the patients least likely to own a car. The analysis itself says these longer journeys "need to be understood through consultation." We ask for the mitigations for public-transport-dependent patients in these areas to be spelled out, not left to implementation.

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Vascular surgery at Manchester Royal Infirmary

This is different from cardiac surgery in one important way. It has not happened yet. Royal Oldham is still an arterial centre, so the consultation really can still shape the outcome, which makes the completeness of the case matter more. Our concerns here are more substantial.

The money is not settled

The NHS GM Board minutes of 20 May 2026 record that the Board backed consultation only on condition that the vascular financial case was finalised and assured, and note that the PCBC itself flagged it as "still under development." The PCBC version history shows the financial case was added on 5 June 2026 (v2.2), just weeks before the consultation opened. The finance chapter then says the preferred option only "appears broadly affordable," and hangs that judgement on income flows and payment arrangements that are not yet confirmed, benefits that are not yet quantified or cash-releasing, stranded and repatriation costs that are unresolved, and a £500k transition figure that does not separately identify programme-management or mobilisation costs. A PCBC-stage figure is bound to be provisional. The problem is that the public is being asked to support a preferred option whose affordability the ICB itself calls a proportionate judgement rather than a confirmation, and that conditionality is buried in a long document rather than put plainly to consultees.

Emergency access and the promise to reach the spokes

We will not overstate this. The PCBC is honest that vascular trauma rarely needs an immediate on-site response (its own audit found fewer than one patient a month), and MRI is a large arterial and critical-care centre. But the whole model rests on a firm promise: that a vascular surgeon will reach a spoke site within 30 minutes for major trauma and within 60 minutes for other cases where the patient cannot be moved, and that "30-minute vascular availability" will hold. The Travel Analysis shows car journeys from parts of Oldham to MRI of 30 to 45 minutes at peak times. So we ask NHS GM to publish the modelling that shows those 30- and 60-minute standards can actually be met to Royal Oldham and the other units in real traffic, and to publish the expected time to treatment for ruptured AAA and acute limb ischaemia for Oldham patients once ROH becomes a spoke. This is asking for the evidence behind a promise the model already makes.

Three things for Oldham are still unfinished

The PCBC admits that three of the pieces that matter most to Royal Oldham are not yet done. The interventional radiology deployment model "will be addressed through the bipartite service."

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The repatriation SOPs have agreed principles, but "patient volumes and local processes are still being refined." The cost model needs "further sensitivity testing." The promise that care stays local for Oldham rests on exactly these unfinished pieces. They should be completed and published before a decision, because they decide whether the spoke model works as described.

The Clinical Senate added a specific worry we share: it asked NHS GM to consider what removing vascular interventional radiology from Oldham would do to non-vascular interventional radiology there. In plain terms, the vascular IR service at Royal Oldham may hold up the general IR service that other Oldham specialties, including emergency general surgery, renal and trauma, rely on. Taking it out could weaken that wider service. This was raised by NHS GM's own independent reviewers, and it should be assessed and resolved on the record before a decision.

No one has spoken to Royal Oldham staff

The PCBC states, in terms, that "there has been no formal engagement to date with staff at ROH." For the hospital losing the service, that is a serious gap. The clinicians who run vascular care at Royal Oldham are among the best placed to see what happens to co-located services and to the emergency take once the arterial centre moves. They should be engaged formally, and what they say should be reflected, before any decision.

The Clinical Senate's own points are not yet closed

The North West Clinical Senate (March 2026) raised several points that line up with ours, and in places the PCBC answers them with intent rather than completed work. The Senate advised that it would be prudent to consult neighbouring providers at the next stage, including the ambulance service, on how they would cope with future service changes and possible rises in transfer demand. Since this model increases reliance on transfer and repatriation, we ask for the North West Ambulance Service impact assessment the Senate called for, and for confirmation that the Senate's recommendations have been closed out rather than just noted.

What this means for general practice

Both PCBCs say openly that their models involve "a redistribution of responsibilities across the system," with prevention, optimisation, recovery and long-term management increasingly done in primary and community services. The Clinical Senate asked NHS GM to set out the effect on primary and community care. The vascular PCBC describes that effect as an ambition but not as a resource. It does not say which work moves to general practice and community nursing (wound care, anticoagulation monitoring, triage of post-operative problems, diabetic-foot surveillance, coordinating care across a wider network), or what funding and staffing move with it. General practice is already under real pressure.

If responsibility shifts toward it, that shift has a cost, and the resource has to move too. We ask for a proper primary care and community impact assessment for both schemes, with the resource identified.

There is a further point that formal impact assessments always miss. General practice becomes the default coordinator whenever a pathway spreads out geographically. When patients are unsure where they are being sent, worried after an operation, chasing a complication, sorting transport, or caught between two providers who are not talking to each other, they ring the GP, because the GP is local and reachable. That is real work, and it does not show up anywhere in the PCBCs, precisely because no formal task has been transferred. It should be recognised and counted.

Fairness and health inequalities

The travel and access costs of both proposals fall hardest on older people, disabled people, people without a car, people with several long-term conditions, and deprived communities. For us this is concrete. Oldham has one of the highest shares of any GM borough of its population in the most deprived tenth of the country, and both schemes move services away from that population, vascular surgery physically and cardiac surgery by public transport. NHS GM has a legal duty to have due regard to these effects under section 149 of the Equality Act 2010 and the health-inequalities duties in the Health and Care Act 2022. The cardiac EIA is the clearest example of the problem: it concludes "no disproportionate negative impact" for several protected groups while also admitting that the data for those groups (disability, ethnicity with over half "unknown," religion, sexual orientation, carer status) is not reliably held. You cannot safely conclude there is no disproportionate impact from data you admit you do not have. Those conclusions should be revisited wherever they rest on missing data.

The equality work should also look past the patient's own journey time, which is the narrowest way to measure the burden. Vascular admissions are inpatient stays of several days or more, for major limb salvage, amputation and aortic surgery. The heavier costs there fall on families and carers: getting to a more distant hospital day after day to visit, lower-income relatives being unable to take repeated time off work, the mounting cost of repeat journeys, and the strain on carers who have to travel too. Family presence is not a nicety. It supports communication, shared decisions, discharge planning and getting carers ready, all of which affect whether discharge is safe. These costs land on the Oldham households least able to carry them, and that is a fairness issue in its own right. It should be assessed directly, and the mitigations, travel and transport support and, where needed, help with accommodation for families facing the longest journeys, should be set out rather than promised.

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One receiving centre, and what happens if it goes down

Consolidation can improve resilience in one respect. A single, larger team of consultants supports steadier rotas and better surge cover than two fragile sites, and the vascular PCBC makes that case. But it also turns two sites into one, and neither PCBC really deals with the exposure that creates. Once all the activity sits on one site, the whole system depends on that site staying open. So we ask something the documents do not answer. What is the plan if the single receiving centre (Wythenshawe for cardiac, MRI for vascular) is badly disrupted by a major incident, a theatre closure, a critical-care capacity failure, a workforce problem or an infrastructure failure, and cannot take patients? The current two-site model gives a fallback that the new model removes. A regional service should be judged not just on a normal day but on a bad one. The business continuity and escalation plans for each receiving centre should be published.

What we are asking for before a decision

So that we and others can respond properly, and consistent with the Gunning and Moseley tests, we ask NHS Greater Manchester to provide the following, and to allow a reasonable further period to comment on anything materially new.

Cardiac surgery

C1 A clear account of how the consultation is at a formative stage when the model was implemented in 2024, setting out what could realistically change as a result of consultation responses.

C2 Reweighting of the "travel ranked lowest" survey finding in light of the fact that 84% of respondents were already treated at Wythenshawe and the finding was never analysed by patients' home location, and analysis of the travel question against where patients actually live.

C3 Concrete mitigations for public-transport-dependent patients in Oldham, Rochdale and Tameside.

Vascular surgery

V1 The finalised and assured financial case, with its conditionality made plain and the income and payment arrangements confirmed.

V2 The modelling showing the 30-minute (trauma) and 60-minute (other) surgeon-to-spoke standards can be met to Royal Oldham in real traffic, with projected time to treatment for ruptured AAA and acute limb ischaemia for the Oldham population.

V3 The completed repatriation SOPs, interventional radiology deployment model and cost-model sensitivity testing that the PCBC still lists as in development.

V4 Evidence of formal engagement with Royal Oldham staff, and the interdependency assessment for services co-located with vascular surgery at ROH, including the effect on general (non-vascular) interventional radiology.

V5 The North West Ambulance Service and transfer-demand impact assessment the Clinical Senate asked for, with confirmation that the Senate's recommendations have been closed out.

Both schemes

B1 An explicit primary care and community impact assessment, with any associated funding and workforce identified.

B2 Equality conclusions revisited wherever they rest on incomplete data, together with an assessment of the family, carer and wider access costs (visiting, lost earnings, repeat journeys) and concrete mitigations for the worst-affected Oldham communities.

B3 The business continuity and contingency arrangements for the single receiving centre should it be unable to accept activity.

In closing

West Pennine LMC supports safe, sustainable, high-quality specialist surgery, and we do not oppose consolidation as a principle. We have said clearly where the case is well made, including the genuine volume and workforce problems at Royal Oldham and the detailed co-dependency work in the vascular PCBC. Our concerns are specific. For cardiac surgery: whether a consultation on an already-implemented model is really at a formative stage, and the use of an unrepresentative survey to play down a real public-transport burden on Oldham. For vascular surgery: a financial case the ICB itself calls provisional, an emergency-access promise not yet backed by transfer-time evidence, unfinished repatriation and cost work, no formal engagement with the staff of the site losing the service, and Clinical Senate points still open. In both, the burden falls hardest on the deprived Oldham population we represent.

We ask that the information above be provided before any final decision, that there be a fair chance to comment on anything materially new, and that this response be properly taken into account, in line with NHS Greater Manchester's legal duties. We would welcome a clinical seat at the relevant pathway, interdependency and repatriation workstreams.

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Because the vascular proposal removes a service from Royal Oldham Hospital, we have copied this to the MPs whose constituents are most affected and to the relevant Health Overview and Scrutiny Committee, all of whom are on NHS Greater Manchester's own stakeholder circulation for these consultations.

Please acknowledge receipt.

Yours sincerely,

Dr Amir Hannan, MBE

Chair, West Pennine LMC

Dr Alan Dow

Secretary, West Pennine LMC

Dr Mark Wilshere

Vice Chair, West Pennine LMC