Lancashire County Council

Joint Lancashire Health Scrutiny Committee

Tuesday, 22 January, 2013 at 10.00 am in Cabinet Room 'C', County Hall, Preston

Agenda

Part 1 (Open to Press and Public)

No.	Item	
1.	**Apologies**	
2.	**Disclosure of Pecuniary and Non-pecuniary Interests** Members are asked to consider any disclosable pecuniary and non-pecuniary interests they may have to disclose to the meeting in relation to matters under consideration on the agenda.	
3.	**Confirmation of Minutes from the meeting held on 13 November 2012**	(Pages 1 - 4)
4.	**Vascular Services Review**	(Pages 5 - 46)
5.	**Dementia Care Services Consultation - update**	(Pages 47 - 48)
6.	**Urgent Business** An item of urgent business may only be considered under this item where, by reason of special circumstances to be recorded in the minutes, the Chair of the meeting is of the opinion that the item should be considered at the meeting as a matter of urgency. Wherever possible, the Chief Executive should be given advance warning of any Member's intention to raise a matter under this heading.	
7.	**Date of Next Meeting** To be arranged as and when required.	

I M Fisher
County Secretary and Solicitor

County Hall
Preston

Lancashire County Council

Lancashire County Council

Joint Lancashire Health Scrutiny Committee

Minutes of the Meeting held on Tuesday, 13 November, 2012 at 2.00pm at the Cabinet Room 'C', County Hall, Preston

Present:

Lancashire County Councillors

K Bailey (Chair)	C Evans
R Bailey	P Malpas
M Brindle	J Mein
F Craig-Wilson	M Welsh

Blackburn with Darwen Borough Council
Councillor R O'Keeffe

Blackpool Borough Council
Councillor A Stansfield

Non-voting Co-opted Members

Councillor J Robinson – Wyre Borough Council
Councillor D Wilson – Preston City Council

1. Apologies

Apologies for absence were presented on behalf of Councillors J Jones and A Matthews of Blackpool Borough Council, Councillor P Riley of Blackburn with Darwen Borough Council and Councillor B Foster of Burnley Borough Council.

2. Disclosure of Pecuniary and Non-Pecuniary Interests

None disclosed.

3. Confirmation of Minutes from the meeting held on 24 July 2012

The minutes of the Joint Lancashire Health Scrutiny Committee meeting held on the 24 July 2012 were presented and agreed.

Resolved: That the minutes of the Joint Lancashire Health Scrutiny Committee held on the 24 July 2012 be confirmed and signed by the Chair.

4. Mental Health Inpatient Reconfiguration Update

The Chair welcomed guest speakers from the NHS:

- Emma Foster – Transformation Director, Lancashire Care Trust

- Paul Hopley – Head of Programmes, NHS Lancashire
- Alistair Rose – Project Director, Lancashire Care Trust
- Amanda Thornton – Clinical Director, Adult Community Network, Lancashire Care Trust

The report explained that at the meeting of the Joint Health Committee on 31 May 2012 members had been presented with an update on the progress made and planned relating to the development of new mental health inpatient services and the transition arrangements for existing services to be de-commissioned. It was agreed that further updates would be presented to the Committee at appropriate stages.

Appendix 'A' to the report now presented provided the latest of these updates and specifically related to proposed revised timescales of the overall re-configuration of services.

Alistair Rose used a PowerPoint presentation to inform the Committee about the timescales for the provision of The Harbour, a new inpatient service for the Fylde Coast. He explained that some re-design work was being undertaken and consequently there would be a requirement to re-submit relevant planning applications. There was an expectation that work on site would now begin in Spring 2013. A copy of the presentation is appended to these minutes.

Emma Foster then explained to the Committee how changes to the timescales for construction work at the Harbour had affected the timescales for service changes and the transition plan. She summarised key points contained in the report now presented.

Councillors were invited to ask questions and raise any comments in relation to the report, a summary of which is provided below:

- Regarding the site in East Lancashire, it was explained that as the site was Royal Blackburn Hospital, which was owned by East Lancashire Hospitals Trust work was underway to see how the LCFT's plans fitted with ELHT's plan. It was anticipated at the current time that the original plan would not change and that 72 adult mental health beds would be provided. The Committee would be informed as soon as possible if things changed. It was explained that one of the options to be shortly consulted upon included the provision of dementia inpatient beds at Blackburn.
- The Trust was currently using a number of private sector beds and it was confirmed that these were mostly not within Lancashire and that this was one of the reasons why it had been decided to slow down the pace of change.
- The report indicated that there would eventually be 16 Psychiatric Intensive Care Unit (PICU) beds at the Harbour, Blackpool. This figure would be kept under constant review and whilst there was no expectation that the PICU bed provision would be fewer the number of beds might increase; the Trust did not want to have to use beds outside Lancashire.
- In response to a question about the financial position within LCFT the Committee was assured that the Trust's finances were sound and the development plans presented were affordable. It was pointed out that its accounts were publicly available.
- The report indicated that a closure date for wards 20, 22 and the PICU at the Burnley site would be determined "by the measured reduction in in-patient demand rather than by a pre-determined date" and clarification what this actually meant was sought. In

response it was explained that the Trust needed to be confident that it was safe to close those wards before a decision was taken. The Board was to assess the position in January.

- Regarding the site for Central Lancashire, the Trust was currently working on a long-list from which preferred sites would be short-listed.
- Regarding the provision of services for West Lancashire it was explained that services were currently available at Ormskirk; future provision was subject to the location of the site which would provide services for Central Lancashire.
- It was explained that two planning applications for the 'Harbour' at Blackpool were necessary and that two local authorities were involved (Blackpool Borough Council and Fylde Borough Council). One of the applications had already been submitted and it was expected that the second one would be submitted in early December. A decision about each application was expected within 13 weeks of its receipt by the planning authority.
- In response to a question about the impact of the changes on jobs it was explained that there would be more members of staff per patient and those staff would be better qualified. Workforce planning was required but it was not envisaged that wholesale changes would be necessary.
- It was confirmed that when the specialist dementia beds became available at The Harbour patients would transfer from Ribbleton Hospital in Preston and the ward there would close.

Paul Hopley gave a short presentation about the consultation on dementia care services that was to begin on 3 December 2012 and run to 22 February 2013. Much pre-consultation work had already been carried out. He used a diagram which set out visually the background, the current position and two options for future provision to be consulted upon. The Trust's preferred option was Option 1. A copy of the diagram is appended to these minutes.

There would be 16 public events starting in January 2013 across Lancashire at various locations and at various times. These would be advertised in local newspapers, on local radio and there would be posters in GP practices and libraries. People would be given a range of ways by which to contact the Trust and assistance would be provided if necessary. The Trust also stated that additional meetings with community based groups would also take place if requested.

Part way through the consultation independent experts at UCLAN (University of Central Lancashire) would conduct a check on the demographics of the responses to that point and, if necessary, under-represented groups would be targeted as appropriate. At the end of the consultation UCLAN would produce a report for the LCFT on all responses. This Committee would be informed of the outcome.

It was confirmed that all elected members would be included in the consultation and details of the venues for the public meetings, referred to above, would be provided to the Committee via the Scrutiny Officer.

Following the consultation, the decision regarding the model for future provision would be taken by the Clinical Commissioning Groups. The programme of meetings with the CCGs and the PCTs had already been set and there was no reason to believe that the timetable for a decision would falter.

Regarding support for carers, it was explained that during August the PCTs and LCFT had jointly commissioned an organisation called Insight Network, comprising 63 charities and third sector organisations, to run 15 carers events at which carers were asked what support they would like to see developed. The solutions suggested, for example, patient transport, volunteer drivers, improved advocacy arrangements, would be included in the consultation document and respondents would be asked to rank, in order of preference, what type of support they wanted.

The question of adequate transport had been raised by members previously and also by carers. The Committee was assured that the needs of those clients who lived beyond the direct transport routes had been explored.

The Chair thanked officers from the NHS for attending.

Resolved: That,

i. The report be received;

ii. The proposals set out in Appendix A to the report now presented be supported.

5. Urgent Business

No urgent business was reported.

6. Date of Next Meeting

The next meeting of the Joint health Scrutiny Committee had been scheduled for Tuesday 22 January at 10.00am.

Ged Fitzgerald
Chief Executive

County Hall
Preston

Joint Lancashire Health Scrutiny Committee
Meeting to be held on 22 January 2013

Electoral Division affected:
All

Vascular Services Review
(Appendices A, B and C refer)

Contact for further information:
Wendy Broadley, 07825 584684, Office of the Chief Executive,
wendy.broadley@lancashire.gov.uk

Executive Summary

At the Joint Health Scrutiny Committee on 24 July 2012 members were presented with a report outlining proposals for the reconfiguration of vascular services across Lancashire and Cumbria.

The recommendation of the Vascular Clinical Advisory Group of the Lancashire and Cumbria Cardiac and Stroke Network was that one site should be in the north of the region due to geography and travelling distances. It was felt two sites were needed in the south of the network as the population coverage would be just over 2 million. All hospitals within the region were asked to submit bids should they wish to be nominated as a specialist vascular intervention unit working within the proposed vascular network.

Following a procurement process it was recommended that the specialist intervention centres should be located at Carlisle, Blackburn and Preston. These centres would undertake all major inpatient vascular work. Day case work and outpatients would continue in all local hospitals within the region.

Following a discussion members concluded that further information should be requested and a letter was sent to Dr Jim Gardner, Medical Director NHS Lancashire setting out the information the Committee required for the next meeting. Attached at Appendix A is the response from NHS Lancashire to this request.

Since the meeting on 24 July University Hospitals Morecambe Bay Trust (UHMBT), who were unsuccessful in their tender submission, wrote to NHS Lancashire expressing their intention to challenge the recommendation of the Vascular Clinical Advisory Group. A copy of their letter is attached at Appendix B.

A meeting had been planned for 25 September but was postponed to allow the appeal process undertaken by UHMBT to take place. Attached at Appendix C are details of the outcome of the appeal and further updates since the Committee met in July last year.

Lancashire County Council

Recommendation

The Joint Health Scrutiny committee is asked to:

i. Determine whether the proposals are considered to be a 'substantial variation';
ii. Consider whether the level of engagement has been adequate; and
iii. Provide NHS Lancashire with their views and comments on the proposals and if appropriate recommend a course of action.

Background and Advice

At the Joint Health Committee on 24 July 2012 officers from NHS Lancashire presented a report which explained that the aim of the service review was to reconfigure vascular services and secure improved outcomes for patients across Lancashire and Cumbria. The Vascular Service Review formed part of the wider review being undertaken simultaneously across England.

It was proposed to provide specialist intervention services for Lancashire and Cumbria from three centres with 24 hour, 7 days a week (24/7) facilities. Bolton, Wigan and Dumfries & Galloway were also included within the review area.

It was explained that bids from five hospitals had been carefully considered and three sites had been recommended. The recommendations of the procurement team had been made in line with recommendations from the Vascular Clinical Advisory Group, following short-listing, interviews and scoring, which included assessment of risks. The approach taken was also supported by the All Parliamentary Select Committee for Vascular Surgery. The three proposed specialist intervention centres were located at Carlisle, Preston and Blackburn.

The Committee received a presentation on the current status of the review which included:

- A summary of the reasons why the review was being undertaken
- The rationale for three specialist centres
- Details of communication and engagement
- The results of a patient and public survey

Following a discussion members felt unable to support the proposal for the 3 vascular intervention centres (Carlisle, Preston and Blackburn) as there were still many unanswered questions. It was agreed to hold another meeting of the Joint Health Scrutiny Committee to provide officers with a further opportunity to explain the background to the proposals in greater detail and demonstrate evidence of engagement and support from other stakeholders.

A summary of the main points and actions required by the Committee were detailed in a letter dated 27 July to Dr Jim Gardner, Medical Director NHS Lancashire which included:

- Evidence of engagement and support of the Lancashire and Cumbria Clinical Commissioning Groups (CCGs)
- A copy of the 'Patient and Public Survey' data and an engagement action plan.
- Further information on the estimated numbers of the population of South Cumbria (160,000) expected to travel to Preston instead of Lancaster.
- Evidence that transport issues (both public and private) have been considered when looking at site selection.
- Further detailed evidence of the background to the proposals, including information on the existing services that will remain in the current locations and within local communities and supporting criteria for the selection of the 3 locations.
- Ambulance target data.
- It was stressed in the presentations that Royal Lancaster Infirmary came fourth out of the four sites under consideration following a risk assessment. Therefore an explanation was required as to why it was marked down as members feel it was important to understand in what areas it was perceived as weak.

The response to this request is attached as Appendix A. In Section 9 of the document there is a comprehensive list of supplementary information in the form of web links. These web links are intended to demonstrate evidential support of the statements made in the preceding sections. Due to the volume of this supporting information it has not been included within the main body of the report however a hard copy can be made available upon request.

As members are aware, University Hospitals Morecambe Bay Trust (UHMBT) were unsuccessful in their submission to host a specialist intervention centre at Royal Lancaster Infirmary (RLI); an issue which raised concerns relating to the access of services for patients living in South Cumbria. The Trust subsequently announced its intention to appeal against the recommendation of the Vascular Clinical Advisory Group and undertook this through the NHS Blackpool Dispute Resolution Process.

This action was separate to, and independent of the considerations of this Committee.

However as the concerns of the Committee at its meeting on 24 July included those relating to the location of a specialist intervention centre at RLI it was agreed that the Committee should be made aware of the specific grounds for the appeal by UHMBT. A copy of UHMBT's letter to NHS Lancashire dated 6 September setting out their intentions is attached as Appendix B.

The outcome of the appeal by UHMBT and an update on previous information presented is attached as Appendix C.

Once the Committee has been presented with the information provided by NHS Lancashire and UHMBT, members will need to determine a number of factors:

a) Is the proposal to move from the present configuration of services in Cumbria and Lancashire on five sites to a vascular network with specialist inpatient

operations being delivered on three hospital sites considered to be a '*substantial variation'*?

b) Has the engagement and communication of the review and subsequent development of the proposals been robust and inclusive?

Following the agreement of these factors the Committee is then asked to provide NHS Lancashire with its comments on the proposals and whether it will recommend any further course of action prior to a final decision being taken by the Board of NHS Lancashire.

Consultations
N/A

Implications:
This item has the following implications, as indicated:

Risk management
There are no risk management implications arising from this report.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel

Reason for inclusion in Part II, if appropriate

Vascular Services Review in Cumbria & Lancashire

Joint Health Committee
Tuesday 25th September 2012

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Introduction

On Tuesday 24th July 2012 a presentation to the Joint Health Overview and Scrutiny Committee (OSC), concerning proposed changes to Vascular Services across Lancashire and Cumbria, was given by the Vascular Review Team. Following on from this meeting a request was made by the OSC Chair asking for further clarity on a number of areas.

This paper addresses the seven key areas which the Committee asked the Network to provide further evidence on, as well as providing supplementary information and supporting evidence. The paper also contains a number of patient scenarios in order illustrate further the proposed patient pathways.

Section 1 – CCG and GP Engagement

Throughout the review of Vascular Services in Lancashire and Cumbria a continuing key priority of the Network has been to engage both CCGs and GPs. This initial engagement began in September 2010 and is on-going (appendix 1.1).

As part of this engagement process a number of briefings or e-bulletins were created and distributed to GPs in Lancashire and Cumbria to communicate the progress of the review and identify any key developments (appendix 1.2).

One of the key ways in which we engaged GPs was through the use of on-line and paper surveys which were produced in partnership with an independent research group, CRACS, who are funded by local authorities and the NHS in East Lancashire, and hosted by Pendle Council on behalf of the funding bodies. The fieldwork took place between March and May 2012, and we received a total of 154 GP responses.

The key findings from the survey are as follows:

- 90% stated that they agreed with the principles of the review. Prior to completing the survey, 50% of the GP respondents were not aware of the principles of the review prior to the survey, however after reading the principles, this figure increased to 90%.

- 93% were supportive of the proposals. After reading the consultation document 59% of GPs stated that they totally agreed with the proposals, 34% stated that they partly agreed with the proposals and only 2% stated that they did not agree with the proposals.

- 56% of GPs felt that the proposals would have a positive impact for their practice and patient care and 23% were unsure.

Please see appendix 1.3 for a copy of the questionnaire, and appendix 1.4 for a detailed breakdown of results.

Further communication with CCGs and GPs has been sought through a series of meetings where a number of updates have been given concerning the progress of the review (appendix 1.5 and 1.6).

Local Clinical Commissioning Groups have been supportive of the case for change.

As part of the engagement process briefings were sent out to providers and other stakeholders (appendix 1.7 and 1.8).

NHS
Blackburn with Darwen
Clinical Commissioning Group

Blackburn with Darwen Teaching Care Trust Plus
Guide Business Centre
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Enquiries to be directed to: Catherine Baron
Direct No: 01254 282120
Email: catherine.baron@bwd.nhs.uk

13th September 2012

Councillor Keith Bailey
Lancashire County Council
PO Box 78
County Hall
Fishergate
Preston
PR1 8XJ

Dear Councillor Bailey

I am writing in my capacity as the Chair of the Network of Lancashire CCGs to confirm that since the launch of the Review of Vascular services in Cumbria and Lancashire there has been a significant amount of activity undertaken by the Review Team to engage with GPs and latterly with the Clinical Commissioning Groups. This activity has taken the following forms:

- Chairing of the initial Vascular Review Steering Group by a GP, Dr Mammen Ninan.
- Presentations and Updates on the progress of the Review being given to the Lancashire Clinical Transformation Board on 6 separate occasions
- A letter sent to all GPs within Cumbria, Lancashire, Wigan and Bolton explaining the rationale for the Review and seeking their views by either a paper or online survey
- GP newsletters were sent out regularly to update GP colleagues with the progress of the Review
- Analysis of the GP survey responses indicating that 90% of those responding supported the principles of the Vascular Review

Dr Jim Gardner recently gave an update on the progress of the Vascular Review at the Network of Lancashire CCGs meeting on the 26th July 2012 including the identification of the three arterial intervention sites. I can confirm that the 8 Lancashire CCGs continue to support the process and have committed £500,000 of funds to supporting the implementation of a Vascular Network.
We believe that the clinical case for the reconfiguration of vascular services has been well made and look forward to seeing improved outcomes for our patients.

Yours sincerely

Dr Chris Clayton
Lancashire CCG Network Chair

Section 2 – Public and Patient Engagement

Understanding the needs and expectations of patients and the public has been a key priority of the Network. Patient and Public engagement begun at the inception of the vascular review in September 2010 and has continued through the period of the review to the present (please see appendix 1.1 for a timeline which illustrates this).

A communication and engagement strategy was developed, and this was supported by a communication and engagement strategy (appendix 2.1).

The communication and engagement strategy used the following approach:

- Presentations to representative bodies such as LINks and the OSC
- Briefings to stakeholders, including LINks, who used the briefings in their member newsletters
- Interviews of patients in vascular service outpatient clinics to understand their experiences and expectations
- An online and paper-based survey to members of the public and patients
- Press releases issued to local media (newspapers and radio) to promote the review and encourage engagement with the survey

Examples of media coverage include:

- Interview on Bay Radio, 31st August 2011
- BBC North West Tonight, 26th October 2011
- Interview on Radio Cumbria and Radio Lancashire, 31st July 2012
- Interview on Preston FM, Autumn 2011
- Lancashire LINKs meeting 1st December 2011
- Lancashire LINKs Newsletter November 2010
- Lancashire LINKs Newsletter October 2010

Examples of press statements include:

- Media statement April 2012
- Media statement November 2011
- Media statement April 2011
- Media statement October 2011
- Media statement July 2012

Vascular services may appear complex to the general public, particularly if they have not experienced the need for them or used them. The aim of interviewing patients who were using vascular services was, therefore undertaken to understand their experience and expectations of service users. The use of ‘expert patients’ in this way is well regarded and invaluable.

Following this, we undertook a paper-based and online survey of patients and the public. We promoted this in the media, online and via LINks. We receive 503 responses.

The key findings from the survey are as follows:

- 64% of respondents were either a current or former patient of vascular services, and 16% were currently attending their first outpatient appointment.

- 70% stated that all their care was carried out in the same hospital.

- Quality of care was viewed as more important, however than travelling distance.

- 75% of respondents are able to travel further to be seen by a specialist consultant and 65% are willing to travel further.

- The above finding accords with health service commissioner experience where we know that under choice, patients can and do opt to receive specialist care and treatment further afield, for example patients in Blackburn electing to have hip operations in Wigan; Lancaster patients electing to receive cancer treatment in Manchester, Burnley patients electing to receive neurology treatment in Liverpool, and Cumbria patient electing to receive treatment in Newcastle.

Please see appendix 2.2 for a copy of the questionnaire, and appendix 2.3 for a detailed breakdown of results.

Rationale for engagement rather than formal consultation:

The network and the vascular review team considered whether they should undertake a formal consultation with the public, or whether they should conduct ongoing engagement. It was clear that without any clear preferences, nor any agreed locations during the review period, it would not be practical to consult on locations. Good practice in consultations requires a series of options for consultees and up to the identification of preferred sites this was not possible.

This is an extract of a paper which was considered by the Lancashire PCT Cluster Executive Team which sets out the reasons for engagement rather than formal consultation (appendix 2.4).

The change that patients and stakeholders will potentially experience as a result of this development is that patients who do not reside in close proximity to the three preferred sites will need to travel for specialised inpatient vascular surgery and treatment.

The other components of vascular care such as follow-up appointments, day case surgery, and outpatient treatment will continue to be provided from the local district general hospitals. This element of the service will not change for patients.

The engagement of stakeholders has been on-going throughout 2010 and 2011. An agreed communication and engagement plan is the basis of this activity. Typically, ‘engagement’ is a process adapted to local circumstances and contexts. For many,

engagement represents an on-going relationship and series of contacts and communication with local communities and stakeholders. It is regarded as good practice and appreciated by stakeholders. Engagement enables organisations to maintain a relationship with and, more importantly to test the reaction of stakeholders throughout the period of time that services are being designed, planned, developed, procured and delivered.

Formal consultation is a structured and co-ordinated process. This is undertaken typically with a consultation document that outlines a clear set of questions, proposals or options presented to key stakeholders or audiences. Mechanisms for receipt of responses are established. Preferences are analysed and a report produced. As the preferences for the vascular intervention centres have not yet been established, there is little sense in formally consulting when we are not in a position to offer options for stakeholders to respond to. Engagement is the ideal means by which to keep stakeholders informed and lines of communication open.

The Cabinet Office Code of Practice on Consultation sets out seven consultation criteria. Among these is the requirement to be clear about the scope and impact of the proposal(s). Where stakeholders have a clear set of options or proposals – such as the site preferences for the vascular intervention centres – and an understanding of the impact of the preference – they can make reasoned choices, and their views can be heard. As commissioners we are required to 'have regard to' their views, and as long as we have considered and responded to them this is acceptable. A much reported criticism of consultations is that respondents were not clear about what they were being consulted on, what the options were, and the amount of information available to make an informed response.

Once preferences are identified, there will be a window of time in which it would be possible to formally consult. The 'trigger' for this will be through representation to any of the overview and scrutiny committees involved, the appropriate LINks and the SHA. If these bodies request a formal consultation, this will occur.

Section 3 – Population of South Cumbria

The overall population covered by the Cumbria and Lancashire Vascular Review is 2.8 million people.

The practice population of South Cumbria is 194,468, although the census population is 172,800.

	Practice Population	Aortic aneurysm	Carotid Disease	Limb Ischaemia
Vascular Network	2,800,000	230	225	2200
South Cumbria	194,468	16	16	154
Barrow in Furness	82,146	7	7	65
South Lakeland	112,322	9	9	89

With the implementation of the AAA screening programme it is expected that the number of patients presenting requiring an emergency aneurysm repair is likely to fall to just two or three cases a year from the South Cumbria area over the next ten years.

The model of service delivery developed as part of the Vascular Review by the Vascular Clinical Advisory Group is for the **provision of the vast majority of Vascular Services to continue to be provided locally.**

This includes:

- primary care management and prevention
- AAA screening
- diagnostics and investigations
- day case procedures
- outpatient follow up care

Patients will continue to be referred to their local hospital and the intention is that clinicians based at local hospitals will continue to care for their local population in both the local hospital and the arterial intervention centres.

As part of the implementation of the Vascular Review funding has been secured from the Lancashire Clinical commissioning Groups. This will allow investment in the IT infrastructure that will allow:

- Development of an Image Exchange Portal allowing X-rays and scans to be safely and rapidly transferred between arterial and non-intervention centres. This will avoid the need for duplication of investigations for patients and limiting the need for travel to the Arterial centre apart from for the actual procedure.

- Utilisation of current telemedicine technology (as used by Telestroke across Cumbria and Lancashire) in the Emergency Departments in the non-intervention centres to support urgent clinical assessment and decision making for vascular patients.

- Development of Multi-Disciplinary Team and audit meetings across the whole of the Cumbria and Lancashire Vascular Network.

Section 4 – Transport

Travel time analysis was undertaken as part of the Vascular Review and is included in *A Case for the Centralisation of Vascular Services in Lancashire and Cumbria*. Isochrones from the various hospital sites were mapped. A maximum patient transfer time of 90 minutes from all non arterial centres to the nearest Arterial Centre of 90 minutes was agreed by the Vascular Clinical Advisory Group (VCAG) as clinically acceptable given our local geography. This was an extension of the 60 minutes transfer time described as ideal by the Vascular Society, but was accepted by the NAAASP as acceptable (appendix 4.1). However from most hospitals there will be a much shorter transfer time to an Arterial Centre.

The data used in the Vascular Review analysis showed that the distance from Barrow in Furness to Royal Preston was on the cusp of the 90 minute travel time. The isochrones were dated to 2006 prior to the further improvement to the A590 in 2008 and recent analysis has shown that the travel times are achievable within this timescale within most circumstances.

MILEAGE MATRIX

	Barrow	Blackburn	Blackpool	Burnley	Carlisle	Chorley	Kendal	Lancaster	Preston	Whitehaven
Blackburn	79		32	17	98	13	56	39	19	109
Carlisle	86	98	101	99		97	52	69	88	42
Preston	64	19	16	33	88	14	41	24		98

*Mileage via M6 (mileage via A682 = 76 miles)

TIME MATRIX

	Barrow	Blackburn	Blackpool	Burnley	Carlisle	Chorley	Kendal	Lancaster	Preston	Whitehaven
Blackburn	1h41m		0h40m	0h21m	1h46m	0h16m	1h02m	0h44m	0h23m	2h28m
Carlisle	1h48m	1h46m	1h47m	2h06m		1h39m	1h03m	1h14m	1h31m	1h08m
Preston	1h26m	0h23m	0h22m	0h38m	1h31m	0h30m	0h47m	0h30m		2h14m

*Mileage via M6 (mileage via A682 = 76 miles)

Mileage and approximate times taken from RAC website

KEY:
Intervention Centre
Local Hospital

NWAS performance data show that 95% of journeys between FGH and RPH carried out in the last financial year were achieved in less than 90 minutes. Journey times from South Lakeland show that this can easily be achieved within the hour.

According to *The Provision of Services for Patients with Vascular Disease 2012*, (VSGBI),

> **patients arriving at a non-vascular hospital with a vascular condition requiring emergency intervention should be diagnosed and referred within one hour of arrival.**

Services should be arranged to minimise transfer times (target less than one hour).

> **95% of patients should be triaged, referred and have arrived at the vascular unit within two hours of arrival at the spoke hospital.**

(Appendix 4.2)

The patient and public engagement exercise that was conducted asked questions concerning the importance of transport. The results indicated that although travel still remains an issue for some, **overall quality and safety of care was considered to be of more importance than travelling distances**. Furthermore, 75% of respondents were able to travel further to be seen by a specialist consultant and 65% were willing to travel further.

In addition to this the three Arterial Centres that have been chosen are accessible via public transport, seven days a week, throughout the day and into the evening (appendix 4.3 details public transport access). Moreover, patients who have mobility issues and meet the Patient Transport Services (PTS) Criteria will be eligible for free return transportation from their homes (appendix 4.4). There is strong evidence to show that implementation of the Vascular Review will reduce the length of stay for patients undergoing arterial interventions. Where rehabilitation is required following arterial intervention patients will be transferred back to their local district or community hospitals.

The selected Arterial Centres have confirmed that they have facilities that will enable the next of kin of patients who have been admitted for an emergency vascular procedure requiring an intensive care setting, to stay overnight. It is also worth noting that the number of emergency aneurysm patients will reduce from over 70 per year to approximately 20, as the Abdominal Aortic Aneurysm (AAA) screening programme starts to have an impact over the next ten years.

Most patients will be diagnosed as having a vascular emergency at the local hospital. However, pathways will be developed within the Cumbria and Lancashire Network that will allow a GP who recognises that a patient has a likely vascular emergency (e.g. patient has a known aneurysm) to instruct the ambulance to go directly to the nearest Arterial Centre.

Section 5 - Background to Proposals and Existing Services

The focus of this review of Vascular Services has been to improve quality and safety for patients. Evidence based standards have been developed and agreed by local vascular clinicians which seek to ensure the highest standards of quality and patient safety. Implementation of those standards will require a change from the way services are currently provided.

The initial impetus for a review of vascular services arose from the unsuccessful business case for an Abdominal Aortic Aneurysm (AAA) Screening Programme within Cumbria and Lancashire.

The National AAA Screening Programme told us in 2010 that a screening programme could only be implemented when a full review of present vascular surgical providers had been completed. Commissioners instructed the Cardiac and Stroke Networks for Lancashire and Cumbria to carry out that review. A Vascular Clinical Advisory Group was established to ensure that the review was clinically led. Further national guidance came with the publication by the Vascular Society of Great Britain and Northern Ireland of *The Provision of Services for Patients with Vascular Disease* (appendix 4.2).

The Vascular Review concluded that:

The present configuration of services in Cumbria and Lancashire does not promote the transfer of patients to high-volume centres so that these important advantages are available to them. The advent of screening for abdominal aortic aneurysms adds further importance to this work.

Presently across Cumbria and Lancashire, there is a significant variance in the uptake of minimally invasive vascular surgery (EVAR). This means that the hospital where the patient has their surgery is a bigger determining factor in deciding the type of surgery they will have rather than their clinical need.
In Lancashire and Cumbria the numbers of vascular procedures are classed as low volume - and mortality and length of stay compare badly to the rest of the UK.

Remodelling vascular services by reducing the number of providers delivering arterial intervention will reduce mortality and morbidity after major vascular surgery by concentrating medical and nursing expertise (appendix 5.1).

The Vascular Clinical Advisory Group developed a model for the delivery of vascular services through the creation of a Vascular Network, with all hospitals collaborating to improve outcomes for patients. A service specification was also developed (appendix 5.2).

Commissioners accepted the recommendations of the VCAG for the development of three arterial intervention centres, as opposed to the current eight hospitals performing these interventions often in low numbers. After a co-operative procurement exercise three arterial intervention centres were selected at the Cumberland Infirmary, Royal Preston Hospital and Royal Lancaster Infirmary. Although full population coverage was not achieved through these three bids the boards of NHS Lancashire, NHS Cumbria and NHS Greater Manchester accepted

the recommendations. It was accepted that further work with clinicians and providers would need to be undertaken to ensure full population coverage (appendix 5.3).

The model of service delivery developed as part of the Vascular Review by the Vascular Clinical Advisory Group is for the **provision of the vast majority of Vascular Services to continue to be provided locally.**

This includes:

- primary care management and prevention
- AAA screening
- diagnostics and investigations
- day case procedures
- outpatient follow up care

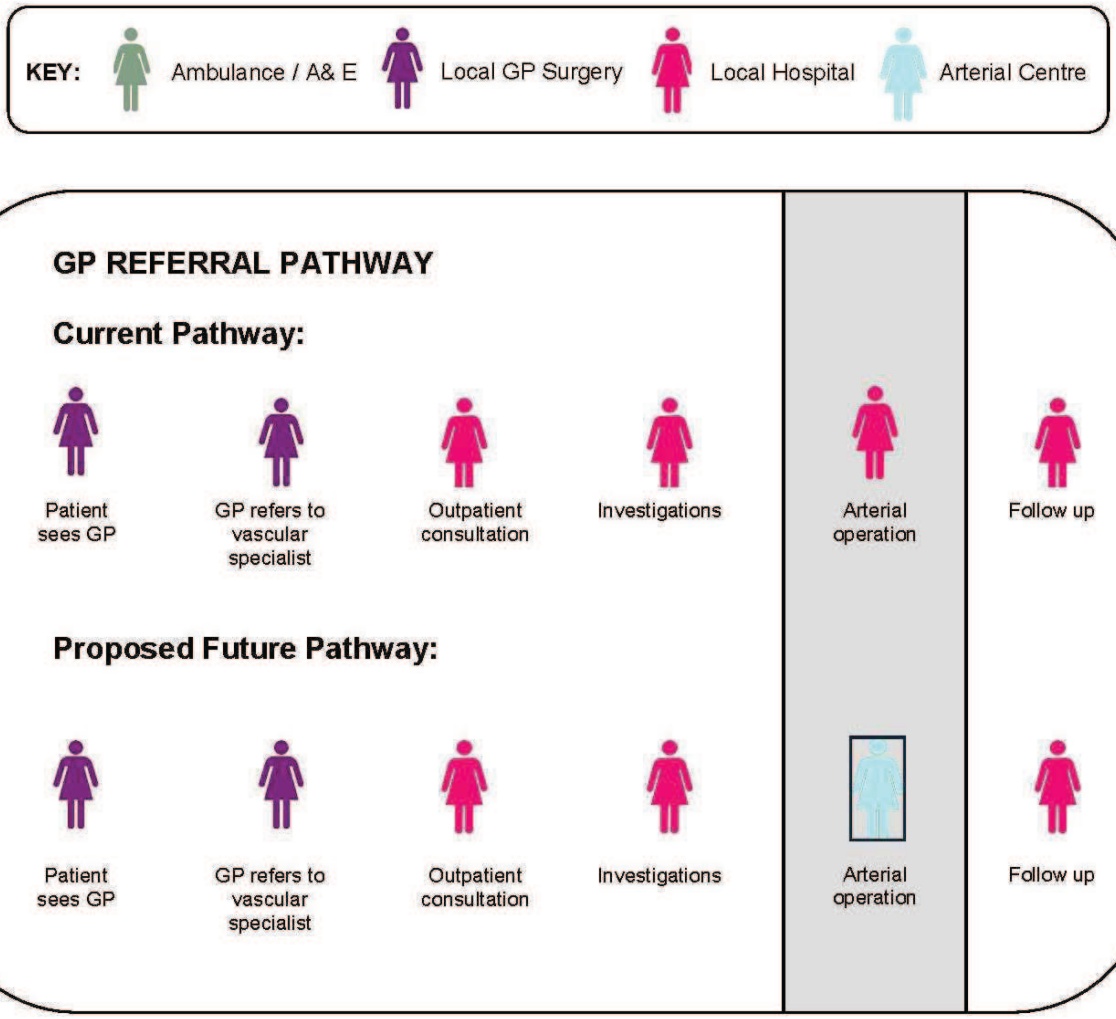
Patients will continue to be referred to their local hospital and the intention is that clinicians based at local hospitals will continue to care for their local population in both the local hospital and the arterial intervention centres.

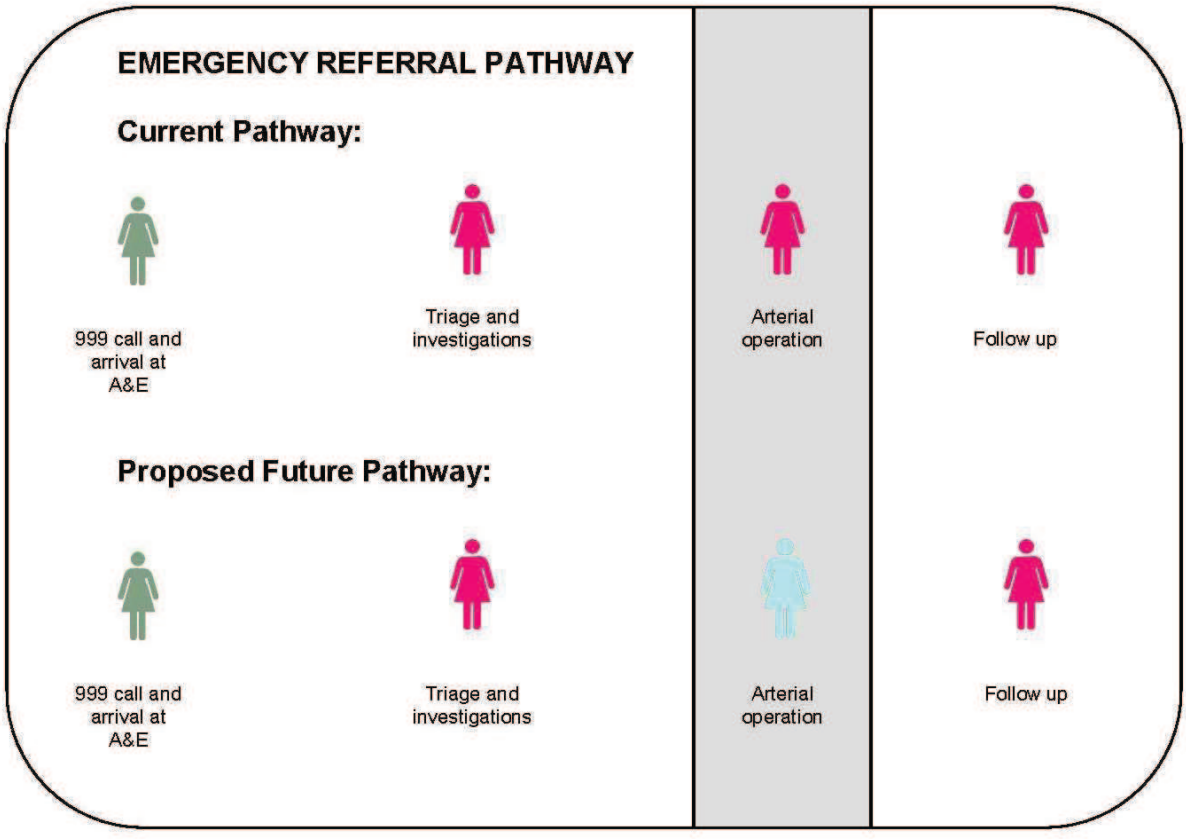
Where patients can be managed in primary care they will continue to do so. An example would be the management of patients with leg ulcers.

In order to help illustrate the type of improved experience and care that patients will receive due to the proposed changes, we have used a series of pathway diagrams.

The diagram overleaf shows elective and emergency pathways of care for patients with vascular problems. The diagram is displayed in a way which demonstrates the present pathway and the proposed future pathway.

Only one of the key steps in the pathway of care will change as a result of the proposed improvements to vascular services:


KEY:
Ambulance / A& E
Local GP Surgery
Local Hospital
Arterial Centre
GP REFERRAL PATHWAY
Current Pathway:
Patient sees GP
GP refers to vascular specialist
Outpatient consultation
Investigations
Arterial operation
Follow up
Proposed Future Pathway:
Patient sees GP
GP refers to vascular specialist
Outpatient consultation
Investigations
Arterial operation
Follow up


EMERGENCY REFERRAL PATHWAY
Current Pathway:
999 call and arrival at A&E
Triage and investigations
Arterial operation
Follow up
Proposed Future Pathway:
999 call and arrival at A&E
Triage and investigations
Arterial operation
Follow up

Section 6 - North West Ambulance Service (NWAS) Data

When a person calls 999, the call is categorised by the Trust's Advanced Medical Priority Dispatch System (AMPDS). This is the internationally recognised system that is used by the majority of Ambulance Trusts in this country. The call is then assigned one of three categories to ensure an ambulance can be allocated most appropriately. The categories used are described as follows:

- Category 'A' calls are prioritised as immediately life threatening
- Category 'B' calls are serious but not immediately life threatening
- Category 'C' calls are prioritised as neither life threatening nor serious

All ambulance services are currently measured and assessed annually on how they respond to these categories of calls against the following performance standards set by the Department of Health:

- Ambulance response within 8 minutes across 75 percent of all Category A calls
- Ambulance response (in a vehicle that can transport the patient) within 19 minutes across 95 percent of all Category A calls
- Ambulance response within 19 minutes across 95 percent of all Category B calls
- Ambulance response within 60 minutes across 95 percent of all category C calls (this is not a national target but set locally with ambulance commissioners across the North West.)

From 1 April 2011 there was a significant change to this system, both from a measurement and reporting point of view but also from an operational response perspective. New clinical quality indicators are being introduced to replace the Category B response time target and to provide a more comprehensive view of the quality of care received patients using ambulance services.

999 call categorisation:

Category 'A' call standards – in terms of response times, there is no change to Category 'A' calls. The national standard for these calls will continue to be set that 75% of calls must be reached within 8 minutes. The current Category 'A' 19 minute (95%) from request of transport standard also remains. It is recommended by the national advisory group of ambulance clinicians that Category A calls are identified within ambulance control rooms (and presented to ambulance crews) as either Red 1 or Red 2. This will help provide an even faster response to patients in cardiac arrest.

- Red 1 – ECHO codes (those normally related to breathing or respiratory difficulties) – National Standard response in 8 minutes - identified at call-

taking as calls such as cardiac arrest so an appropriate response is despatched immediately enough information is gathered as to the location.

- Red 2 – All other nationally approved Category A calls requiring a response in 8 minutes.

Category 'B' calls standards - the current Category 'B' Amber response will cease to exist from the 1 April 2011 and these calls will be integrated into the appropriate place within the Category 'C' response.

Category 'C' – this new category will include all existing Category C (or green) calls and the ones that were previously categorised as amber. All call standards will be agreed locally with commissioners.

North West Ambulance Service Performance:

The following tables shows Category A8 and A19 performance at NWAS, County and Sector Level. It is important to note that NWAS is measured (and commissioned) to achieve performance at Trust level only. For 15 consecutive months the Trust has achieved Category A8 performance. The Category A19 was missed during periods of high activity but good progress has been made in recent months. Further breakdown of the performance data is provided below.

Performance for NWAS

Month	Cat A Response	Cat A 8 Min	Cat A 8	Cat A 19
2011/12	355,739	272949	76.7%	95.5%
April	28,419	21374	75.2%	96.4%
May	29,101	21586	74.2%	96.1%
June	28,939	21474	74.2%	96.0%
July	28,797	22162	77.0%	96.3%
August	27,583	22291	80.8%	96.6%
September	28,080	21944	78.1%	95.5%
October	30,225	23401	77.4%	95.2%
November	28,560	22290	78.0%	95.7%
December	32,520	24600	75.6%	94.6%
January	30,989	24518	79.1%	96.4%
February	30,326	22938	75.6%	93.9%
March	32,200	24371	75.7%	94.4%
2012/13	165,257	128964	78.0%	95.3%
April	30,817	23776	77.2%	94.8%
May	32,788	24957	76.1%	94.2%
June	30,368	24014	79.1%	95.6%
July	31,630	25155	79.5%	96.0%
August	30,778	24116	78.4%	95.8%
Grand Total	520,996	401913	77.1%	95.5%

Performance for Lancashire

Month	Cat A Response	Cat A 8 Min	Cat A 8	Cat A 19
2011/12	76,419	60640	79.4%	96.3%
April	5,949	4680	78.7%	97.5%
May	6,011	4765	79.3%	97.0%
June	5,970	4719	79.0%	96.9%
July	6,288	5128	81.6%	97.6%
August	5,914	4979	84.2%	97.8%
September	6,012	4905	81.6%	97.0%
October	6,664	5358	80.4%	96.2%
November	6,076	4897	80.6%	96.8%
December	7,051	5381	76.3%	94.7%
January	6,701	5345	79.8%	96.7%
February	6,705	5108	76.2%	93.6%
March	7,078	5375	75.9%	94.5%
2012/13	35,569	28191	79.3%	96.2%
April	6,662	5185	77.8%	95.3%
May	6,910	5380	77.9%	95.4%
June	6,464	5177	80.1%	96.7%
July	7,027	5666	80.6%	97.0%
August	6,651	5290	79.5%	96.5%
Grand Total	111,988	88831	79.3%	96.2%

Performance for NWAS

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Grand Total	**520,996**	**401913**	**77.1%**	**95.5%**

Performance for Lancashire

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2011/12	76,419	60640	79.4%	96.3%
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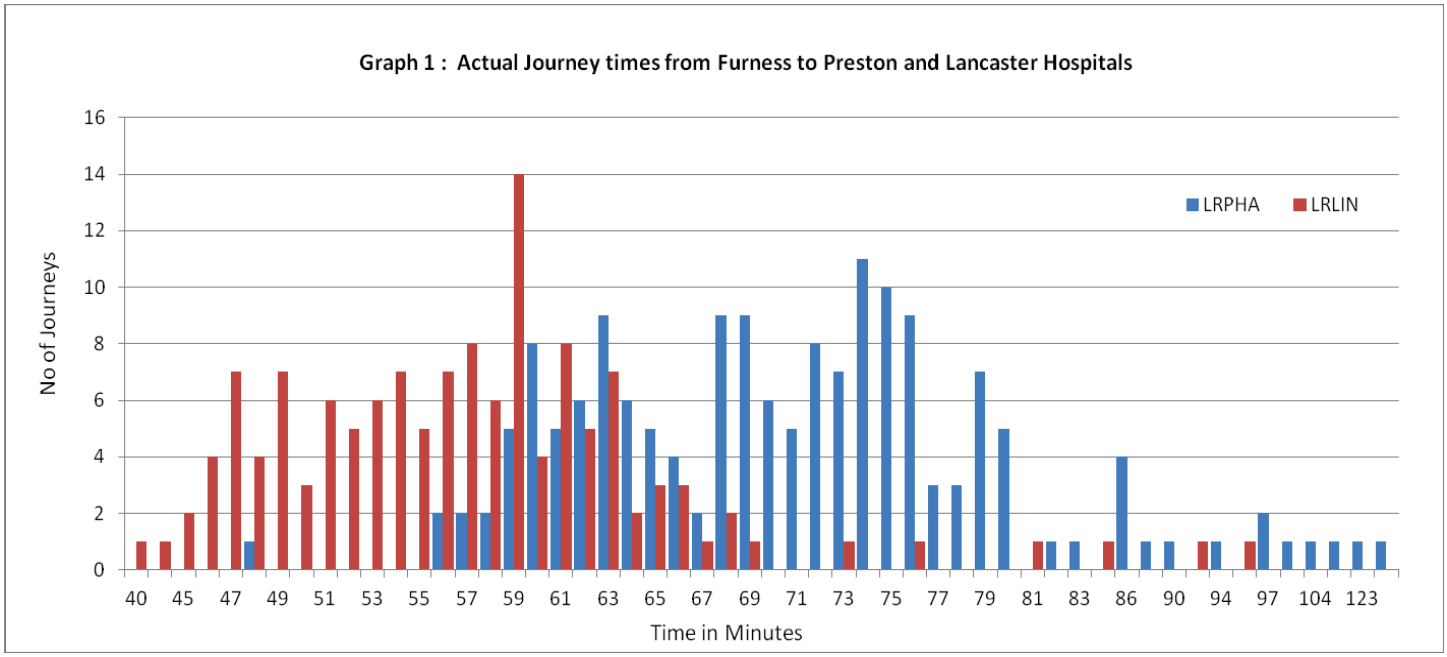
July	7,027	5666	80.6%	97.0%
August	6,651	5290	79.5%	96.5%
Grand Total	111,988	88831	79.3%	96.2%

At the request of the Joint Health Committee the Ambulance Service has provided data showing the journey times between Furness General and Royal Preston, Royal Lancaster and Cumberland Infirmary, Carlisle. Table 1 provides the average journey times. Table 2 shows the actual number of journeys for each category of call. The graph shows the actual journey times by individual time bands.

Data Period	01/01/2011 to 30/07/2013							
Table 1: Average Time (hh:mm)	**Category of Call**							
Hospital	Red Calls			GREEN				Grand Total
Preston	01:04	01:03	01:05	01:24	01:04	01:11	01:15	01:09
Lancaster	00:56		00:52	00:58	00:53	00:53	00:58	00:54
Cumberland Infirmary Carlisle			01:50				01:29	01:40
Difference from Lancaster to Preston HH:MM	00:08		00:13	00:26	00:11	00:18	00:16	00:14
Table 2: Number of Journeys	**Category of Call**							
Hospital	Red Calls			GREEN				Grand Total
Preston	7	1	52	7	7	7	20	101
Lancaster	9		38	6	6	5	20	84
Cumberland Infirmary Carlisle			1				1	2
Grand Total	**16**	**1**	**91**	**13**	**13**	**12**	**41**	**187**

Time measured is actual journey times from leaving scene to arriving hospital


Graph 1 : Actual Journey times from Furness to Preston and Lancaster Hospitals
No of Journeys
16
14
12
10
8
6
4
2
0
LRPHA
LRLIN
40 45 47 49 51 53 55 57 59 61 63 65 67 69 71 73 75 77 79 81 83 86 90 94 97 104 123
Time in Minutes

Section 7 - Scoring Criteria

The Committee asked for an explanation as to why Royal Lancaster Infirmary was marked down following a risk assessment.

The reasons why the bid was unsuccessful were:

Intensive Care and High Dependency bed capacity (Level 2 and 3 bed capacity)

University Hospitals of Morecambe Foundation Trust *(UHMBFT) were asked to provide assurances that adequate level 2 and level 3 bed capacity will be available for vascular patients. Their response was that they could not give an assurance that their level 2 and 3 bed capacity would be adequate, and stated that critical care bed capacity would need to be expanded. UHMBFT also stated that an expansion of Critical Care by this amount could precipitate a need to review the medical staffing arrangements at night due to the increased work.*

Routine monitoring of UHMBFT's medium and long term outcomes from treatment

UHMBFT were asked to provide assurance that their proposed intervention centre will routinely monitor its medium and long-term outcomes from treatment?

The evaluators assessed that the responses to questions 34a, b, c, d were insufficient and were not robust.

Risk assessment

The Service Transition Delivery risk scored was downgraded to a high risk score of 0. The reason for this considered the responses to questions 24 and 34 above and concerns that UHMB's *processes as described are likely to prove unsuccessful in transitioning the service.*

In addition the evaluators were aware of official reports by Monitor (The Independent Regulator of NHS Foundation Trusts) of 11th October 2011 and 6th February 2011 in particular relating to leadership and governance and with concern around their approach to quality governance; in particular:

Monitor Report 11th October 2011

Monitor's Board found the Trust to be in significant breach due to its failure to comply with the following terms of its Authorisation:

i) exercising functions effectively, efficiently and economically

ii) governance

iii) healthcare and other standards

Monitor Report 6th February 2012

Monitor's original concerns about governance and leadership at the trust have been reinforced by the findings of these reviews and an additional review into problems with outpatient follow-up appointments. Monitor's Board has therefore decided to intervene to strengthen the leadership of the Trust so that it can quickly fix the problems identified, for the benefit of patients

At this moment UHMBFT remains in breach of its Authorisation and Monitor continue to exercise their formal intervention powers to protect the services it provides to patients.

In addition evaluators were aware that the Care Quality Commission (CQC) had issued warning notices to UHMBFT in March 2012 in relation to a CQC investigation focusing on the emergency care pathway looking in-depth at the care patients received when they arrive at the Royal Lancaster Infirmary for emergency care, and what happened to them subsequently. These warning notices were served following inspections carried out as part of the investigation (appendix 7.1, 7.2 and 7.3).

The evaluators felt it would be negligent not to take this knowledge into account when assessing the organisational risk score of UHMBFT. Commissioners have a duty of care to provide safe and sustainable services, and are publicly accountable for their decision making.

As of September 2012 the position in relation to Monitor and CQC remains unchanged. The following documents demonstrate that UHMBTFT still faces considerable challenges:

University Hospitals of Morecambe Bay NHS
NHS Foundation Trust

Trust Headquarters
Westmorland General Hospital
Burton Road
Kendal
LA9 7RG

Tel: 01539 716695
Fax: 01539 795313
Web: www.uhmb.nhs.uk

13 September 2012

Dear colleagues

We would like to update you on developments with part two of our recovery plan - "Transforming Morecambe Bay", which will ensure that the Trust continually develops services that are safe, high quality and sustainable.

The Trust has met today with its Council of Governors to discuss these plans before we submit them to Monitor at the end of the month.

Staff across our hospitals have been working extremely hard to ensure services are safe for patients. Whilst we have made great progress, there is still a lot to do to ensure that services remain safe and sustainable in the long term. The meeting today gave the Board another opportunity to share the size of the challenge facing the Trust with the Governors and to outline how the Trust intends to deal with it.

We have always said that we would share our plans with the public, stakeholders and staff, and this is part of that process. Governors provide a critical link between our Foundation Trust members and the Board, ensuring that they can help us plan for the future and hold us to account on behalf of local people.

We have previously said, the safety of our patients must always be our priority and in order to stabilise the Trust and make services safe, we needed to spend extra money. As result of this, and additional cost pressures faced by the whole of the NHS, if we do nothing, the Trust will face a serious financial challenge. That is clearly not an option.

The plan we have shared with Governors today is the framework for the long term recovery of the Trust. It reinforces our commitment to working in collaboration with local Clinical Commissioning Groups to review services and ask for the views of staff, stakeholders and the public as the people who use and pay for our services. At the moment, we don't have a list of detailed options, these will be developed with local doctors, staff and the public. What we do have at this stage are items for future consideration such as perhaps emergency helicopter links to improve patient transfer times across Morecambe Bay.

Trust Headquarters:
Westmorland General Hospital
Burton Road
Kendal
LA9 7RG
Tel: 01539 716698

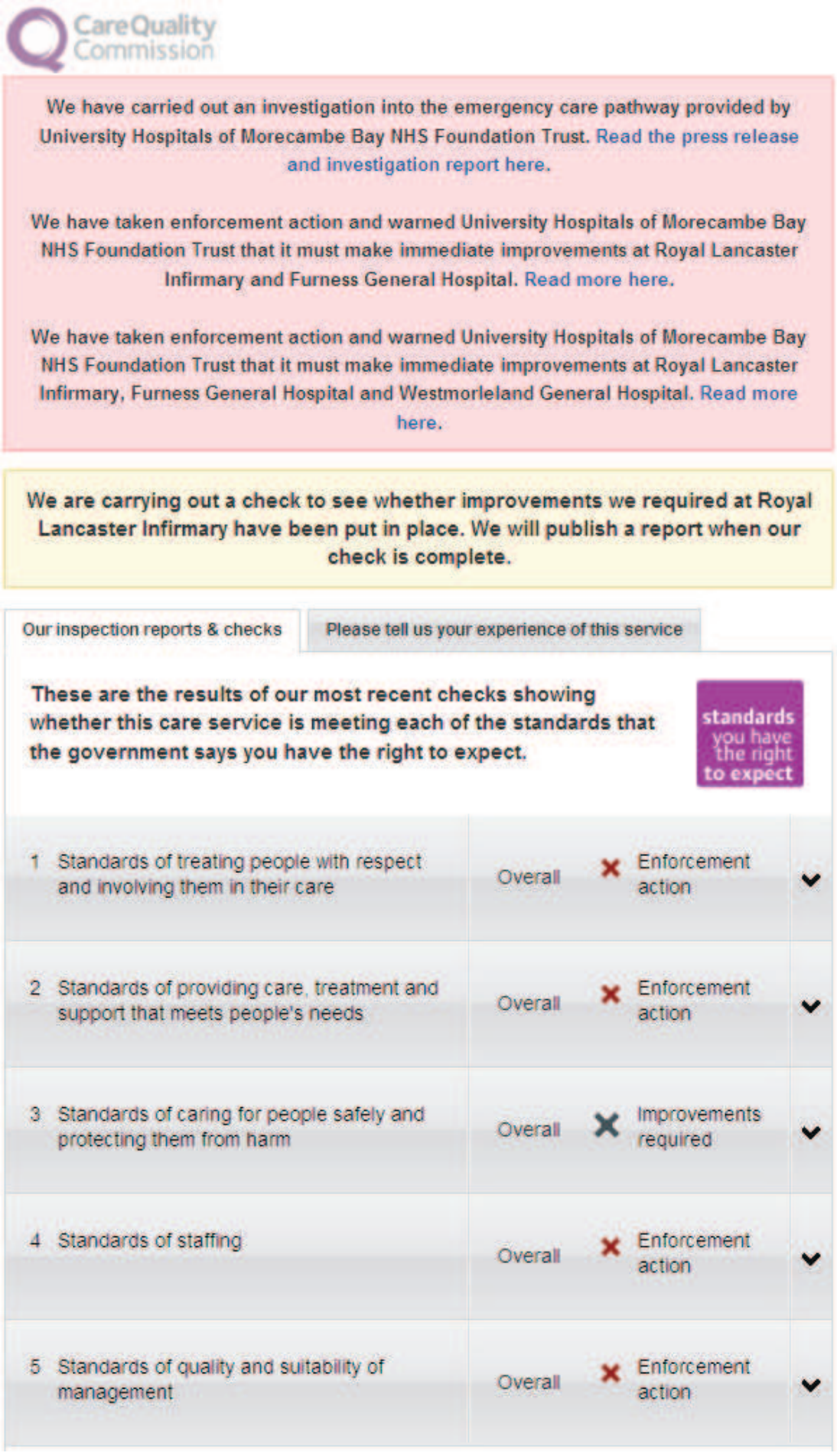
The Trust forecasts that it will take up to five years for it to return to a positive financial position, with the need to save the equivalent of £1 for every £5 it currently spends, whilst at the same time ensuring that the safety and quality of care of its patients is not compromised. We will be discussing the challenges ahead and outlining our plans at our Annual Members' meeting on Wednesday 26 September in Kendal.

We have begun to have meetings with many of our stakeholders to discuss our plans, however I am sure you will appreciate the difficulty in coordinating so many diaries. Therefore we will be arranging three regional presentations for stakeholders on our recovery plan and discuss in greater details.

Finally, we would like to take this opportunity to thank you for your continued support of our Trust. We are confident that we share the same aims of ensuring safe, high quality and sustainable services for our patients.

Yours sincerely,

Sir David Henshaw
Chair



CQC website accessed on 12/9/12

Section 8 - Patient Scenarios

In order to help illustrate the type of improved experience and care that patients will receive due to the proposed changes, we have used a series of patient scenarios.

Please find below some patient scenarios in order to help illustrate the benefits of the proposed pathways:

AAA Screening

Patient attended for AAA screening at his local health centre

- AAA was diagnosed
- Patient was listed for an EVAR
- Patient had his intervention at the Specialist Arterial Centre and was discharged the next day
- He made an excellent recovery and is now living independently

AAA Rupture

A 62 year old male patient collapsed at home and an ambulance was called

• He was taken to his local A&E where he was assessed and diagnosed with having a leaking Abdominal Aortic Aneurysm

• He was transferred directly to the Specialist Arterial Centre, who were expecting him, took him directly the state of the art vascular theatre where they repaired the aneurysm using key hole surgery

• He made a full recovery

NHS Health Checks

45 year old male patient attended GP practice for NHS Health Check

• Told he was 'at risk' of developing CVD and offered the following:
  - Referred to NHS stop smoking service
  - Personal training on physical activity
  - Free membership at a local gym
  - Weight management advice given

• Patient stopped smoking, changed his diet and started exercising

• He now maintains a healthy weight, is physically more active and eats a healthy and balanced diet. He is now at lower risk of developing CVD

Leg Ulcer

- An 80 year old lady presented with a new leg ulcer to her GP who referred her to the community vascular clinic who managed her condition locally
- Once the ulcer had healed, the patient underwent minimally invasive varicose vein surgery at her local hospital
- There was no need for the patient to be referred to a Specialist Arterial Centre. However, community nurses were supported by Specialist Vascular Nurses based at the local hospital

TIA - Weekends

"I was talking to my son early one Saturday morning and I remember this quite clearly, I was going to say something to my son and I just couldn't speak. It only lasted about 4 minutes and then I was just back to normal"

• This patient attended the A&E Department in her local DGH on the Saturday morning and was deemed to be at high risk of developing a stroke

• She was referred to the Specialist Vascular Centre for diagnostic investigations the same day

• She required a Carotid Endarterectomy and underwent her intervention on Sunday at the Specialist Vascular Centre and made a full recovery and went home the following day

Section 9 – Appendix

All documents can be accessed through the following link:

http://www.csnlc.nhs.uk/vascular/vascular_local_documents/

Number	Document Title
1.1	Vascular Review Comms and Engagement Plan
1.2	Bolton, Wigan, Lancashire and Cumbria GP Briefings October 2011
1.3	GP survey questions January 2012
1.4	GP survey finding March 2012
1.5	CTB and CCG meeting dates timeline
1.6	Confirmation of engagement with Cumbria Senate
1.7	Provider Briefings October 2011 (all areas)
1.8	Stakeholder Briefing October 2011 (all areas)
2.1	Communication and Engagement Strategy 7.12.10
2.2	Public and patient survey questions
2.3	Public and patient survey finding
2.4	Rationale for engagement vs consultation 7.11.11
4.1	Letter from Jonothan Earnshaw

4.2	The Provision of Services for Patients with Vascular Disease 2012
4.3	Public Transport Links
4.4	Patient Transport Services Criteria
5.1	Vascular Model May 2011
5.2	Vascular Service Specification
5.3	Vascular Review paper for NHS Lancashire
7.1	CQC Report Royal Lancaster Infirmary Dec 2011
7.2	CQC Report Royal Lancaster Infirmary Feb 2012
7.3	CQC UHMBFT investigation report final 2012

University Hospitals of Morecambe Bay NHS Foundation Trust

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Burton Road
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Web: www.uhmb.nhs.uk

06 September 2012

Our Ref: DH/JB

EMAIL: Janet.Soo-Chung@northlancs.nhs.uk

Dear Ms Soo Chung,

The Reconfiguration of Vascular Services in Lancashire and Cumbria
Procurement Reference 11862

Enclosed herewith is a full copy of the decision that the University Hospitals of Morecambe Bay NHS Foundation Trust intends to challenge together with all relevant earlier decisions relating to the matter. By way of this letter, please take note that we are requesting an appeal under the NHS Blackpool Dispute Resolution Process.

Background

The Vascular Clinical Advisory Group of the Lancashire and Cumbria Cardiac and Stroke Network recommended that the resident population of Lancashire and Cumbria should be provided with three vascular intervention centres, and that these should function as part of a regional clinical vascular network, providing good strategic and geographical fit for the region. It was recommended that the maximum travel time for patients to any intervention centre be 90 minutes (this being less restrictive than the national guidance that states 60 minutes). Evaluation of travelling times to existing vascular units has demonstrated that for the populations of West Cumbria (Barrow, Whitehaven and Workington) provision of service within these parameters would be challenging, and members of the Vascular Clinical Advisory Group raised concerns as to whether this was achievable with only three centres, particularly for West Cumbrian residents.

A tender bid process was instigated, initially led by NHS Blackpool, to identify suitable centres to provide all scheduled and unscheduled major vascular interventions on site, together with outreach out-patient and day surgery services at other sites within their agreed catchment area.

In November 2011 five Trusts submitted bids to provide a vascular service for defined resident populations in Lancashire and Cumbria (Procurement Reference 11862). We proposed a provision of service for a population of 760,000, to include Blackpool Fylde and Wyre, North Lancashire, South Cumbria and a small population in North Yorkshire.

As part of the tender evaluation process we were invited to give a presentation in December 2011 after succeeding to progress to Stage 2.

We understand that recommendations were approved by both Lancashire Cluster and Cumbria PCT Boards on 28 June 2012 and 4 July 2012 respectively.

On 5 July 2012 we received notification that our offer to provide services had been unsuccessful and that NHS North Lancashire/PCTs were entering into contract variations with East Lancashire, Lancashire Teaching Hospitals and North Cumbria University Hospitals Trusts to provide Vascular Intervention Centres.

A meeting was arranged for 10 August 2012 between NHS North Lancashire and the Trust to facilitate an opportunity to debrief and ask questions relating to this procurement. We had been awarded a total score of 7.73 and the winning bids were awarded 8.64, 8.12 and 8.05 out of a maximum possible of 10. All bids were deemed compliant and acceptable bids to host a Vascular Intervention Centre.

Grounds of appeal

The NHS Blackpool "Dispute Resolution Process" identifies the process to follow for appeal. There are 10 principles and rules for cooperation and competition identified in this document per the PRCC 2007 document (the references below reflect the 2007 guidance and the revised references per the latest 2010 guidance). This Trust presents an appeal against the process stating three of these principles have been breached.

- No 1 - Commissioners should commission services from the providers who are best placed to deliver the needs of their patients and population.
- No 3 - Commissioning and procurement should be transparent and non-discriminatory (2010 No 2).
- No 6 - Providers must not discriminate against patients and must promote equality (2010 No 8).

The grounds for appeal are that commissioners have contravened the above three principles by failing to follow the criteria stated, address patient safety concerns and needs of all the population and has acted in a biased and non-transparent manner, which has prejudiced and prevented the Trust from being awarded a Contract. Our case is documented as follows:

No 1 - Commissioners should commission services from the providers who are best placed to deliver the needs of their patients and population

Following the debrief meeting held with Commissioners 10 August 2012 the Trust's view is that the objectives set by the Vascular Clinical Advisory Group have not been delivered by the tendering process adopted i.e. the process was fundamentally flawed. The Trust's main concerns relate to:

(i) The tendering process was focussed upon identifying technically "suitable" vascular units with an evaluation process based on the following principles:

- The PCTs were to reject any response that were not compliant responses;
- The technical performance, risk and timing elements;
- The value for money and affordability offered.

It was not organised to secure a model of provision that fitted with the key recommendations from the Vascular Clinical Advisory Group that:

a) Each unit should cover a population of *approximately* 800,000, but recognising that some flexibility may be required to provide good strategic and geographical fit for the region;
b) There should be a maximum 90 minute transfer time to a vascular unit; and
c) That a functional regional Vascular Clinical Network was established which should seek to build on current established local clinical vascular networks to deliver good strategic and geographical fit for the region

(ii) The tendering process was materially changed in relation to the process in June 2012 (bids submitted November 2011). At the meeting of the Lancashire Cluster Board in June 2012, the Vascular Services paper stated: "Due to geographical constraints, the population served by a centre at North Cumbria University Hospitals NHS Trust will not meet the 800,000 required by Vascular Society recommendations. The Director of the National Aortic Aneurysm Screening Programme has confirmed that this centre (Cumberland Infirmary in Carlisle) will be able to be accredited". Our understanding is that the Carlisle Unit will be accredited even though it does not meet the population criteria due to the geographical challenges faced by the catchment population. This issue does not appear to have been fully considered for the West and South Cumbria population in terms of this Trust's bid.

(iii) The tendering process was materially changed in relation to the process in June 2012 (bids submitted November 2011). At the meeting of the Lancashire Cluster Board in June 2012, the Vascular Services paper stated: "Despite supplementary questions, the bids received in the south of the Network did not result in full population coverage. However, in order to progress with implementation we believe that the interventions centres must first be identified and followed by the necessary negotiations with appropriate HR and operational discussions". This represents a clear material change in relation to process, and reference to centres in the North or South highlights that there appears to have been a pre-existing desire to designate centres at polar ends of the network, despite members of the Clinical Advisory Group questioning such terminology repeatedly within meetings, with their concerns being disregarded. There appears to be failure of due consideration for the central geographical population of the network, and again this Trust's bid as "best placed to deliver the needs of their patients and population" does not appear to have been fully considered for the West and South Cumbria population, nor indeed the

populations of North Lancashire, Blackpool Fylde & Wyre, or Morecambe Bay for whom no other compliant bidder submitted proposals to provide for. There has been failure of process to consider and deliver the requisite strategic or geographical fit recommended by the Vascular Clinical Advisory Group with respect to the requirement to provide both elective and emergency care within this Vascular Network model proposal.

Based upon the above the Trust requests that the tendering process and its proposed way forward are set aside.

No 3 - Commissioning and procurement should be transparent and non-discriminatory

The Trust does not believe the process has been transparent and non-discriminatory for the following reasons:

(i) Travel times – The bids submitted in November 2011 were based upon the travel time iso-maps included in the Vascular Board's paper "Improving Vascular Services: A Case for Centralisation of Vascular Services in Lancashire and Cumbria" pages 114 – 119. These clearly show that a 90 minute transfer time, taking account of road conditions, is not delivered for our South West Cumbria population (Barrow, Millom and Langdale) by other centres except for that based at the Royal Lancaster Infirmary. At the debrief meeting held on 10 August 2012 the Trust was informed that the commissioners have reconsidered their original analysis and have provisional assurance that a Preston Centre could deliver this requirement. It is unclear how this vital issue for our population's perspective has been safely assessed in this process.

(ii) Population coverage – The Commissioners accepted at the debrief meeting that the bids provided incomplete geographical coverage based on the three centres selected. The North Lancashire, Blackpool, South West Cumbria and Morecambe Bay populations were not included in any other tender submissions deemed compliant or acceptable bids (meeting minimum scoring criteria). Despite this the Vascular Board have made recommendations for three vascular intervention centres, and this will require bidders to change their population catchment areas. The structure and robustness of the staffing of these bids has not therefore been assessed and cannot be assured. Furthermore these recommendations will break up current vascular clinical networks with no guarantee that new functional networks are deliverable, and this is specifically against the recommendations of the Vascular Clinical Advisory Group, and undermines the establishment of a functioning Regional Vascular Network. Concerns have been raised that the Bolton and Wigan vascular clinicians who agreed to participate in a combined bid with Preston clinicians (which is now likely to be dissolved as part of the current proposal), may now look to participate in a Manchester Centre not Preston or Blackburn. The Trust asserts that this is a "material change" and that the conclusions of the tender process should be set aside and reconsidered.

(iii) Scoring mechanism – The feedback including the debriefing process identified the Trust had scored zero on the Risk Assessment (service delivery plan) element. The scoring mechanism is considered at an organisational level and is as follows:

- Risk will be regarded as low (and score 4) if robust procedures are in place to initiate the service and transition it to Full Service Commencement, with such procedures both appearing reasonable and likely to achieve acceptable results.
- Risk will be regarded as medium (and score 2) if procedures are in place to initiate the service and transition it to Full Service Commencement, but these procedures have significant shortcomings, or may lead to unsatisfactory outcomes.
- Risk will be regarded as high (and score 0) if no effective procedures are in place to initiate the service and transition it to Full Service Commencement, or such processes as described are likely to prove unsuccessful in transitioning the service.

The feedback from the debriefing meeting identified the following reasons for the zero score. The Trust's questions and concerns against each are given in Table 1.

Table 1 : Scoring – Risk Assessment (Service Delivery Plan)

Commissioner reason for zero score	**Trust question/concern**
Lack of contingency plan associated with delivery plan.	Can the PCT confirm where this requirement was clearly specified in the tender request and scoring guidelines.
Critical care plan – Trust had not started to mobilise the plan.	Can the PCT confirm where this requirement was clearly specified in the tender request and scoring guidelines.
CQC and Monitor concerns/actions relating to overall governance.	Can the PCT confirm where this requirement was clearly specified in the tender request and scoring guidelines. Can the PCT also confirm their logic about how the CQC and Monitor issues are directly related to the tender submitted for vascular service provision within the context of the scoring mechanism.

The Trust requests that the above issues are reviewed and its score is re-scored. At the debrief meeting the Chair of the Panel accepted that scoring in this area was not based on wholly objective measures, but was partly "perceptual". Our view is that the score awarded was not a fair reflection in this area. On this basis the Trust's score should have been at least two, and we have estimated that this would have elevated the Trust's total score from 7.73 to 8.23 effectively placing it second in terms of overall scores for the four bids submitted. On this basis the validity of the conclusions of the tender process are flawed and should be set aside.

(iv) Tendering/scoring sub-criteria – Based upon the above analysis the Trust is concerned that there may have been other sub criteria used as part of the tendering and evaluation process that were not provided to bidders. Can the PCT confirm that there were no unpublished sub criteria used in the process. If this cannot be confirmed the tender process should be regarded as fundamentally flawed and set aside.

(v) Timescale adherence and level of disclosure - Requests for further information prior to and in support of the debrief meeting have not been disclosed in full. This included requests for information that involved our Trust and other providers as well as the process used by commissioners to reach its decision. There has been a failure to provide the detailed scores for this Trust and the output from the Equality Analysis and Impact Assessment Tool, requested prior to and after the debrief meeting. Whilst we acknowledge that certain information cannot be provided to a competitor where it is commercial sensitive our view is that the process lacks transparency.

<u>No 6 - Providers must not discriminate against patients and must promote equality</u>

(i) The population base for this tender was either not all covered or duplicated within the bids submitted. We understand that potential providers may have submitted bids for the same population base resulting in duplication. Both East Lancashire and Lancashire Teaching Hospitals have included elements of the same population in their initial bids. There is dispute amongst Vascular clinicians within the Bolton & Wigan centres that there was any agreement on their part for their populations to be represented in both bids, clinicians having only agreed to be part of the Lancashire Teaching Hospitals bid. Further there is question as to whether the East Lancashire bid did indeed have executive sign-up from all the acute provider trusts for the populations within that bid (i.e. both Bolton Hospitals and Wigan, Wrightington & Leigh Hospitals), and that if not this would call into question the validity of their bid. We request written confirmation from the PCT that there had been confirmation from respective Trusts that they had agreed to their catchment populations being included in the East Lancashire bid. Secondly the population of North Lancashire, Blackpool, Morecambe Bay and South & West Cumbria have not been addressed by any of the providers deemed appropriately compliant other than the bid submitted by the University Hospitals of Morecambe Bay NHS Foundation Trust.

(ii) There are high risk and unpredictable interventions needed each year (approximately 5-6) for the South Cumbria population, calling into question

patient safety. These interventions relate to when vascular surgeons need to attend another hospital site to intervene if another operation has run into difficulties e.g. major bleed or damage to a major vascular structure with consequent threat to life or limb. The Trust does not believe this facility will be available within a timely manner from Preston (or other proposed centres) to Westmorland General Hospital, Kendal or Furness General Hospital, Barrow in Furness.

(iii) In terms of travel times the bids submitted in November 2011 were based upon the travel time iso-maps included in the Vascular Board's paper "Improving Vascular Services: A Case for Centralisation of Vascular Services in Lancashire and Cumbria" pages 114 – 119. These clearly show that a 90 minute transfer time, taking account of road conditions, is not delivered for our South West Cumbria population (Barrow, Millom and Langdale) by other centres except for that based at the Royal Lancaster Infirmary. Deviation from the original iso-chrome maps which were the basis for the Vascular Clinical Advisory Group recommendations is a clear material change in process, yet at the debrief meeting held on 10 August 2012 the Trust was informed that the commissioners have reconsidered their original analysis and have provisional assurance that a Preston Centre could deliver this requirement. It is unclear how this vital issue for our population's perspective has been safely assessed in this process, and it appears that the Review Board have reconsidered travel assessments in an attempt to ensure that they appear satisfactory for the centres proposed, when most reasonable people with knowledge of the journey routes and adverse weather, traffic and travel conditions would deem the revised preliminary transport guidance unrealistic.

(iv) The Trust are also concerned that geographical and travel time issues do appear to have been considered in supporting other bids submissions i.e. North Cumbria University Hospitals NHS Trust, but not with respect to the University Hospitals of Morecambe Bay NHS Foundation Trust bid.

The Trust's view is that the proposals as they stand do not provide for our local population and should be set aside and reconsidered.

Proposed Resolution and Conclusion

We seek to resolve this dispute at the most local level possible and therefore are requesting an appeal under the NHS Blackpool Dispute Resolution Process. We request that the contract variations with the successful providers be set aside while you consider our appeal. Our proposed resolution would be to support a fourth intervention centre at University Hospitals of Morecambe Bay NHS Foundation Trust (Lancaster) to reflect the geography, travel time and safety issues.

We state that there have been breaches of the Principles and Rules for Cooperation and Competition in the process for determining the award of the above tender. Accordingly we request that you consider our complaint in full.

Trust Headquarters:
Westmorland General Hospital
Burton Road
Kendal
LA9 7RG
Tel: 01539 732288

CHAIR: SIR DAVID HENSHAW
CHIEF EXECUTIVE: JACKIE DANIEL

Can you please confirm to the Trust when the PCT Boards will make a definitive/final decision, a list of the Panel members who will consider this appeal and the timetable for a decision on the appeal.

The Trust is taking legal advice to proceed to judicial review in case a satisfactory resolution cannot be secured for our population. The Trust reserves the right to add to its concerns/complaints once it has received full legal advice from our advisors.

I look forward to your response in due course.

Yours Sincerely

Sir David Henshaw
Chair

UPDATE

Vascular Services Review in Cumbria & Lancashire

Joint Health Overview and Scrutiny Committee

Tuesday 22th January 2013

The Vascular Review Team made a presentation to the Joint Health Overview and Scrutiny Committee (OSC) on Tuesday 24th July 2012, concerning proposed changes to Vascular Services across Lancashire and Cumbria. Following on from this meeting a request was made by the OSC Chair asking for further clarity on a number of areas. A paper was produced and was due to be presented at the OSC meeting on 25th September. However University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) submitted an appeal to NHS Lancashire, and in order to not prejudice the appeal it was decided by the OSC Chair that the meeting should be postponed.

The appeal was reviewed and considered by a Local Dispute Resolution Panel appointed under the PCT's Dispute Avoidance and Resolution Process, connected to the Principles and Rules for Co-operation and Competition. Following consideration of the evidence the Panel found the procurement process to adhere to the standards expected and to be fair, robust and transparent. The appeal, which challenged the procurement process has not been upheld. Please see appendix A at the end of the briefing paper for the executive summary of the Panel's decision and findings.

Following the Panel's decision we have been asked to return to the OSC to give a further update to members about the progress of the Vascular Services Review across Lancashire and Cumbria. The paper that was due to be presented to the OSC on 25th September has been circulated to all members and provides background to the review as well as supporting evidence demonstrating public engagement and the rationale behind the review that will improve patient outcomes.

Since the publication of this paper there have been significant changes in the arrangement of vascular services nationally and from April 2013 it has been announced that commissioning of arterial vascular services will become solely the responsibility of specialised commissioners at the NHS Commissioning Board. Services will be commissioned against a national service specification. It is expected that around 50 hospitals nationally will be commissioned to deliver vascular arterial services. These services can no longer be seen as part of a standard district hospital's provision of services.

Evidence shows that the best outcomes are achieved by implementing specialist Arterial Centres with dedicated vascular teams available 24 hours a day, seven days a week. Arterial Centres have already been successfully implemented in other parts of the country and have greatly improved patient outcomes. Two out of three patients who would have died from an Abdominal Aortic Aneurysm (AAA) repair in hospital now survive as a result of implementing Arterial Centres. The evidence suggests that it is in the best interests of patients that hospitals collaborate together as a cohesive Vascular Network. This is supported by the Vascular Society of Great Britain and Ireland (VSGBI), the National Confidential Enquiry into Post Operative

Deaths (NCEPOD), and the joint All-Party Parliamentary Group (APPG) for Cardiovascular Disease, which included the APPG for Vascular Disease.

The Vascular Services Review in Lancashire and Cumbria was developed and led by the Vascular Clinical Advisory Group (VCAG), made up of clinicians from all Network hospitals and included the valued input of clinicians from UHMBT. The VCAG recommended to commissioners the development of a Vascular Network with the implementation of three Arterial Centres across the Network. This proposed Vascular Network will see complex vascular surgery carried out in future at one of three specialist Arterial Centres: Cumberland Infirmary in Carlisle, Royal Preston Hospital and Royal Blackburn Hospital.

The new Cumbria and Lancashire Vascular Network will work closely with the NHS National Abdominal Aortic Aneurysm Screening Programme (NAAASP), with the first patients being screened in January 2013.

The Cumbria and Lancashire programme will cover the populations of Blackburn with Darwen, Blackpool, Central Lancashire, Cumbria, East Lancashire and North Lancashire; a total of approximately 2.1 million people. Men are more likely to suffer from an abdominal aortic aneurysm and therefore each year approximately 13,500 men aged 65 will be invited for abdominal aortic aneurysm screening at community venues across the region. It is expected that men who are found to require treatment for an abdominal aortic aneurysm will be referred into the Vascular Network and if major surgery is required, this will take place in one of the Network's three Arterial Centres.

The new Screening Programme will greatly reduce the number of deaths across Cumbria and Lancashire through early detection, monitoring and treatment of abdominal aortic aneurysms. This means that the number of patients that will actually need specialist inpatient vascular surgery will be very small. It is expected that the number of patients presenting requiring an emergency aneurysm repair is likely to fall to just two or three cases a year from the South Cumbria area over the next ten years.

Furthermore patients will not need to travel to a hospital to be screened as they can be screened locally in the community, including in rural areas. Along with the Vascular Network this is an excellent opportunity to deliver improved, safer services with better patient outcomes across Cumbria and Lancashire.

The benefits to patients of the Screening Programme and the Vascular Network include the lowest possible mortality rates, quicker and trouble-free rehabilitation and recovery, and improved independence and quality of life. The majority of services, such as screening, outpatient clinics, day case surgery, diagnostic tests and rehabilitation services will be enhanced and continue to be delivered locally. Patients will be supported in the community to manage their condition and to prevent the development of more serious disease. These patient-centred services will be delivered across the whole of Cumbria and Lancashire, including rural areas.

However if patients have more serious arterial problems, the aim will be to refer them to their GP, local hospital, or to one of the three specialist Arterial Centres. These specialist centres will allow Vascular Teams to collaborate across the region to provide patients with the best possible care using the latest surgical advances and technology.

We believe this is an exciting new development with a focus on keeping patients well, and giving them access to a wider range of services - some closer to home and others situated in centres of real expertise. We are confident that the implementation of the Vascular Network will be extremely beneficial to patients in Cumbria and Lancashire.

We look forward to working with all Trusts across the Lancashire and Cumbria Vascular Network to develop a service that is in the best interests of all vascular patients across region.

Appendix A

Blackpool PCT

Local Dispute Resolution Panel: Vascular Services Review

EXTRACT FROM THE DECISION

Contents:

- **Background**
- **The Panel**
- **Summary of Decision**
- **Framework for Decision**

Blackpool PCT Local Dispute Resolution Panel: Vascular Services Review

DECISION

Background

Blackpool PCT on behalf of North West PCTs has constituted a Local Dispute Resolution Panel (the "Panel") constituted in accordance with Blackpool PCT's Dispute Avoidance and Resolution Process for complaints connected to the Principles and Rules for Co-operation and Competition ("the Disputes Process") in order to consider a complaint made by University Hospitals of Morecambe Bay NHS Foundation Trust ("the FT") in their letter of 6 September 2012 (Annex 3) and supplemented by a further letter of 19 November 2012 (Annex 4)

Blackpool PCT ("the PCT") on behalf of the other PCTs in the Lancashire PCT Cluster undertook the commissioning process for the review and selection of providers of Vascular Services in Lancashire and Cumbria in order to form a Vascular Network and Centralised Intervention Centres. Blackpool PCT is therefore the PCT to whom the complaint raised by the FT is directed.

Annex 1 sets out minutes of the meeting at which the complaint was accepted for consideration by the Panel and the basis upon which the Panel was constituted. The Panel so constituted and supported and resourced as set out in the minutes at Annex 1 met on 23 November to consider the complaint raised by the FT and has reached a decision as set out in this Decision.

The Panel

Chair of Panel – Roy Fisher (Non Executive Director of the PCT appointed by the NHS Lancashire Cluster Chair)("the Panel Chair")

Member - David Bonson (PCT Director of Commissioning)

Member - David Wharfe (senior manager not previously involved with the matter under dispute)(Director of Finance of NHS Lancashire Cluster).

Summary of Decision

The Panel determined as follows:

- The Panel found that the procurement process had in all material respects satisfied the requirements of Principle 2 of PRCC;

- The Panel recommended additional debrief be provided to the FT as set out below in the "Detailed Findings" of this Decision;

- The Panel determined that the procurement process had been conducted in a manner consistent with Principle 1 of PRCC ; and

- The Panel determined that the procurement process had been conducted in a manner consistent with Principle 8 of PRCC.

Framework for Decision

General

The complaint by the FT has been made on the basis that the process for the review and selection of providers of Vascular Services in Lancashire and Cumbria infringed the 3 Principles set out in the Principles and Rules for Cooperation and Competition ("PRCC"). Described below in this section. Throughout this Decision we have referred to the Principles as described and numbered in the 30 July 2010 publication of PRCC. The FT's letters refer to principles as numbered in a previous superseded edition of PRCC.

In a number of cases the Panel considered that issues raised by the FT had been misclassified against the incorrect Principle, or could be made with greater force in respect of one of the other Principles. In such cases the Panel read in to the FT's complaint that the issues were being raised in respect of the most pertinent Principle.

The Panel only has the remit under the Disputes Process to consider issues connected to the PRCC. Therefore to the extent that other concerns have been raised in the FTs letter the Panel has referred such concerns to the correct organisation for their consideration. In particular the Panel has no remit to consider issues relating to Public Engagement and Consultation.

Principle 2: *Commissioning and procurement must be transparent and non – discriminatory and follow the Procurement Guide issued in July 2010.*

The full Principle is set out at Annex 2. This is referred to as Principle 3 in the FT's letters.

The Panel has considered in summary whether:

1. a fair and transparent process been run?

2. the stated process has been followed?

3. the Procurement guide for commissioners of NHS-funded services been followed?

Principle 1: *Commissioners should commission services from the providers who are best placed to deliver the needs of their patients and population.*

The full Principle is set out at Annex 2.

The Panel has sought to judge the complaints raised by applying a cost/benefit appraisal, balancing (in qualitative as well as quantitative) terms:

1. cost: possible adverse effects of patients and taxpayers (including both financial and non-financial impacts) arising from any loss of patient choice or competition stemming from the conduct under consideration.

2. benefit: benefits to patients and taxpayers that arise from the conduct under consideration.

Principle 8: *Commissioners and providers must not discriminate unduly between patients and must promote equality.*

The full Principle is set out at Annex 2. This is referred to as Principle 6 in the FT's letters.

The Panel has sought to judge the complaints raised by applying a cost/benefit appraisal, balancing (in qualitative as well as quantitative) terms:

3. cost: possible adverse effects of patients and taxpayers (including both financial and non-financial impacts) arising from any loss of patient choice or competition stemming from the conduct under consideration.

4. benefit: benefits to patients and taxpayers that arise from the conduct under consideration.

Joint Lancashire Health Scrutiny Committee
Meeting to be held on 22 January 2013

Electoral Division affected:
All

Dementia Care Services Consultation - update

Contact for further information:
Wendy Broadley, 07825 584684, Office of the Chief Executive,
wendy.broadley@lancashire.gov.uk

Executive Summary

Janice Horrocks from the Lancashire Mental Health Commissioning Network Team will attend the meeting to provide members with a verbal update on the progress of the consultation on dementia care services that began on 3 December 2012, and to discuss the 'sign off' process.

Recommendation

The Joint Health Scrutiny Committee is asked to consider the next steps following the conclusion of the consultation period.

Background and Advice

At the Joint Health Committee on 13 November 2012 officers from the Lancashire Mental Health Commissioning Network Team gave a short presentation about the consultation on dementia care services that was to begin on 3 December 2012 and run to 25 February 2013. Much pre-consultation work had already been carried out. A diagram which set out visually the background, the current position and two options for future provision to be consulted upon was presented. The Trust's preferred option was Option 1. A copy of the diagram can be found appended to the minutes of the meeting held on 13 November 2012, which can be accessed via the following link:

http://council.lancashire.gov.uk/ieListDocuments.aspx?CId=684&MId=2035&Ver=4

There would be 16 public events starting in January 2013 across Lancashire at various locations and at various times. These would be advertised in local newspapers, on local radio and there would be posters in GP practices and libraries. People would be given a range of ways by which to contact the Trust and assistance would be provided if necessary. The Trust also stated that additional meetings with community based groups would also take place if requested.

Part way through the consultation independent experts at UCLAN (University of Central Lancashire) would conduct a check on the demographics of the responses to that point and, if necessary, under-represented groups would be targeted as

Lancashire County Council

appropriate. At the end of the consultation UCLAN would produce a report for the LCFT on all responses. This Committee would be informed of the outcome.

Janice Horrocks, a consultant within the Network Team will attend the meeting to provide members with a verbal update on the progress of the consultation and discuss the process for 'signing off' the final proposals.

Consultations
N/A

Implications:
This item has the following implications, as indicated:

Risk management
There are no risk management implications arising from this report.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Directorate/Tel

Reason for inclusion in Part II, if appropriate