Appendix 'A'

Vascular Services Review in Cumbria & Lancashire

Joint Health Committee
Tuesday 25th September 2012

Contents

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).

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Clinical Commissioning Group

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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:

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%

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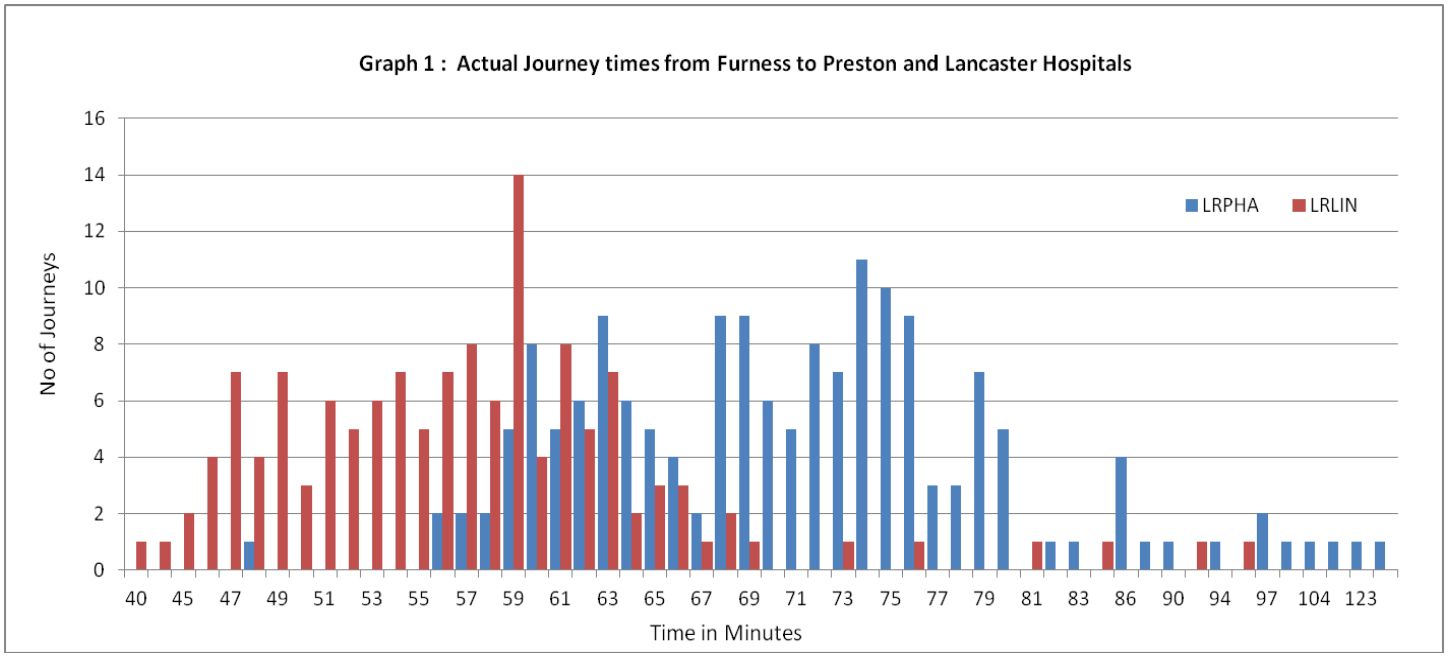
December	7,051	5381	76.3%	94.7%
January	6,701	5345	79.8%	96.7%
February	6,705	5108	76.2%	93.6%
March	7,078	5375	75.9%	94.5%
2012/13	35,569	28191	79.3%	96.2%
April	6,662	5185	77.8%	95.3%
May	6,910	5380	77.9%	95.4%
June	6,464	5177	80.1%	96.7%
July	7,027	5666	80.6%	97.0%
August	6,651	5290	79.5%	96.5%
Grand Total	111,988	88831	79.3%	96.2%

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.

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

We have carried out an investigation into the emergency care pathway provided by University Hospitals of Morecambe Bay NHS Foundation Trust. Read the press release and investigation report here.

We have taken enforcement action and warned University Hospitals of Morecambe Bay NHS Foundation Trust that it must make immediate improvements at Royal Lancaster Infirmary and Furness General Hospital. Read more here.

We have taken enforcement action and warned University Hospitals of Morecambe Bay NHS Foundation Trust that it must make immediate improvements at Royal Lancaster Infirmary, Furness General Hospital and Westmorleland General Hospital. Read more here.

We are carrying out a check to see whether improvements we required at Royal Lancaster Infirmary have been put in place. We will publish a report when our check is complete.

Our inspection reports & checks | Please tell us your experience of this service

These are the results of our most recent checks showing whether this care service is meeting each of the standards that the government says you have the right to expect.

standards you have the right to expect

1 Standards of treating people with respect and involving them in their care	Overall	✖	Enforcement action
2 Standards of providing care, treatment and support that meets people's needs	Overall	✖	Enforcement action
3 Standards of caring for people safely and protecting them from harm	Overall	✖	Improvements required
4 Standards of staffing	Overall	✖	Enforcement action
5 Standards of quality and suitability of management	Overall	✖	Enforcement action

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