Supplementary Information – Scrutiny Board (Health), 25th May 2010

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The Leeds Teaching Hospitals NHS Trust

Foundation Trust costs - summary briefing

We are aiming for Leeds Teaching Hospitals NHS Trust to be a Foundation Trust because we believe that the structures and processes associated with becoming an FT will help us to make improvements in quality and efficiency for patients and the public. At present there is no indication that the new Government will change the policy established previously that all Trusts are required to become FTs.

We have already seen our strategic and business planning processes strengthened as a result of the regime we are moving towards, and we expect to be able to continue making improvements. There are some costs associated with new structures but based on the experience of Trusts which have already become FTs, additional financial investment is regarded as having added value in relation to governance, accountability, and local involvement.

Costs to date
Foundation Trust (FT) preparedness programme, consultation and membership recruitment activity so far has been carried out using current processes or within existing budgets, e.g. use of patient mailings to carry membership invitations; consultation activity managed by communication staff or funded from within current budgets.

Projected costs
There are significant projected costs associated with the application process and development of our membership, including:

Application
Legal and professional fees required to draft and have approved an FT Constitution, and development of Trust structures and processes to meet regulatory and inspection assessment criteria

Membership
Members are not paid but costs will be incurred:

- Recruiting 15,000 public membership
- Creation of a database, and administration associated with membership
- Communications with public and staff members

Governors
Governors are not paid, although their expenses are reimbursed, and costs will be incurred for Governor recruitment, development and support

Elections
Elections are required by Monitor and under the current regulations, costs will be incurred for the Independent administration of elections.

Staff and operational costs
Costs associated with application process; ongoing support for FT management and administration.

Notional staff and non-staff costs in the current financial year are estimated to be in the region of £130k

LTHT
May 2010

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Agenda Item 9

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 25 May 2010

Subject: Renal Services in Leeds: Supplementary Report

Electoral Wards Affected:	**Specific Implications For:**
	Equality and Diversity ☐
	Community Cohesion ☐
☐ Ward Members consulted (referred to in report)	Narrowing the Gap ☐

1.0 Purpose of this Report

1.1 Following the Leeds Teaching Hospitals NHS Trust (LTHT) Board meeting held on 20 May 2010, the purpose of this report is to present the Scrutiny Board (Health) with an outline of some of the issues discussed and a summary of the decision regarding the provision of renal services in Leeds

2.0 Background

2.1 Issues associated with the provision of renal services in Leeds have been a significant consideration over the course of the current municipal year, which resulted in the production of a formal Scrutiny Board statement in December 2009.

2.2 At its meeting on 16 March 2010, the Scrutiny Board (Health) considered the formal response to its statement and recommendations on renal services, and were advised that the Trust Board was due to reconsider its position regarding the proposed dialysis unit at Leeds General Infirmary (LGI).

2.3 At that meeting, the Scrutiny Board (Health) agreed to review the Trust's Board final decision and consider any available and appropriate actions.

3.0 Report Issues

LTHT Board meeting – 20 May 2010

3.1 The LTHT Board met on 20 May 2010 and, as part of the scheduled agenda, considered a report regarding the Renal Haemodialysis Service (attached at Appendix 1). In addition, after the publication of the meeting agenda and the attached report, the following supplementary information was provided to Trust Board members:

- Renal Services - transport supplementary briefing (Appendix 2)
- Travel analysis – commissioned by the Kidney Patients Associated (KPA) (Appendix 3)

3.2 It should be noted that while this information was not formally submitted and considered at the Trust Board meeting, it is provided to the Scrutiny Board for completeness.

3.3 In addition, given the issues previously raised regarding patient transport data (as highlighted in Appendix 2), further assurance has been sought from Yorkshire Ambulance Service (YAS), regarding the information generated to inform the Trust Board's report. The response from YAS is provided at Appendix 4 for the Scrutiny Board's consideration.

3.4 In considering the information provided in Appendix 1, the Trust Board recognised its previous commitment, noted the concerns raised by the KPA and the Scrutiny Board (Health), and considered the conclusions of the regional Specialised Commissioning Group (SCG) in developing the regional strategy for renal services.

3.5 The Trust Board also received assurances from the Medical Director and the Chief Nurse regarding the safety and quality of renal services currently being provided in Leeds. Specific comments raised by members of the Trust Board included:

- Potential use of Wharfedale Hospital to deliver a satellite dialysis services: *The Trust Board was advised that the optimum size for such a unit would be 8 –10 dialysis stations, however this option had been discounted due to there being insufficient need.*
- Clarification of the number of patients likely to be affected by not providing dialysis facilities at LGI: *The Trust Board was advised that the number of patients likely to be directly affected was between 21 and 45. The Trust Board was further advised that at the time of the closure of the Wellcome Wing in 2006, 90 patients had been receiving their care at LGI – of which 25 were still receiving haemodialysis care.*
- Recognition of the Trust's responsibility to the wider community, in the context of a finite budget and the advice provided by the Medical Director and Chief Nurse regarding the safety and quality of current services.

3.6 Furthermore, the Chair of the Trust Board recognised that consultation arrangements, specifically related to renal services and the decision under consideration, had not been good enough and specifically requested a formal report from the Trust's Chief Executive on how improvements would be made around mechanisms to consult patients – specifically with regard to renal patients and more broadly.

3.7 As such, the Trust Board agreed to support the recommendations set out in the report presented (i.e. Appendix 1).

<u>Scrutiny Board involvement</u>

3.8 Over recent years, various aspects associated with the provision of renal services in Leeds have been significant considerations for the Scrutiny Board. Over the past 12 months or so, a number of issues have been re-examined in detail and new issues identified. This process has involved a full range of interested parties – both locally and regionally, and resulted in the production of a formal Scrutiny Board statement in December 2009.

3.9 At its meeting on 16 March 2010, the Scrutiny Board (Health) considered the formal response to its statement and recommendations on renal services. At that meeting, the Scrutiny Board agreed to review the Trust's Board final decision regarding the proposed dialysis unit at Leeds General Infirmary (LGI) and consider any available and appropriate actions.

Overview and Scrutiny of Health

3.10 Guidance produced by the Department of Health[1] sets out the responsibilities and powers associated with the legislation associated with scrutiny of the NHS by local authorities: It specifically addresses the duty placed on NHS organisations to consult appropriate local authority overview and scrutiny committees on any substantial change or development of local NHS services. In summary, the guidance outlines that:

- Where a NHS trust plans to vary or develop services locally, it should discuss the proposal with the overview and scrutiny committee to determine whether the proposal is substantial. If the outcome of those discussions is that it is a substantial development or variation, the trust must formally consult the overview and scrutiny committee.
- In considering whether proposals are substantial, NHS bodies, committees and stakeholders should consider the general impact of the change upon patients, carers and the public who use or have the potential to use a service.

Referrals to the Secretary of State

3.11 The legislation that governs health overview and scrutiny makes provision for the referral of some issues to the Secretary of State (for Health) under certain circumstances. All circumstances relate to substantial changes or developments of local health services and relate to the consultation on proposals or the impact of the proposals being deemed as not in the interests of local health services. Further information on circumstances that may lead to such referrals, and subsequent action are detailed below.

Consultation on proposals

3.12 A committee may report an issue to the Secretary of State (in writing) where is not satisfied with the content of the consultation, does not believe sufficient time has been allowed or that the reasons given for not carrying out consultation are inadequate. Any such referral should make clear the grounds on which the committee has reached its conclusion. It should be noted that, in the context of inadequate consultation, the referral power for overview and scrutiny committees only relates to the consultation with the committee by the NHS and not consultation with other stakeholders.

3.13 On receiving such a referral, the Secretary of State may require the local NHS body to carry out such consultation (or further consultation) with the committee as considered appropriate. Where any such consultation has been required by the Secretary of State, the local NHS body shall, having regard to the outcome of such further consultation, reconsider any decision it has taken in relation to the proposal in question.

Interests of the health service

[1] Overview and Scrutiny of Health Guidance (July 2003)

3.14 Where a committee considers that the proposal is not in the interests of the health service in its area, it may refer the issue to the Secretary of State in writing who may make a final decision on the proposal. In such cases, the Secretary of State can require the NHS body to take such action or stop taking such action as may be directed.

3.15 Referrals on the basis of a proposal not being in the interests of the health service should also set out the grounds on which the committee has come to that conclusion.

3.16 Where a referral has been made, the Secretary of State may ask the Independent Reconfiguration Panel (IRP)[2] to advise on the matter. The IRP will wish to be satisfied that all options for local resolution have been fully explored. Only those contested proposals where it is clear that all other options have been exhausted are likely to be considered in detail by the panel. In these cases, the IRP may visit the local NHS body and will also consider the report and recommendations from the overview and scrutiny committee as part of its work.

Council Resolution

3.17 In considering the issues outlined in this report, members of the Scrutiny Board are also reminded of the following Council resolution from the meeting held on 21 April 2010:

> *'That this Council condemns the failure of the Leeds Teaching Hospitals Trust to fulfil its repeated promises to fund a City Centre Kidney Dialysis Unit at the Leeds General Infirmary.*
>
> *Council notes that since 2006 the City Centre has been without this vital health facility and has every sympathy with those patients who have to make time consuming journeys to receive this essential treatment at Seacroft and St James' Hospitals.*
>
> *Council praises the good work done by Scrutiny Board Health on this issue and instructs the Chief Executive of Leeds City Council to write to the Secretary of State for Health to ask him to reconsider his decision not to intervene in this matter.'*

3.18 On this basis, the Council's Chief Executive wrote to the Secretary of State for Health on 26 April 2010. However, it should be noted that, due to the timing of the Council meeting, the Trust's final decision was unknown at this time.

4.0 Summary

4.1 In setting out the recent decision of the LTHT Board, this report presents a range of information both publicly available and made available to the Trust Board to inform its decision. It also provides supplementary information provided by YAS in terms of the transport analysis commissioned by LTHT.

4.2 The report also sets out some of the legislative provisions associated with the scrutiny of the NHS – specifically around the circumstances where the Board may legitimately refer matters to the Secretary of State.

[2] The IRP is an advisory non-departmental public body. It has a chair and members drawn equally from health service professionals, health service managers and patients and citizens. The panel provides advice to ministers on proposals for NHS change in England that have been contested locally and referred to the Secretary of State

4.3 In considering the matters set out in this report, and if so minded to make a referral to the Secretary of State the Scrutiny Board are advised that:

- The power of referral to the Secretary of State should not be used lightly;
- Any referral that involves the engagement of the IRP is likely to cost several thousands of pounds and take a number of months to fully resolve;
- In considering whether a proposal is in the interests of the local health service, the board should consider the extent to which patients, the public and stakeholders more widely have been involved in the planning and development of the proposal;
- Only by full involvement activity will local NHS bodies be able to take a considered view as to whether its plans are in the interests of the local health service;
- Where possible, local resolution of issues is always preferable and a clear rationale will need to be identified and presented with any such referral. This will need to demonstrate that all avenues for locals resolution have been explored.

5.0 Recommendation

5.1 Members of Scrutiny Board are asked to consider the information presented in this report and determine any action appropriate deemed appropriate.

6.0 Background Papers

- Scrutiny Board (Health) – Renal Services report – 28 July 2009
- Scrutiny Board (Health) – Renal Services report – 24 November 2009
- Scrutiny Board (Health) – Renal Services report – 15 December 2009
- Renal Services in Leeds – Scrutiny Board statement (December 2009)
- Scrutiny Board (Health) – Renal Services in Leeds – Response to the Scrutiny Board's statement and recommendations – 16 March 2010
- Scrutiny Board (Health) – Renal Services in Leeds: Update – 25 May 2010
- Overview and Scrutiny of Health Guidance – Department of Health, July 2003

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APPENDIX 2

The Leeds Teaching Hospitals NHS
NHS Trust

Renal Services - transport supplementary briefing

This briefing is intended to support information in the Leeds Teaching Hospitals NHS Trust paper presented to the Trust Board meeting on 20 May 2010. Copies of the tables included in this paper were provided to representatives of the LGI Kidney Patients Association (KPA) at a briefing meeting on 17 May 2010 and an explanation of the methodology was given.

The Yorkshire Evening Post on Monday 17 May quoted a kidney patient representative who dismissed information in our Board report about transport because it was based on "discredited information". We believe it is important to make clear that our report is based on new data which has been assured by the Yorkshire Ambulance Services (YAS). We are aware that the organisation previously withdrew information presented to the Scrutiny Board that was inaccurate but the information in these tables has been checked and provided under the authority of the Operations Director of the Patient Transport Service, Sarah Fatchett.

The tables provide some examples of travelling times for patients who travel via YAS from their home in the LS21 postcode area to Seacroft Hospital. The average travelling time from LS21 to Seacroft Hospital in the examples provided is 36 minutes. The average return journey time in the examples provided is 39 minutes. These examples are based on actual journeys undertaken by renal patients.

Further examples are provided based on the journey times from Leeds General Infirmary to LS21. The average journey time in the examples provided is 34 minutes. These examples are based on a random selection of patients (non renal patients) who travel to and from LS21 and Leeds General Infirmary.

For a number of patients the travelling journey will be longer as the journey may include a number of 'pick ups' and 'drop offs' of other patients. Between 2 and 3 pick ups or drop offs would not be unusual for some journeys. The tables provide examples of the potential travelling times for patients who experience pick ups and drop offs. The average travelling time to Seacroft Hospital is 56 minutes. The average return journey time in the examples provided is 54 minutes. These examples are based on actual journeys undertaken by renal patients.

Further examples are provided based on the journey times from the sample Leeds postcodes to Leeds General Infirmary. The average journey time in the examples provided is 50 minutes. The average return journey time in the examples provided is 52 minutes. These examples are based on a random selection of patients (non renal patients) who travel to and from Leeds General Infirmary.

It must be noted that these journey times represent a random selection only. Each individual patient experience will be unique. The sample of journey times are included to provide a general guide relating to the difference in travel time that patients may experience.

LTHT
May 2010

Example of Travel Times to Seacroft Hospital and LGI from Leeds 21 Postcode - Direct Route

From	To	Pick up time	Drop off time	Actual Minutes
Actual Renal Patients				
LS21	Seacroft	6.39	7.17	38
LS21	Seacroft	7.33	8.11	38
LS21	Seacroft	12.38	13.09	31
LS21	Seacroft	12.37	13.11	34
LS21	Seacroft	12.31	13.09	38
LS21	Seacroft	12.29	13.07	38
Seacroft	LS21	16.25	16.59	34
Seacroft	LS21	18.44	19.17	33
Seacroft	LS21	18.41	19.23	42
Seacroft	LS21	18.26	18.59	33
Seacroft	LS21	18.30	19.18	48
Seacroft	LS21	18.41	19.23	42

In the examples provided the average travelling time from Leeds 21 to Seacroft Hospital is 36 minutes

In the examples provided the average travelling time from Seacroft Hospital to Leeds 21 is 39 minutes

Patients to/ from LGI (randomly selected)

LS21	LGI Clarendon	8.40	9.12	32
LGI Clarendon	LS21	11.11	11.43	32
LGI Clarendon	LS21	11.50	12.34	44
LGI Brotherton	LS21	11.35	12.07	32
LGI Clarendon	LS21	12.15	12.42	27
LGI Brotherton	LS21	14.36	15.15	39

In the examples given the average travelling time from Leeds General Infirmary to Leeds 21 is 34 minutes

All journey examples are direct journeys and do not include other drop offs or pick ups
All information taken off the Yorkshire Ambulance Service Cleric Database
Full postcodes are available, these have not been included to prevent any potential identification of patients

Example of Travel Times to Seacroft Hospital and LGI from a selection of Leeds postcodes - Drop Off's or Pick Ups

Actual Renal Patients

From	No of Pick Ups	To	Pick up time	Drop off time	Longest Journey Time
LS19/LS21	2	Seacroft	13.20/13.30	14.07	47
LS19/LS21/LS21	3	Seacroft	12.21/12.32/12.32	13.33	72
LS19/LS21/LS21	3	Seacroft	12.10/12.22/12.25	12.56	46
LS21/LS20/LS16	3	St James's/Seacroft	11.22/11.35/12.03	12.20/12.32	70
LS19/LS21/LS21	3	Seacroft	12.30/12.40/12.40	13.15	45
LS19/LS21/LS21	3	Seacroft	11.30/11.43/11.49	12.28	58

In the examples provided the average travelling time from the stated Leeds postcodes to Seacroft Hospital is 56 minutes

From	No of Drop Offs	To	Pick up time	Drop off time	Longest Journey Time
Seacroft	2	LS21/LS21	18.35	19.12/19.17	42
Seacroft	2	LS21/LS21	18.34	19.16/19.23	49
Seacroft	1	LS21	18.05	18.57	52
Seacroft	2	LS21/LS21	18.30	19.25/19.25	55
Seacroft	2	LS6/LS21	17.56/17.59	18.22/18.40	44
Seacroft/St James's	3	LS16/LS20/LS21	17.16/17.20/17.40	18.06/18.26/18.39	83

In the examples provided the average travelling time from Seacroft Hospital to the stated Leeds postcodes is 54 minutes

Patients to/from LGI (randomly selected)

From	No of Pick Ups	To	Pick up time	Drop off time	Longest Journey Time
LS21/LS19	2	LGI	12.53/13.08	13.42	49
LS21/LS16	2	LGI	13.10/13.37	14.03	53
LS19/LS21	2	LGI	13.20/13.30	14.07	47

In the examples given the average travelling time from the stated Leeds postcodes to Leeds General Infirmary is 50 minutes

From	No of Drop Offs	To	Pick up time	Drop off time	Longest Journey Time
LGI	2	LS21/LS21	12.34	13.25/13.38	64
LGI	2	LS5/LS21	14.04	14.22/14.57	53
LGI	2	LS6/LS21	15.39	15.51/16.18	39

In the examples given the average travelling time from Leeds General Infirmary to the stated Leeds postcodes is 52 minutes

Journeys include drop offs or pick ups
All information taken off the Yorkshire Ambulance Service Cleric Database
Full postcodes are available, these have not been included to prevent any potential identification of patients

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Yorkshire Ambulance Service NHS
NHS Trust

Response to Leeds OSC Questions re Renal Data

21 May 2010

(a) When the analysis was commissioned, what the 'brief' was and when was the analysis was subsequently undertaken;

The analysis was commissioned by LTHT in mid to late April 10.

The brief was to

1. provide patient travel times from post codes in LS21 to Seacroft Hospital
    a. Direct journeys
    b. Multiple pick ups and drop offs en route
    c. Provide information for both inwards and return journeys

2. Provide patient travel times from post codes in LS21 to LGI
    a. Direct journeys
    b. Multiple pick ups and drop offs en route
    c. Provide information for both inwards and return journeys

The analysis was undertaken week commencing 26 April 10 using patient journey data from the period 1st January 2010 to April 2010.

The journeys reviewed for Seacroft hospital were actual renal patients' information.

For the journeys to the LGI, actual patients from LS21 were used but these were not renal patients.

(b) The methodology adopted and how this was decided upon;

This was a manual process of identifying patients from a specified postcode area travelling to Seacroft Renal Unit or LGI. Where patients were travelling to LGI they were only included in the sample if all patients on that vehicle were going to the same pick up and drop off point in the hospital site.

Journeys were excluded from the sample if the first pick up point wasn't in the LS21 area.

Only patients booked as able to walk were considered in the sample of patient journeys to the LGI. This was so a direct comparison could be made with patients travelling to Seacroft who all had this level of mobility.

The methodology was agreed between YAS PTS management and the renal services managers at LTHT who commissioner the work.

(c) The assurance processes to ensure data quality

To ensure that data provided has been reviewed thoroughly before release we have developed a data quality reporting process that identifies any inaccuracies with data due to omissions or data input errors.

If any of the following criteria apply, a follow up check is made. No changes are made to the data but if errors are found these journeys are discounted from the sample.

- Patients arriving early or late greater than 180 minutes
- Patients arriving early or late less than -180 minutes
- Time patients spend travelling on a vehicle is a minus time
- Time patients spend travelling on a vehicle 0
- Time patients spend travelling on a vehicle greater than 180 minutes
- Waiting time for transport minutes greater than 180
- Waiting time for transport minutes less than -180
- Planned desk errors, journeys allocated to a default planning desk
- The patient PCT is null, therefore none provided
- The patients drop off time is less than pick up time
- The patients drop off time is recorded but no pick up time given
- The patient is pick up time is recorded but no drop off time given
- Bookings with both abortive and cancellation reasons

The checks are recorded on a monthly basis, giving an assessment of the number of data errors. We review data quality every month and have an action plan to ensure we continue to improve.

(d) How representative the data is;

The project brief did not specify a minimum number of journeys for the analysis. The journeys were identified by manual review of records of journeys undertaken.

The journeys included in the sample were all those which met the specified criteria.

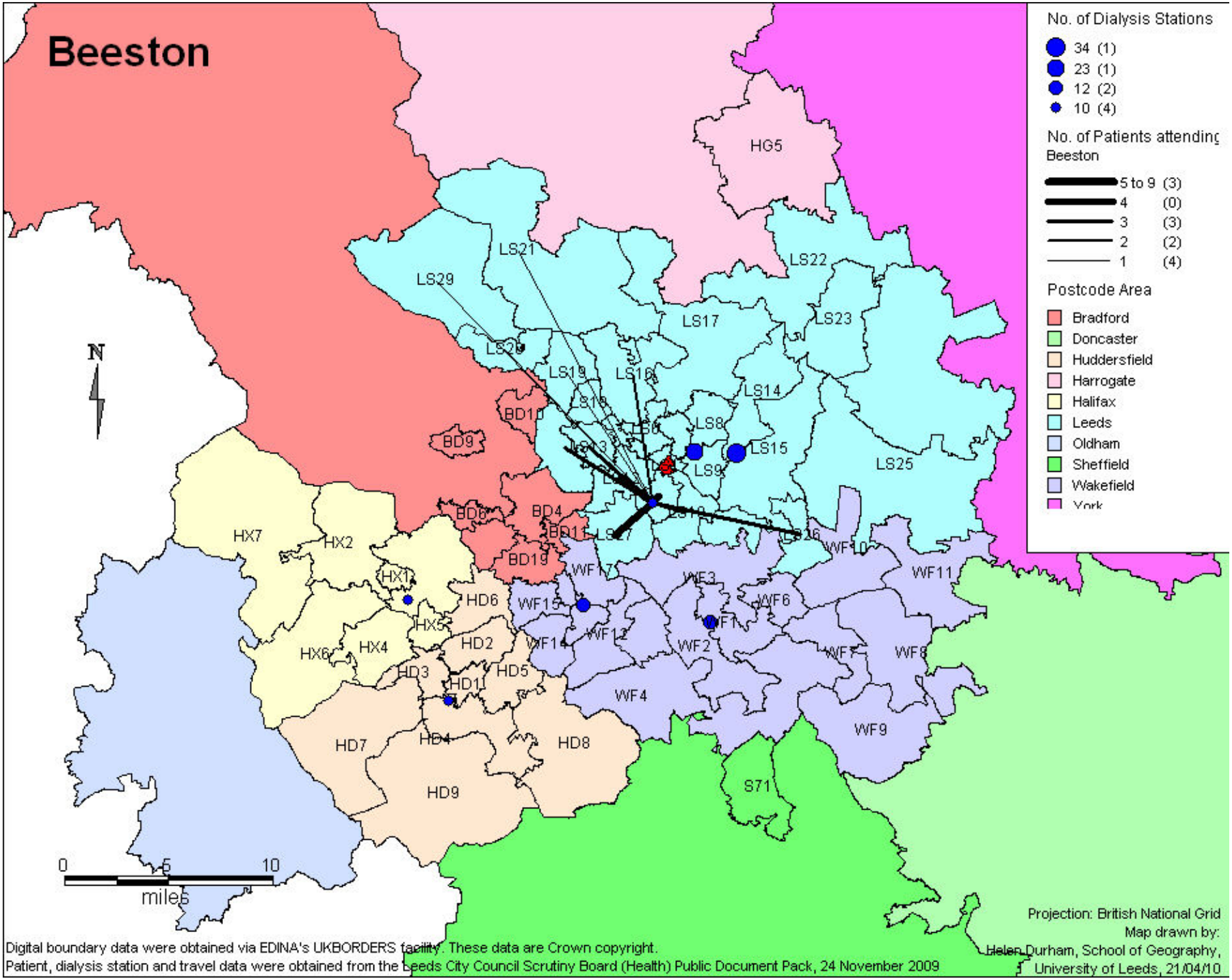
Each journey relates to a different individual (or number of individuals travelling together). Renal patients undertake the same journeys on a regular basis but repeat journeys were excluded from the sample.

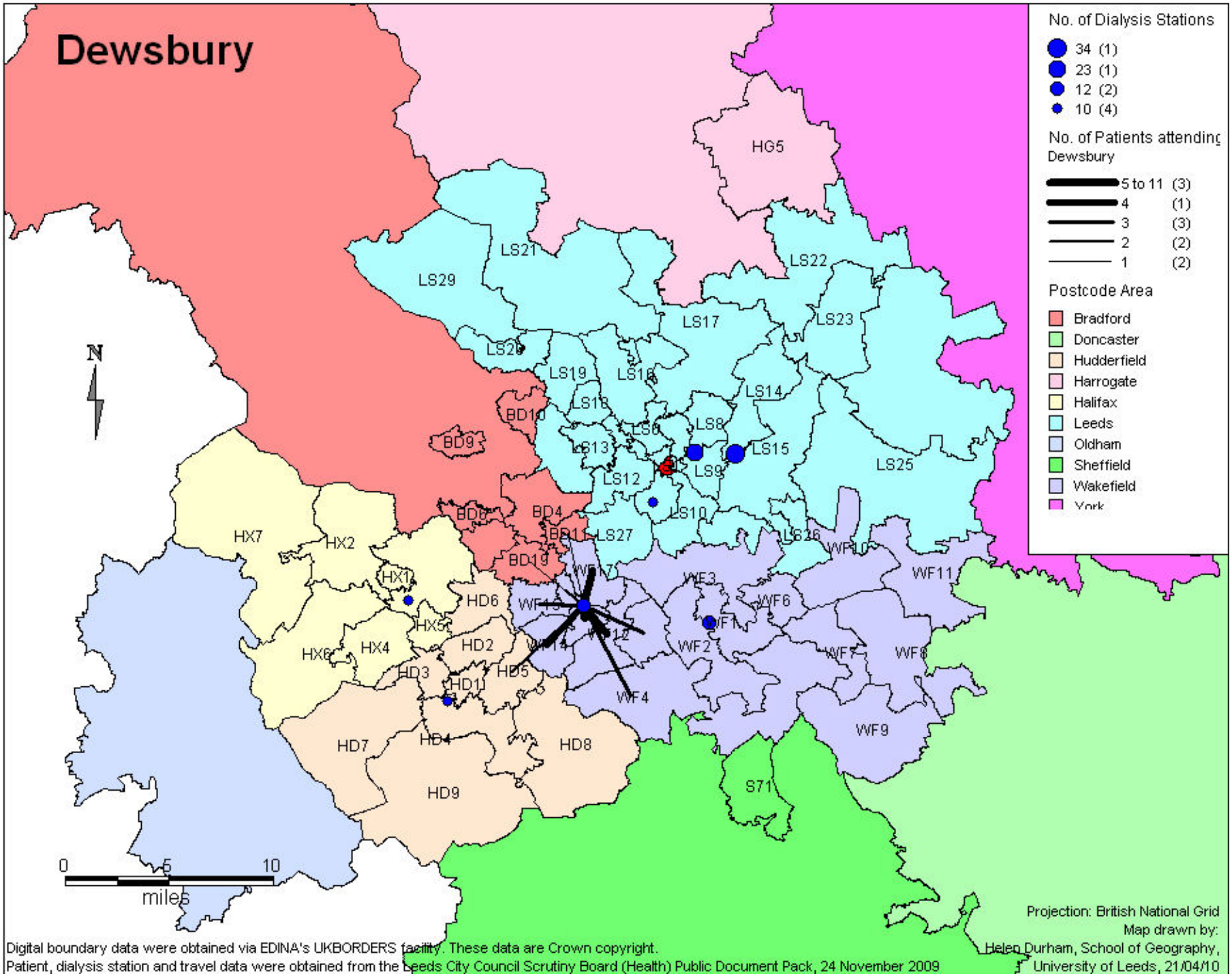
The data is representative for renal patients travelling to Seacroft.

The data for the LGI is representative from a post code point of view but the patients randomly selected are attending outpatient appointments and are not renal patients

(e) The statistical significance of the results.

We were not asked to provide confidence intervals for the data.


Beeston
No. of Dialysis Stations
34 (1)
23 (1)
12 (2)
10 (4)
No. of Patients attending Beeston
5 to 9 (3)
4 (0)
3 (3)
2 (2)
1 (4)
Postcode Area
Bradford
Doncaster
Huddersfield
Harrogate
Halifax
Leeds
Oldham
Sheffield
Wakefield
York
N
0
5
10
miles
Projection: British National Grid
Map drawn by:
Helen Durham, School of Geography,
University of Leeds, 21/04/10
Digital boundary data were obtained via EDINA's UKBORDERS facility. These data are Crown copyright.
Patient, dialysis station and travel data were obtained from the Leeds City Council Scrutiny Board (Health) Public Document Pack, 24 November 2009


Dewsbury
No. of Dialysis Stations
34 (1)
23 (1)
12 (2)
10 (4)
No. of Patients attending Dewsbury
5 to 11 (3)
4 (1)
3 (3)
2 (2)
1 (2)
Postcode Area
Bradford
Doncaster
Huddersfield
Harrogate
Halifax
Leeds
Oldham
Sheffield
Wakefield
York
N
0
5
10
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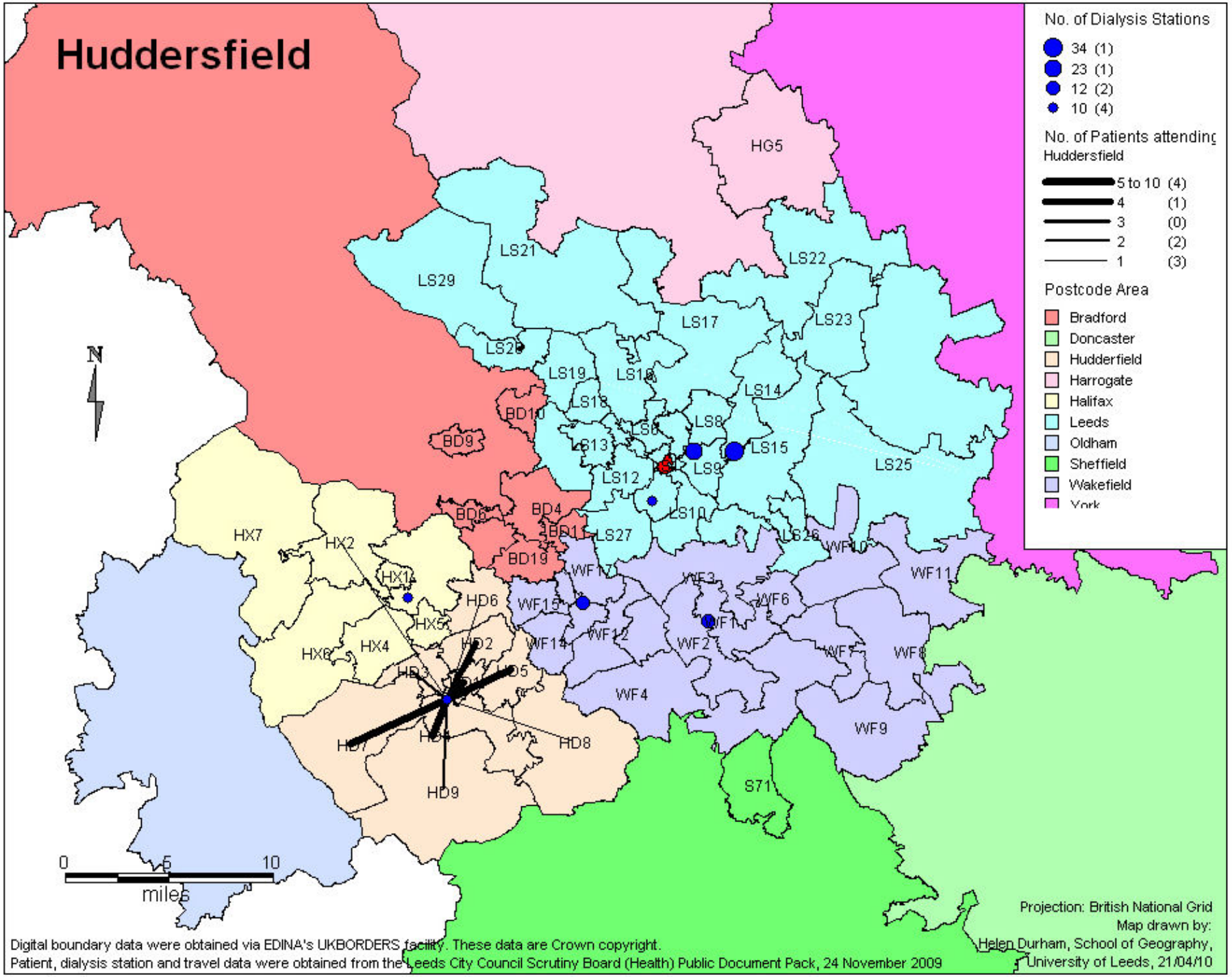
Huddersfield
No. of Dialysis Stations
34 (1)
23 (1)
12 (2)
10 (4)
No. of Patients attending Huddersfield
5 to 10 (4)
4 (1)
3 (0)
2 (2)
1 (3)
Postcode Area
Bradford
Doncaster
Huddersfield
Harrogate
Halifax
Leeds
Oldham
Sheffield
Wakefield
York
N
0
5
10
miles
HG5
LS21
LS22
LS29
LS17
LS23
LS20
LS19
LS18
LS14
BD10
LS8
BD9
LS13
LS15
LS9
LS25
LS12
BD6
BD4
LS10
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HX2
BD11
LS27
LS26
WF10
BD19
WF11
HX1
HD6
WF15
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WF6
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WF1
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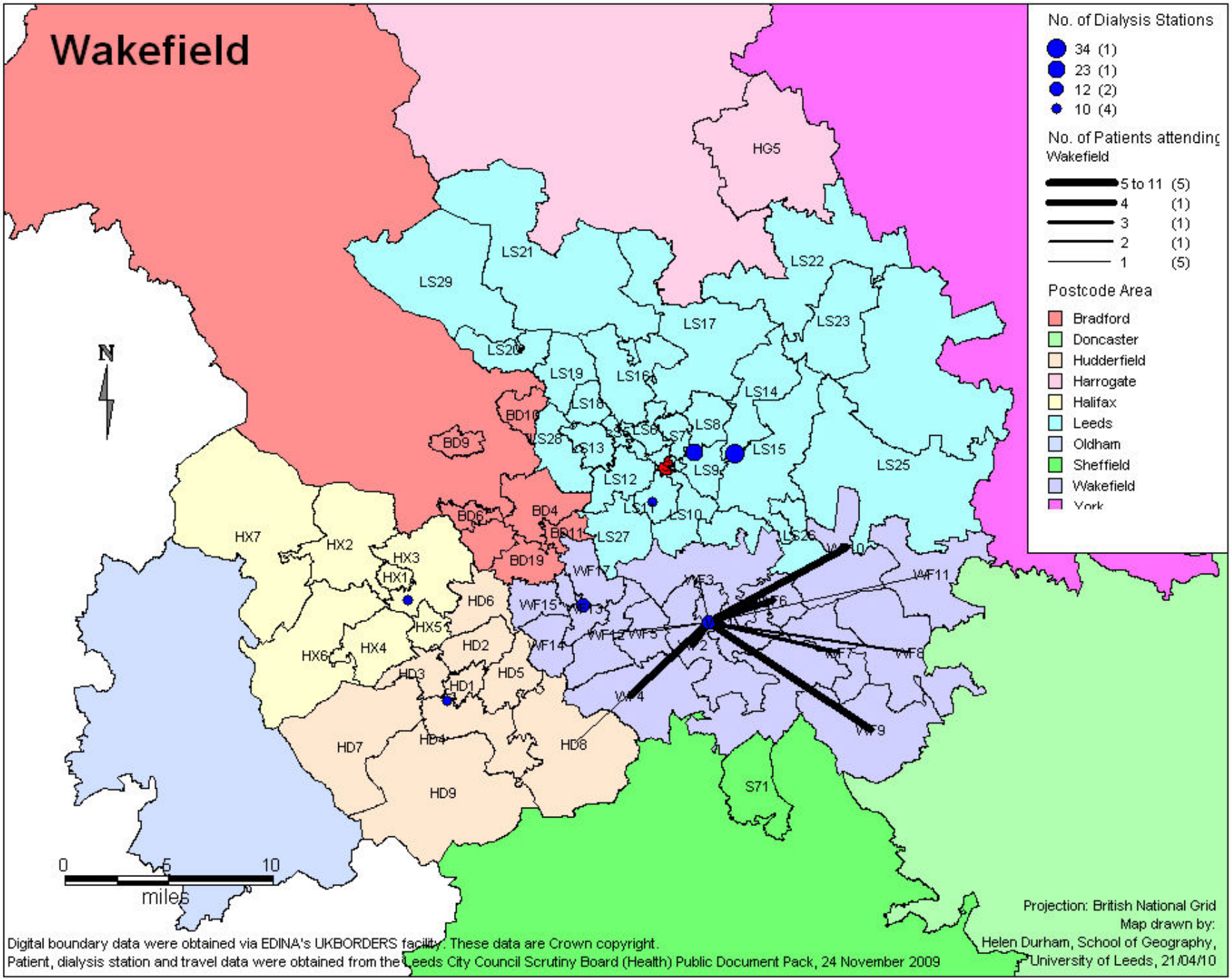
Wakefield
No. of Dialysis Stations
34 (1)
23 (1)
12 (2)
10 (4)
No. of Patients attending Wakefield
5 to 11 (5)
4 (1)
3 (1)
2 (1)
1 (5)
Postcode Area
Bradford
Doncaster
Huddersfield
Harrogate
Halifax
Leeds
Oldham
Sheffield
Wakefield
York
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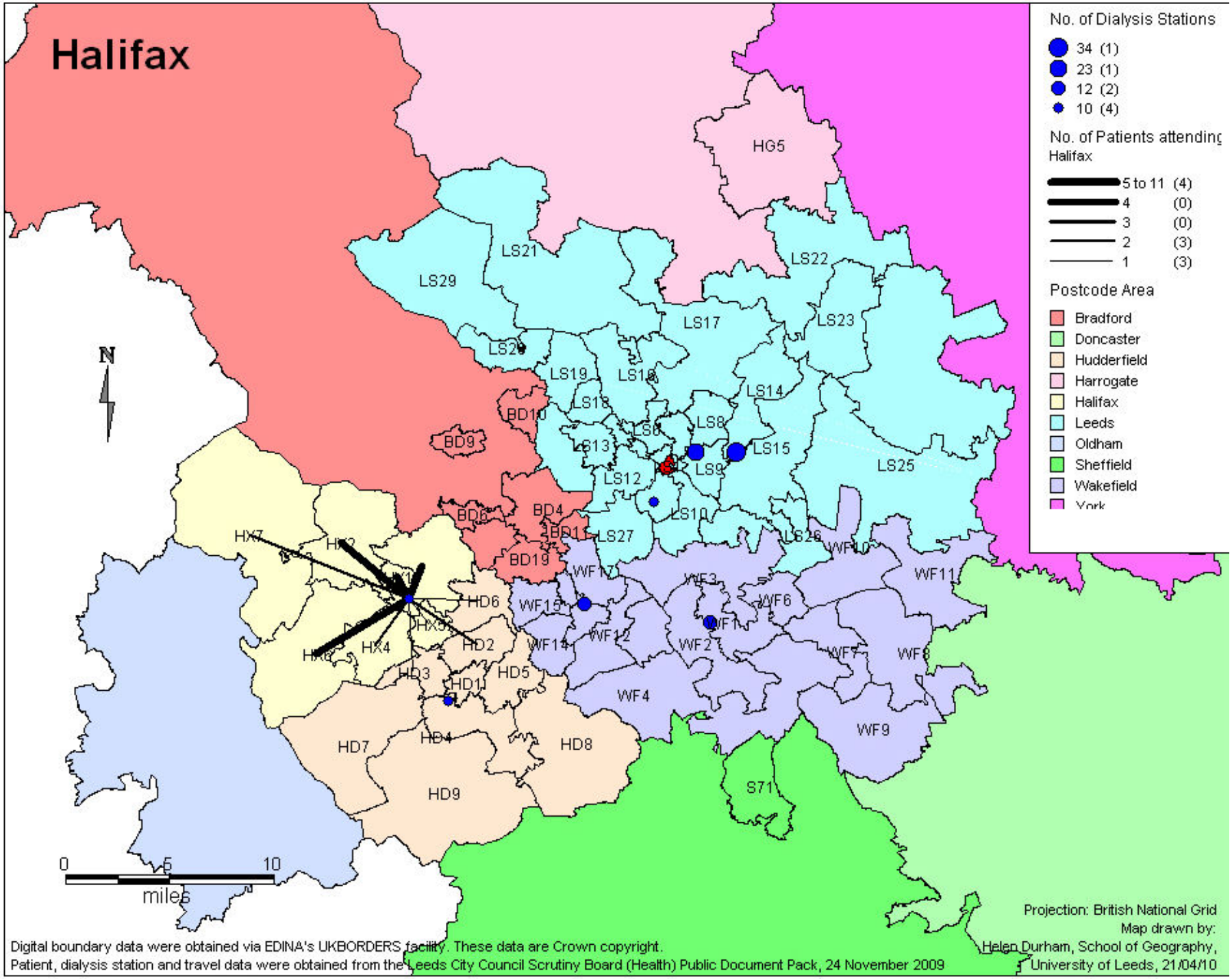
Halifax
No. of Dialysis Stations
34 (1)
23 (1)
12 (2)
10 (4)
No. of Patients attending Halifax
5 to 11 (4)
4 (0)
3 (0)
2 (3)
1 (3)
Postcode Area
Bradford
Doncaster
Huddersfield
Harrogate
Halifax
Leeds
Oldham
Sheffield
Wakefield
York
N
0
5
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miles
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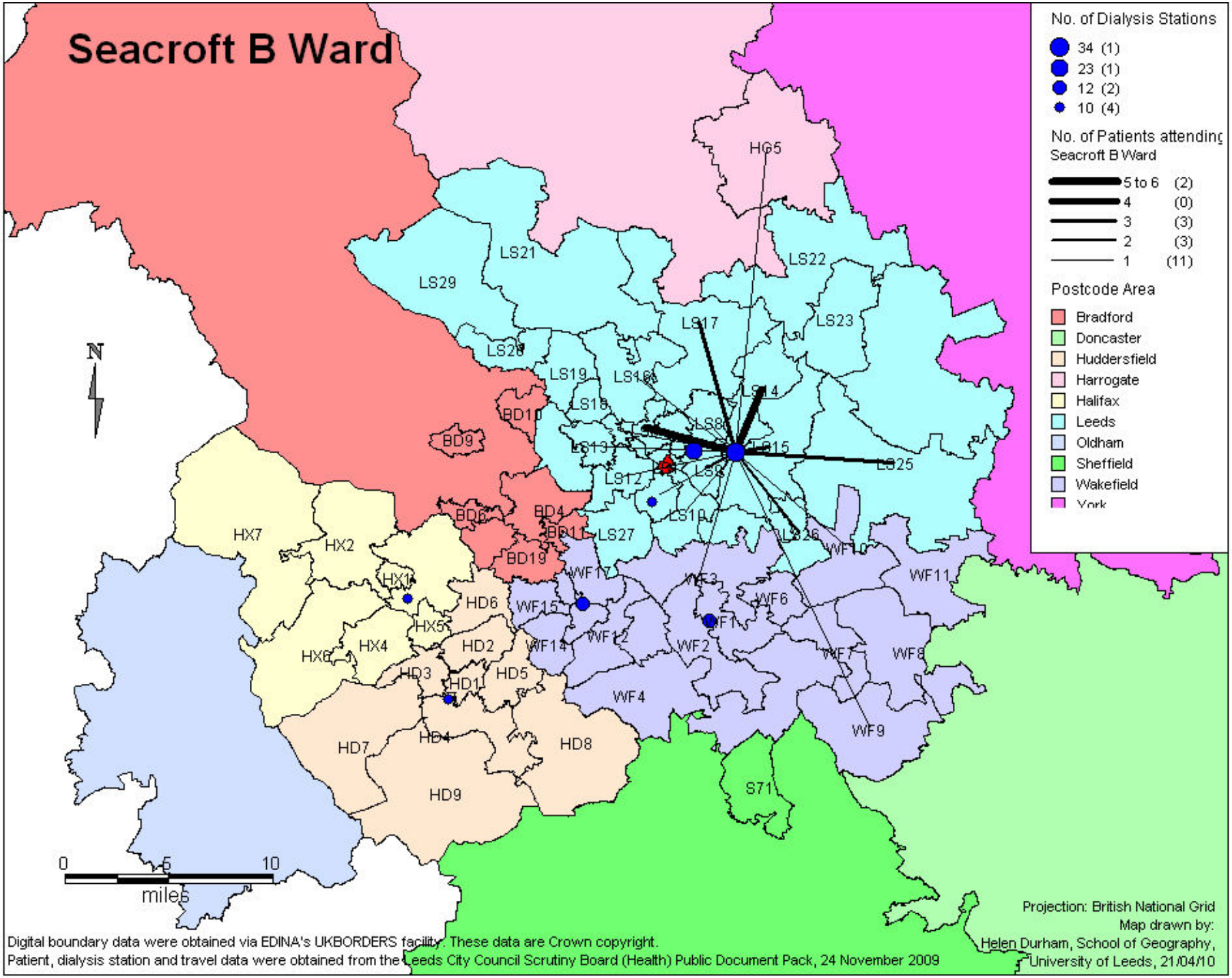
Seacroft B Ward
No. of Dialysis Stations
34 (1)
23 (1)
12 (2)
10 (4)
No. of Patients attending Seacroft B Ward
5 to 6 (2)
4 (0)
3 (3)
2 (3)
1 (11)
Postcode Area
Bradford
Doncaster
Huddersfield
Harrogate
Halifax
Leeds
Oldham
Sheffield
Wakefield
York
N
0
5
10
miles
Projection: British National Grid
Map drawn by:
Helen Durham, School of Geography, University of Leeds, 21/04/10
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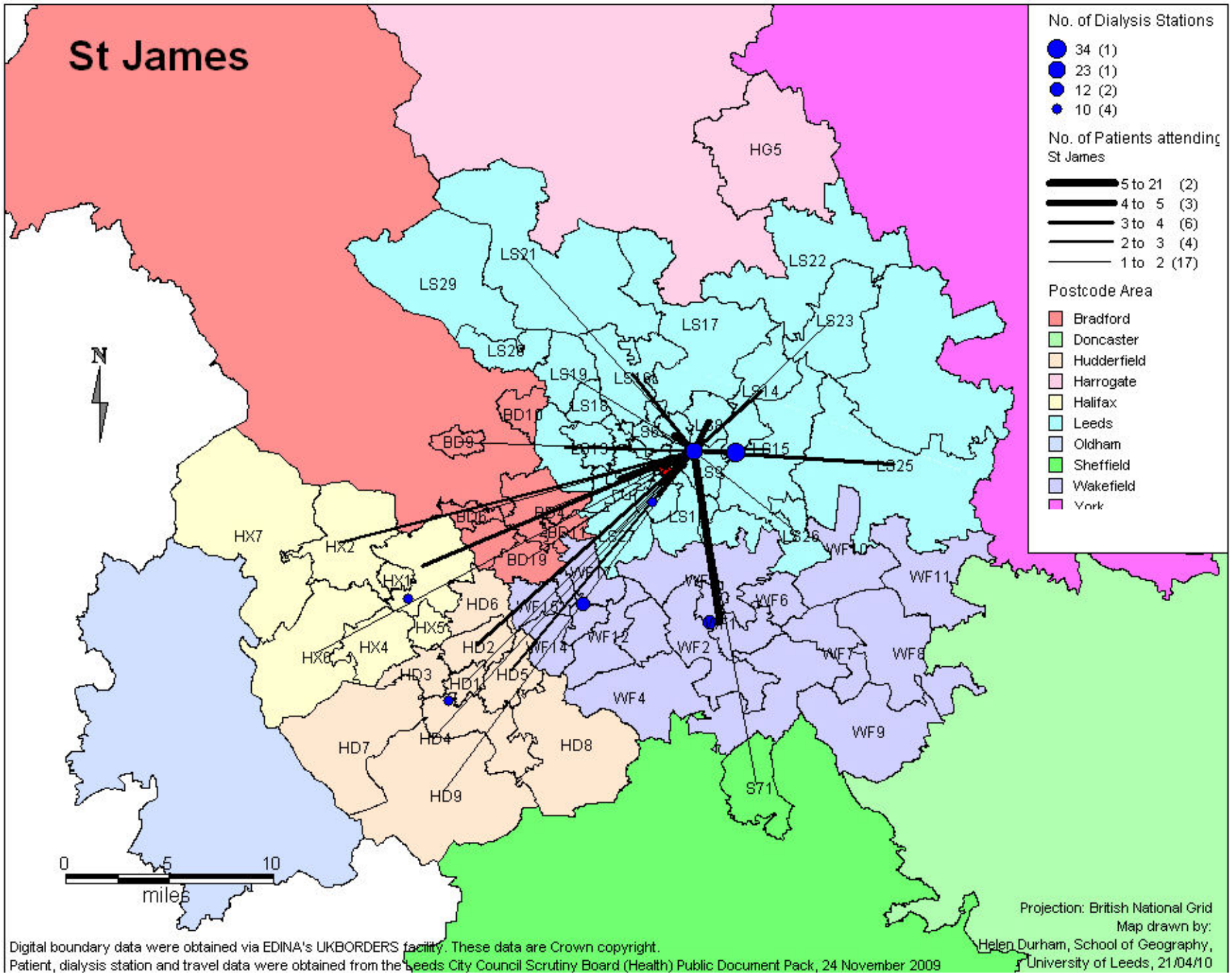
St James
No. of Dialysis Stations
34 (1)
23 (1)
12 (2)
10 (4)
No. of Patients attending St James
5 to 21 (2)
4 to 5 (3)
3 to 4 (6)
2 to 3 (4)
1 to 2 (17)
Postcode Area
Bradford
Doncaster
Hudderfield
Harrogate
Halifax
Leeds
Oldham
Sheffield
Wakefield
York
N
0
5
10
miles
Projection: British National Grid
Map drawn by:
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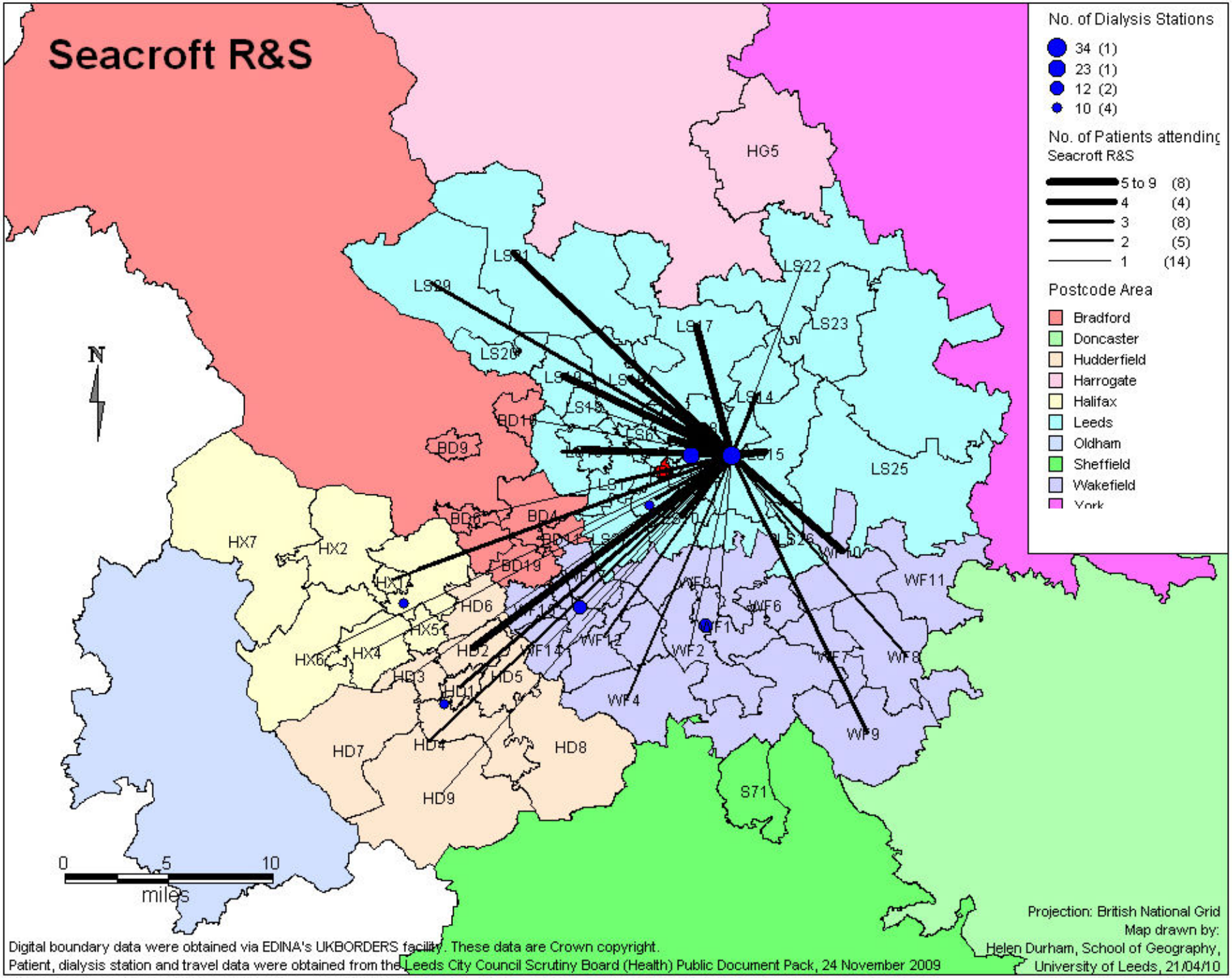
Seacroft R&S
No. of Dialysis Stations
34 (1)
23 (1)
12 (2)
10 (4)
No. of Patients attending Seacroft R&S
5 to 9 (8)
4 (4)
3 (8)
2 (5)
1 (14)
Postcode Area
Bradford
Doncaster
Huddersfield
Harrogate
Halifax
Leeds
Oldham
Sheffield
Wakefield
York
N
0 5 10
miles
HG5
LS22
LS23
LS25
LS17
LS14
LS15
LS20
BD16
BD9
BD4
HX7
HX2
HX1
HX5
HX6
HX4
HD6
HD2
HD3
HD1
HD5
HD7
HD4
HD8
HD9
WF14
WF1
WF2
WF6
WF11
WF8
WF4
WF9
S71
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Scrutiny Inquiry Report

The Role of the Council and its Partners in Promoting Good Public Health

Advice from Directors and comments Chief Officers

The Council's Constitution[1] states that where a Scrutiny Board is considering making specific recommendations it shall invite advice from the appropriate Director(s) prior to finalising its recommendations. In this regard, the Director shall consult with the appropriate Executive Member before providing any such advice, the detail of which will be reported to the Scrutiny Board and considered before the report and recommendations are finalised.

A summary of the advice received from the appropriate Directors is provided in the table below. Comments from other Chief Officers are also provided for information.

Director	Details of advice received
Director of Adult Social Services	Thank you for sending the above report. I have no specific comments on accuracy and am pleased that the report so strongly endorses and seeks to extend the direction of travel in a number of the key areas. My one comment is in relation to the use of the word 'lobby' in 2 of the recommendations (7 and 4). I wonder if the recommendation should be either for the Director(s) to write to the Minister on behalf of the authority or to seek to influence policy through relevant professional bodies. It would not be usual to associate the role of Director with direct individual 'lobbying' to Government.
Assistant Chief Executive (Corporate Governance)	With regard to recommendation 10, it should be noted that the Council has a legal duty to consider a raft of things when taking decisions e.g. equality of opportunity and then these legal duties are overlain by the Council's own policies. To pick public health out for "special treatment" would, I think lead to a tick box mentality which has happened when we have tried things like this before. However, public health matter can certainly be added to the list of issues report authors are asked to consider when drafting reports. This can be done as part of the review of current guidance.
Director of City Development	No advice received.
Interim Director of Children's Services	No advice received.
Chief Executive of NHS Leeds	No advice received.

[1] Scrutiny Board Procedure Rules – paragraph 16.3

Chief Officer	Details of comments received
Head of Scrutiny and Member Development	In relation to recommendation 1 I would offer the following advise: This recommendation is agreed with the following caveat; the development of Scrutiny Board work programmes rests with members of the Board alone However, the role of the Board's Principal Scrutiny Adviser is to provide guidance to the Chair and Board Members as to what that work programme might be. The analysis and review of Public Health issues are of great importance and a fundamental remit of the Health Board therefore advise from officers would be to ensure such work is incorporated into the annual work programme.
Head of Licensing and Registration Services	Further to production of the draft scrutiny report, it should be noted that the government, very recently published the document *'The Coalition: our programme for government'*. Under item 6 (Crime and Policing) there are several key points concerning the licensing regime, which are of particular relevance to recommendations 7 and 8 set out in the draft report. Specifically, regarding recommendation 8 (minimum pricing per unit alcohol), the government's document sets out proposals to '…ban the sale of alcohol below cost price'. As such, it may be appropriate to review this recommendation as currently drafted to reflect the current position and recognise that the government plans will most likely include specific consultation on this matter with a wide range of partners and agencies. Any such consultation will provide an opportunity for all key stakeholders in Leeds to comment, including local NHS Trusts and the Council (both generally and as the local Licensing Authority).

The Chair's summary

In my first year as Chair of the Health Scrutiny Board, it is with a great deal of satisfaction and sense of pride that I submit this year's annual report.

The year has been particularly challenging as we have strived to make a significant contribution to the well being of the people of Leeds. The Board has taken a very proactive role in raising and responding to public concerns over some proposals put forward by some of our key NHS partners. In order to protect local health services and the patients they support, we have robustly challenged proposals and sought clarity from a wide range of NHS organisations on a number of issues.

We have covered a considerable range of areas and different issues over the course of the year. The main issues and areas covered include:

- Scrutiny inquiry into Promoting Good Public Health;
- Renal Services in Leeds;
- Dermatology Services; and,
- Leeds Teaching Hospitals NHS Trust – Foundation Trust proposals.

A brief outline of these areas is provided elsewhere in this report, along with an summary of the Board's full work programme. However, I think some of the Boards highlights over the year have been:

- Identifying the need to strengthen the consideration of 'health implications' within the Council's decision-making processes – similar in nature to legal and financial implications;
- Recognition of the Board's work, leading to a positive profile across an increasing range of local, regional and national NHS organisations;
- Successfully championing the views of patients – demonstrated through the work around dermatology and renal services. Specifically in terms of renal services, this included a public apology that collectively, the local NHS had failed to fully engage with the Scrutiny Board and other interested parties early enough in the process.
- Being instrumental in a significantly improved working relationship between LTHT and dermatology patients – which included the forming of a recognised dermatology patients panel;
- Receiving assurance from the Strategic Health Authority (NHS Yorkshire and the Humber) that the issues highlighted by the Board's work around renal services would be considered as part of appropriate accountability processes for both NHS Leeds and LTHT.
- Amended constituency boundaries and a clear commitment to improving patient involvement and engagement arrangements as part of LTHT's revised Foundation Trust proposals: This was a direct result of the Board's consultation response on the original proposals, which drew on the experience of the Board's work around renal services and dermatology services;

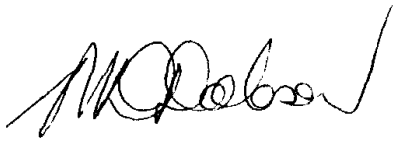
I feel that the Board has also established an approach to some aspects of its work programme that need to be maintained and developed over coming years. These include:

- Regular discussions with each of the local NHS trusts;
- Improved quarterly performance management arrangements – which includes a joint NHS Leeds and Leeds City Council performance report;
- Re-establishment of arrangements to consider potential service changes and/or developments.

However, there is still work to do – and the Board needs to be flexible to adopt to the ever changing environment it operates in. As public finances take the strain of the global economic downturn, I feel the work of the Board and the role it plays will be increasingly important. Clearly, responsibility for decisions within local NHS Trusts is not just the responsibility of the Scrutiny Board or Executive Directors: Trust Boards and non-executive directors have a significant role, and I believe it is important to establish better working relationships in this area – by establishing clearer, and more consistent terms of engagement. In this regard, and with the Board's consent, I have written to the current Chair of each local NHS Trust seeking their views on how these relationships can be more clearly established and developed. I see this as an area for further development over the coming year.

In summary, through our work as the Council's watchdog for health, I believe that Board has effectively and significantly raised the public profile of its work – receiving regular and frequent coverage through the local media. In addition, the Board has been successful in looking beyond the traditional boundaries of our local NHS partners for contributions to its work – highlighting the cross-cutting nature of health issues. As such, I would like to thank everyone who has contributed to the work of the Board during the year, including internal and external witnesses, scrutiny and governance officers and to Members of the Board for completing our busy work programme with such enthusiasm and commitment.

I look forward to the improved ways of working continuing to develop and become more established over the coming year.



Cllr Mark Dobson, Chair of Scrutiny Board (Health)