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Leeds CITY COUNCIL

SCRUTINY BOARD (HEALTH)

Meeting to be held in Committee Rooms 6 and 7 on Tuesday, 22nd July, 2008 at 10.00 am

(A pre-meeting will be held for ALL Members of the Board at 9.30 a.m.)

MEMBERSHIP

Councillors

D Atkinson	-	Bramley and Stanningley
J Bale	-	Guiseley and Rawdon
A Blackburn	-	Farnley and Wortley
J Chapman	-	Weetwood
P Grahame (Chair)	-	Cross Gates and Whinmoor
J Illingworth	-	Kirkstall
M Iqbal	-	City and Hunslet
G Kirkland	-	Otley and Yeadon
A Lamb	-	Wetherby
J Langdale	-	Temple Newsam
A McKenna	-	Garforth and Swillington
J Monaghan	-	Headingley
L Rhodes-Clayton	-	Hyde Park and Woodhouse

Agenda compiled by:
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A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded). (* In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the Chief Democratic Services Officer at least 24 hours before the meeting).	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC** 1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report. 2 To consider whether or not to accept the officers recommendation in respect of the above information. 3 If so, to formally pass the following resolution:- **RESOLVED –** That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows:-	

Item No	Ward/Equal Opportunities	Item Not Open		Page No
3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATIONS OF INTEREST** To declare any personal / prejudicial interests for the purpose of Section 81 (3) of the Local Government Act 2000 and paragraphs 8 to 12 of the Members Code of Conduct.	
5			**APOLOGIES FOR ABSENCE** To receive any apologies for absence.	
6			**MINUTES OF THE PREVIOUS MEETING** To receive and approve the minutes of the previous meeting held on Monday, 17 June 2008.	1 - 6
7			**REVIEW OF THE NATIONAL BLOOD STRATEGY** To receive and consider the attached report of the Head of Scrutiny and Member Development	7 - 88
8			**CLINICAL SERVICES RECONFIGURATION** To receive and consider the attached report of the Head of Scrutiny and Member Development.	89 - 108
9			**PCT PERFORMANCE REPORT** To receive and consider the attached report of the Head of Scrutiny and Member Development.	109 - 136

Item No	Ward/Equal Opportunities	Item Not Open		Page No
10			**SCRUTINY INQUIRY: GP LED HEALTH CENTRES (POLYCLINICS) – DRAFT TERMS OF REFERENCE** To receive and consider the attached report of the Head of Scrutiny and Member Development	137 - 142
11			**SCRUTINY INQUIRY: TEENAGE PREGNANCY – DRAFT TERMS OF REFERENCE** To receive and consider the attached report of the Head of Scrutiny and Member Development	143 - 156
12			**WORK PROGRAMME** To receive and consider the attached report of the Head of Scrutiny and Member Development	157 - 190
13			**DATE AND TIME OF NEXT MEETING** Tuesday, 16 September 2008 at 10.00 a.m. (Pre-meeting at 9.30 a.m.).	

SCRUTINY BOARD (HEALTH)

TUESDAY, 17TH JUNE, 2008

PRESENT: Councillor P Grahame in the Chair

Councillors J Chapman, A Lamb,
A McKenna and L Rhodes-Clayton

1 Declarations of Interest

Councillor McKenna declared a personal interest in Agenda Item 6, Work Programme as she is a trustee of Relate. (Minute No. 3 refers).

2 Apologies for Absence

Apologies for Absence were received on behalf of Councillors Atkinson, Bale, Blackburn, Kirkland, Langdale and Monaghan.

3 Work Programme

The Head of Scrutiny and Member Development submitted a report which provided information and guidance to the Board on developing the work programme for the 2008/09 Municipal Year. Appended to the report was a series of information to help inform the development of the Board's work programme, including:

- A copy of the Board's terms of reference;
- Measuring the Gap (extract);
- Leeds PCT Strategy (2008- 2011) (extract) – Strategic Direction;
- Leeds PCT Strategy (2008- 2011) (extract) – Priorities for 2008/09;
- Draft Memorandum of Local Area Agreement;
- Leeds Strategic Plan;
- Corporate Performance Management Information;
- Corporate Assessment Actions 2008;
- Details of planned key policies and strategies reviews (including those items which make up the Council's Policy framework);
- Previous issues outstanding from the Scrutiny Board (Health and Adult Social Care).

The Chair welcomed the following to the meeting:

- Jill Copeland, Leeds Primary Care Trust (PCT)
- Chris Butler, Chief Executive, Leeds Partnerships NHS Foundation Trust (LPFT)
- Maggie Boyle, Chief Executive, Leeds Teaching Hospitals Trust (LTHT)

- John England, Deputy Director – Strategy and Performance, Adult Social Services
- Councillor Peter Harrand, Executive Member with portfolio responsibility for Adult Health and Social Care

Jill Copeland addressed the Board and reported on the PCT's priorities for the following year. These included the following:

Short-term issues

- To meet the 18 week target for referral to treatment;
- To meet waiting time targets for cancer patients;
- Genito-urinary medicine and sexual health care;
- Urgent care, accident and emergency admissions to be dealt with within 4 hours;
- To reduce ambulance waiting times;
- Increasing opening hours for accessing primary care; and
- Reduction of healthcare associated infections – MRSA and C-Diff

Longer-term issues

- Meeting the Local Area Agreement (LAA) targets associated with tackling Health Inequalities;
- Continuation of care closer to home – this had already been provided for those Chronic Obstructive Pulmonary Disease and work had started to provide services for stroke patients;
- Dental care – increase the number of dentists and appointments available; and,
- The World Class Commissioning Programme.

Chris Butler of the Leeds Partnership NHS Foundation Trust informed the Board of the Trust's role in providing specialist mental health and disability services. He reported that the Trust delivered services across 48 sites with a budget of £108M. It was also reported that the Trust was to undergo a substantial programme of change and highlighted the following areas:

- Re-design of older people's mental health services
- Re-design of services for those with special learning disabilities.
- Re-design of psychological therapy services.

The Board was also informed of plans to rationalise community mental health teams which would make pathways to services run more smoothly. It was stated that partnership work was undertaken with the PCT and Strategic Health Authority to meet these aims.

John England reported that Health and Well Being was considered as a strategic priority for the Council and the Health and Well Being Strategic Plan had been incorporated as part of the Council's Policy and Budgetary Framework. He also highlighted work undertaken on the Leeds Strategic Plan

and Local Area Agreement that covered Health and Wellbeing themes and joint working arrangements with the LPFT, the PCT and LTHT.

Maggie Boyle informed the Board of the services provided by Leeds Teaching Hospital Trust. These included a wide range of secondary and tertiary care services along with specialist referrals both on a regional and national basis. It was reported that some of the Trust's priorities included:

- Working towards achieving Foundation Hospital status and hoped to be achieved this in late 2009/ early 2010;
  (It was suggested that the Board may wish to receive a presentation on LTHT's services at a future meeting).
- Wharfedale Hospital;
- How to get public involvement in the provision of services;
- Services at peripheral hospitals and how to make best use of these sites; and,
- Children's services provision.

Members discussed the following issues in response to information presented and as potential additions to the Board's Work Programme:

- Transfer of services between hospitals – Jill Copeland hoped to address this at a future meeting of the Board
- Polyclinics (GP led Health Centres)
- Out of Hours Services
- Review of the National Blood Service
- Renal Services – Transport Issues
- Monitoring of hospital acquired infections (along with progress and performance against other priority areas/ targets in general)
- Teenage pregnancies
- Maternity services / neonatal care transfers

RESOLVED – That the report and discussion be noted and be used to inform the development of an outline work programme.

4 Determining the Work Programme

The Head of Scrutiny and Member Development submitted a report which contained information on determining the Board's Work Programme for the 2008/09 Municipal Year. Attached to the report was information on Inquiry Selection Criteria and dates for commissioning reports and meetings of the Board.

Members considered and discussed the issues and areas presented as part of the previous item (agenda item 3), including those matters outstanding from the previous Board. Specifically, Members considered:

- The request for scrutiny in relation to: '*The implications of government's review of entitlement to primary care for refused asylum seekers on for*

healthcare in Leeds'. Members were advised that, to date, the government's review had not been published with no indication of a likely future publication date. For these reasons, the Board agreed to defer any future consideration of this matter until such time that the government's review and its findings/ implications were known.

- The request for scrutiny in relation to: '*Maternity Services / neonatal care transfers'*. Members agreed to request a briefing on the service, including any relevant performance data, in order to determine whether to proceed with an inquiry.

- Establishing a Health Proposals Working Group (as in previous years) with Councillors Grahame, McKenna and Chapman expressing interest in being part of its membership. It was agreed that all members of the Board (in particular those not present at the meeting) would be given the opportunity to express an interest in being part of the membership for such a working group.

RESOLVED –

1. That issues discussed under Agenda Item 3, Work Programme be used to determine the Board's Work Programme and be presented to the July Board meeting.

2. That the Board establish a 'Health Proposals Working Group', with precise membership to be determined at a future meeting.

5 Co-opted Members for the Board

The Head of Scrutiny and Member development submitted a report which outlined the provision to allow the appointment co-opted members to Scrutiny Boards. It was reported that up to five non-voting co-opted members could be added to the Board for a term of office which did not go beyond the next annual meeting of Council and up to two non-voting members for a term of office which related to a particular scrutiny inquiry.

Members were informed of previous arrangements for the Scrutiny Board (Health and Adult Social Care) and expressions of interest for co-option to the Scrutiny Board (Health).

RESOLVED – That the following be co-opted to the Scrutiny Board (Health) for the 2008/09 Municipal Year:

- Eddie Mack – Leeds Voice Health Forum Co-ordinating Group
- Samoud Saqfelhait – Touchstone

6 Dates and Times of Future Meetings

RESOLVED –

That the dates and times of meetings of the Scrutiny Board (Health) for the 2008/09 Municipal Year be held as follows:

Tuesday, 22 July 2008 – 10.00 a.m.
Tuesday, 16 September 2008 – 10.00 a.m.
Tuesday, 21 October 2008 -10.00 a.m.
Tuesday, 18 November 2008 – 2.00 p.m.
Friday, 12 December 2008 – 10.00 a.m.
Tuesday, 20 January 2009 – 10.00 a.m.
Tuesday 17 February 2009 – 10.00 a.m.
Tuesday 24 March 2009 – 10.00 a.m.
Tuesday 28 April 2009 – 10.00 a.m.

Pre-meetings at 9.30 a.m.

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Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 22 July 2008

Subject: Review of the National Blood Strategy

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

1.0 Introduction

1.1 The purpose of this report is to present Members of the Board with a range of information in relation to the proposed changes to the National Blood Strategy (NBS) and the implications for the City of Leeds.

1.2 In July 2007, following a meeting of Sheffield City Council's Health and Community Care Scrutiny and Policy Development Board, the Council received notification of that Boards resolutions (from a meeting on 25 June 2007), as follows:

That in light of the information made available, this Board:

(a) Views with grave concern the proposals outlined by the National Blood Service to re-organise the Service in England and Wales without sufficient evidence of the need to re-organise the Service and particularly with regard to the impact of the re-organisation proposals in the City;

(b) Believes that these proposals could result in Manchester being the nearest Testing and Processing Site to the City and serving the whole of the North of England and Wales and the transfer of blood storage and distribution facilities in the City to Leeds, thereby putting at risk the availability of blood and blood products in the City, particularly in emergency situations;

(c) Views with disquiet the lack of clarity as to whether or not the Strategy was formulated in consultation with medical experts and laboratory managers from local hospitals and if the strategy has the support of these professionals;

(d) Notes with concern the fears expressed by the trade unions and others that the proposals would have a serve impact upon the ability of the Children's Hospital

to continue its internationally renowned work on children's leukaemia, the training arrangements for Consultant Haematologists in the city, the immediate availability of specialist blood components and the carrying out of specialist research and development activities such as stem cell research, which are presently supplied by the Sheffield Centre;

(e) Does not accept the premise put forward by the national Blood Service that the NSB Centre in Sheffield was 'not fit for purpose' when the Centre has recently undergone several major refurbishment projects and, in the opinion of managers, is now fit for purpose for at least another 10 years;

(f) Would wish to express its dissatisfaction at the apparent lack of accurate costings for the proposals including transportation costs thereby not giving the Board any opportunity to reach 'judgement' on the economic veracity of the proposals;

(g) Is of the view that the underlying philosophy behind the proposals is driven by economic consideration rather than service improvements particularly as no information regarding costings and deployment was made available to the Board;

(h) Is concerned thatthis matter was brought to the attention of the board in the first instance by the trade unions representing employees of the NBS in the City and not by the NBS and would urge the Secretary of State for Health to remind health bodies of their responsibility to engage in meaningful and comprehensive consultations with Local Authorities and other parties regarding proposals for service change and also to request in the strongest possible terms to examine closely the processes for disseminating information and engaging in consultation so as to ensure that substantial systemic improvements are made to prevent this situation arising again;

(i) Believes that at a time when all agencies are committed to taking positive steps to reduce the environmental impact of road travel there would be every possibility of an adverse environmental impact through increased transportation of blood products to the City together with the concomitant dangers of inaccessibility to the City in adverse weather conditions;

(j) Whist recognising that it is not within its remit to become involved with or comment upon the possible adverse economic impact of the proposals upon the City's regeneration would nevertheless urge the Leader of the City Council, the cabinet member with responsibility for Economic Regeneration, Culture and Planning and the Chief Executive to pursue this aspect of the proposals with the upmost vigour;

(k) Requests that further proposals about the tre-organisation be reported to the Board as a matter of urgency; and,

(l) Requests that copies of this resolution be forwarded to the Sheffield Members of Parliament, the Secretary of State for Health, the Core Cities and the other South Yorkshire Authorities.

1.3 As a result, this matter became a matter for consideration for the previous Board and included on its work programme. For a number of reasons, this was not considered during the previous municipal year.

1.4 In November 2006, the NBS was published, proposing the consolidation of the existing processing and testing centres into three major centres. It also proposed a reduction to the number of blood issue centres (where blood is stored and dispatched to hospitals). A review of the NBS was commissioned in July 2007 and undertaken between October and December 2007. The review sought to address concerns raised by key stakeholders about some aspects of the strategy published in November 2006. The revised strategy is attached to this report.

2.0 Report Issues

2.1 To help the Board consider the current proposals and the associated implications for Healthcare in Leeds, submission from the following organisations have been received and are appended to this report:

- NHAS Blood and Transport
- AMICUS (trade union)
- Leeds PCT

2.2 Representatives from these organisations will attend the meeting to address any questions identified by the Board.

3.0 Recommendations

3.1 The Board is requested to consider the information provided in the attached report and determine what further action to take and/or any specific recommendations.

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NHS
Blood and Transplant

Strategic Plan 2008/11

Table of Contents

Section One:
Introduction and Priorities for 2008/09

1. NHSBT was established as a Special Health Authority in England and Wales in October 2005 with responsibilities across the United Kingdom in relation to organ transplantation. Its remit is to provide a reliable, efficient supply of blood, organs and associated services to the NHS.

2. NHSBT provides products and services in four key areas:

   - Blood Components,
   - Specialist Services,
   - Organ Donation, and
   - Fractionated Products.

3. This document sets out:

   - Our strategic objectives over the period 2008/09 to 2010/11,
   - Our priorities for 2008/09,
   - Our plans to achieve the above,
   - The outcomes we expect to deliver, and
   - The metrics by which we will measure our success.

4. Our strategic objectives over the period 2008/09 to 2010/11 are as follows:

   a) Blood Components
   To provide a sustainable supply of blood component products and services that meet all safety, quality, service provision and compliance standards, as efficiently as possible, via the modernisation of the blood component supply chain.

   b) Specialist Services
   To move Specialist Services towards financial sustainability, while maintaining quality, service provision and compliance standards.

   c) Organ Donation
   To identify and refer increasing numbers of potential donors and to increase the number of actual donors, enabling an increase in the number of transplants.

   d) Fractionated Products
   To achieve financial viability while continuing to meet all quality, service provision and compliance standards.

   e) An Organisation fit for Purpose
   To establish NHSBT as an acknowledged, effective and efficient provider of products and services, focused on service to donors and customers, flexible to meet changing needs and ambitious to succeed.

5. To successfully deliver these objectives we will undertake a demanding programme of work over the next three years – a programme that will require significant levels of progress in the coming twelve months. The underpinning work-plan for 2008/09, which contains the detailed activities and initiatives through which this progress will be delivered, is attached as Appendix One.

6. Our priorities for action in 2008/09 are as follows:

   i. To provide a stable supply of blood component products, collecting sufficient blood to meet demand while maintaining stocks of all blood group types at or above target, through successful delivery of a series of donor service initiatives.

   ii. Implement year-one of our strategic blood supply change programme. Specifically:

   - Complete the preparation for the medium to long-term transformation of blood collection (additional donor marketing and communications activity, improved session convenience and commencing the operational improvement programme),

   - Open the new blood centre at Filton, Bristol on time and within budget, completing the consolidation of activity within the South West and West,

   - Commence delivery of the Processing and Testing (PT) operational improvement programme. Plan the delivery of an updated replenishment model; test and confirm the efficiency and effectiveness of the new PT processes within Filton; and ensure that good practice is defined in preparation for consolidation at other PT sites,

   - Commence the estates optimisation programme, relinquishing the lease on Aztec West and developing an estates strategy,

   - Continue to implement agreed blood safety initiatives, expanding production of platelets by component donation from 60% to 80%, reducing demand for red cells through support of Better Blood Transfusion III and implementing production of cryoprecipitate for children via the importation of virus inactivated plasma. In addition, we will evaluate a number of potential future blood safety interventions.

   iii. Implement 'year-one' of the specialist services strategic programme, growing sales volumes by 5%, delivering the consolidation programme, completing the move of Tissue Services and Reagent Production to a single site at Liverpool, while planning delivery of further changes programmed for 2009/11.

   iv. Establish NHSBT as an Organ Donor Organisation and begin the implementation of the ODTF recommendations as they relate to NHSBT. In 2008/09 the levels of organ and cornea donation will increase by 0.6% and 3.7% respectively and the foundations will be laid for a fundamental change to Donor Referral, Donor Co-ordination and Organ Retrieval, supported by the development of a major publicity awareness campaign.

v. Progress the fractionated products strategic programme by increasing capacity utilisation (by 4%) through contract fractionation (Gammacan), securing sales of Optivate and Replenine products in Europe and growing sales by 13%. We will also remain prepared for any future potential ownership issues arising out of ministerial consideration of the outline business case.

vi. Maintain and, where appropriate, improve compliance with standards and improve customer and donor satisfaction with service levels.

vii. Deliver the 2008/09 financial plan and balance the income and expenditure account, including a reduction in grant in aid funding for fractionated products of 41%, delivery of the blood component cost reduction targets of £10.2m, working within agreed blood component prices and reducing the gap between income and expenditure in specialist services from £23.7m to £17.6m.

viii. Implement a unified management structure and develop systems for NHSBT, which further consolidate the benefits from the 2005 merger and establish NHSBT as the Organ Donation Organisation. These changes will ensure we are fit for purpose for future clinical and organisational challenges.

7. Progress against this plan will be monitored through a clear performance management framework based on our Performance Scorecard (see section three), which focuses on the key performance measures and targets related to the strategic outcomes.

8. The following pages (section two) outline the broader context in relation to each of our strategic objectives and describes:

   - The challenges that we must address over the next three years to enable continued successful delivery of the high-quality services that our customers require,

   - The strategic objectives, supporting activities and associated performance measures and targets to be achieved over the 2008/11 period, plus

   - The individual initiatives through which they will be delivered.

9. Section three summarises the key corporate financial headlines over the 2008/11 period and our approach to performance management and assurance.

Section Two: Strategic Objectives for 2008/11

a) Blood Components

Strategic Objective: To provide a sustainable supply of blood component products and services that meet all safety, quality, service provision and compliance standards, as efficiently as possible, via the modernisation of the blood component supply chain.

10. NHSBT manufactures and supplies blood components to the NHS. In order for the blood component supply chain to continue to serve patients effectively and deliver an efficient service for the NHS, it must fundamentally change in response to three key challenges:

    - The falling numbers of blood donors (outstripping the fall in demand for blood),
    - Rising costs, and
    - Over-capacity within Processing and Testing, coupled with an inappropriate infrastructure.

The falling numbers of blood donors (outstripping the fall in demand for blood)

11. The decline in demand for blood, driven partly as a result of increased efficiency in its use by hospitals, continues. However, both the number of donors bled and the active donor base has fallen at a faster rate than the decline in demand for blood. The table below illustrates this trend over the last five years since the end of 2001/02.

The number of donors bled, active donors and red cell issues

Percentage change in active whole blood donor base			-19.6%		Ave/year -3.9%	
Percentage change in whole blood donors bled			-17.2%		Ave/year -3.4%	
Percentage change in red cell issue levels (demand)			-15.1%		Ave/year -3.0%	
	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07
No of active whole blood donors (m)	1.82	1.69	1.63	1.61	1.54	1.46
No of whole blood donors bled (m)	2.38	2.33	2.30	2.16	2.04	1.97
Red cell issue levels (m)	2.21	2.19	2.16	2.03	1.94	1.87

12. Research evidence confirms that the blood donor base will continue to decline. The situation is not yet critical, but it will become so if we are unable to reverse the established trends. Scenario planning suggests that a shortfall of between 100,000 and 300,000 units could arise by 2011/12 unless decisive action is taken now.

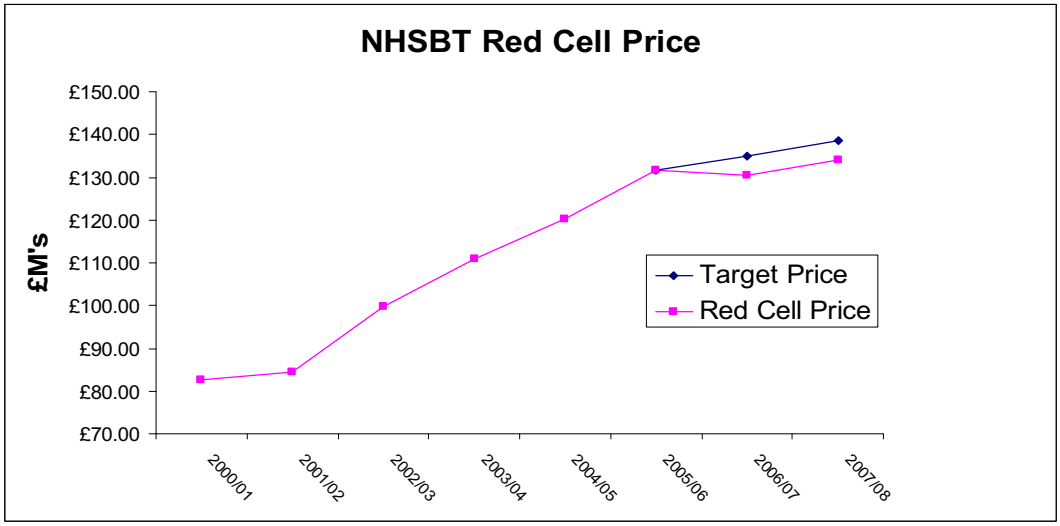
13. Donor surveys indicate that many donors would like to donate during evenings and weekends. However, very few donor sessions currently operate after 7.30 pm and there are only a limited number operating at the weekend. It is also clear that we will need to strike an appropriate balance between those donors who wish to 'drop in' to donate blood and those who would like to make an appointment in advance.

14. During 2007/08, we met just under 100% of requests for red cell and platelet products. Progress was also made in delivering the first steps of the modernisation of blood collection activity. However, blood stocks were consistently below the optimal target and the level of stock within some blood group types required specific action, in conjunction with hospital colleagues, to avoid activation of the emergency blood management arrangements. In addition, the ability of the donor panel to meet demand (currently at c91%) remained significantly below the target of 100%, indicating a potential problem in meeting demand in the future.

Rising costs

15. The unit cost of red cells increased significantly during the period 2001 to 2006, predominantly as a result of implementing new and expensive blood safety requirements, coupled with the impact of reduced demand. The price of a unit of red cells rose from £84.56 in 2001/02 to £131.80 in 2005/06 (see figure one).

Figure one – NHSBT Red Cell Price



16. In response, we have delivered a significant cost reduction programme (£c38m) during 2006/07 and 2007/08. This has stabilised the price of blood with prices in each of the last two financial years being significantly below the target of 'inflation only rises' from the 2005/06 baseline price (see table below).

Financial Year	Target Price	Actual Price	+/- Target Price
2005-06 baseline	n/a	£131.80	
2006-07	£135.02	£130.52	£-4.50
2007-08	£138.61	£133.99	£-4.62

17. NHSBT remains committed to keeping red cell prices as low as possible, while also taking action to maintain continuity of safe supply.

18. Whilst we have made good progress in delivering efficiencies within the blood component supply chain, there are significant opportunities available to further reduce costs, as we are still markedly behind many of our European counterparts in terms of collection and processing productivity.

19. There is significant variability in our blood collection productivity levels across the country, with a gap of c32% between the highest and lowest performing blood collection teams. In addition, an estimated 40% of our blood collection staff time is spent on non-donor contact.

Over-capacity within Processing and Testing, coupled with an inappropriate infrastructure

20. There is excess capacity of c35% in Testing and c40% in Processing based on productivity benchmarking (using a 2001/02 baseline). This excess capacity, although linked to some extent to contingency planning, has arisen as a result of the decline in demand for blood component products. We processed and tested c16% less units per day in 2006/07 than we did 6 years ago. The level of excess capacity is likely to continue to increase (if not addressed) as product demand is expected to reduce further over coming years. There are, therefore, significant opportunities for operational improvement, removing variations and standardising processes.

21. Our challenge is to provide a robust and flexible manufacturing infrastructure that can deliver the level of service customers expect, respond effectively to future safety and regulatory standards and reduce operating costs to meet our pricing targets in the face of declining demand for blood components.

22. Taking these constraints into account therefore, consolidations that take place in order to address over-capacity will also ensure that compliance is achieved with best value for NHSBT and its customers.

23. During 2007/08, good progress has been made in the South West, with the consolidation of Testing and Donor Records into Southmead being completed as part of the phased implementation of consolidation. Detailed planning is also underway for the consolidation of Processing, including development of logistical support. The Filton new build is being delivered on programme and is forecast to remain within budget.

24. Against this backdrop, we will pursue initiatives within four Blood Supply Chain (BSC) strategic activities to effectively deal with the challenges outlined above:

    a) BSC1 - ensure the collection of sufficient red cells and platelets to meet current and future demand by modernising blood collection activities,

    b) BSC2 - avoid further significant increases in red cell prices by reducing costs and improving efficiency in line with expected falls in blood demand,

    c) BSC3 - ensure that the organisation has the appropriate level of capacity and capability to process blood to the standards required by modernising its production and testing infrastructure,

    d) BSC4 - reduce the residual risk of transfusion through continued implementation of agreed blood safety initiatives.

25. The following pages capture our high-level activities, key outcome measures and initiatives planned over the 2008/11 period.

Strategic Objective measures and targets (level 1)	2007/08	2008/09	2009/10	2010/11
Percentage of product requests met	>99.9%	>99.9%	>99.9%	>99.9%
Number of weekdays where red cell stocks (for any blood group) are below the three day alert level	Ave c7 days / month	0	0	0
Number of days where platelet stocks are 100 below agreed stock level	Ave c2 days / month	0	0	0
Number of 'critical' regulatory non-compliances	0	0	0	0
Unit price of red cells	£133.99	£139.72	£140.00	£140.00

Strategic Objective: To provide a sustainable supply of blood component products and services that meet all safety, quality, service provision and compliance standards, as efficiently as possible, via the modernisation of the blood component supply chain.

BSC1 NHSBT will ensure the collection of sufficient red cells and platelets to meet current and future demand by modernising blood collection activities.

BSC2 NHSBT will avoid further significant increases in red cell prices by reducing costs and improving efficiency in line with expected falls in blood demand.

BSC3 NHSBT will ensure that the organisation has the appropriate level of capacity and capability to process blood to the standards required by modernising its production and testing infrastructure.

BSC4 NHSBT will reduce the residual risk of transfusion through continued implementation of agreed blood safety initiatives.

Strategic Activity measures and targets (level 2)	2007/08	2008/09	2009/10	2010/11
BSC1a Percentage of blood collection target achieved	100%	100%	100%	100%
BSC1b/1c Percentage of blood donors very / totally satisfied	63%	65%	68%	73%
BSC2 Income and expenditure position (cost reduction target reflected within financial plan)	£0m (£10.5m)	£0m (£10.2m)	£0m (£11.1m)	£0m (£15.4m)
BSC3a Productivity within Processing and Testing - number of red cell (equivalent) units per WTE	5,200 / WTE	5,300 / WTE	6,300 / WTE	7,000 / WTE
BSC3b Percentage of external non-compliances with overdue actions	14%	0%	0%	0%
BSC3c Percentage of hospitals very / totally satisfied with overall service	50%	53%	56%	60%
BSC4 Year on year reduction in red cell issues	1.820m	1.765m (-3.0%)	1.724m (-2.3%)	1.700m (-1.4%)

Planned Initiatives	2007/08	2008/09	2009/10	2010/11
BSC1 NHSBT will ensure the collection of sufficient red cells and platelets to meet current and future demand by modernising blood collection activities.				
1a) Redress the decline in blood collection focusing on targeted donor marketing and communications activities.				
• Short term initiatives focused on retention and frequency.	Plan and begin	Complete short-term initiatives	Embed in operations	Ongoing
• Medium to long-term initiatives focussed on defined sections of the donor population and on areas where collection rates are currently poor (London and North West).		Plan segments and target areas	Implement	Embed in operations
1b) Increase donor satisfaction through improved session convenience.				
• Decoupling panels.		Plan	Implement	
• Revised opening times and more accessible locations.		Plan approach, Retail partner pilot, Double RC feasibility	Plan and Implement	Ongoing
1c) Increase operational productivity (and improve donor experience) through the implementation of a donation operational improvement programme.	Plan resource	Redesign, pilot and roll out processes	Ongoing Roll out new processes	Ongoing Roll out new processes
1d) Develop plans to import red cells as an important aspect of NHSBT contingency planning.		Feasibility Study	TBD	TBD
Key (level 3) outcome-measures:				
• Reduction in “do nothing” shortfall		50k	120k	300k
• Donation Frequency	1.32	1.41	1.43	1.56

Planned Initiatives	2007/08	2008/09	2009/10	2010/11
BSC2 NHSBT will avoid further significant increases in red cell prices by reducing costs and improving efficiency in line with expected falls in blood demand.				
2a) Reductions in supply chain costs related to the continued decline in blood component demand.		£4.6m	£3.9m	£2.2m
2b) Reductions in cost and efficiencies from increasing capacity utilisation through consolidation and productivity improvements within Processing and Testing and by implementing best practice (linked to 3a).		£0.3m	£2.8m	£4.2m
2c) Implementation of an operational improvement programme to deliver greater productivity in blood collection (linked to 1c above).		£1.4m	£0.9m	£3.6m
2d) Procurement savings.		£2.5m	£3.1m	£2.0m
2e) Release of non-recurring safety funding in prices.		£1.4m	£0.4m	£0.4m
2f) Efficiencies delivered from within NHSBT support functions.				£3.0m
TOTAL COST REDUCTION PROGRAMME	**£10.5m**	**£10.2m**	**£11.1m**	**£15.4m**

Planned Initiatives	2007/08	2008/09	2009/10	2010/11
BSC3 NHSBT will ensure that the organisation has the appropriate level of capacity and capability to process blood to the standards required by modernising its production and testing infrastructure.				
3a) Increasing capacity utilisation through consolidation, productivity improvements and by implementing best practice.				
• Complete the consolidation in the South West (SW) on-time and to budget.	Ongoing	Filton Build complete full operati onal by year end	Benefits realised	
• Develop logistics infrastructures in the SW to support consolidations in the region.		Plan and implement	Ongoing	Ongoing
• Consolidation in the South East (SE) and North: ○ Move Tooting Processing into Colindale. ○ Move Brentwood and Tooting Testing into Colindale / Filton. ○ Move Leeds Testing to Sheffield.		Plan	Consult April to Sept Implement from October	Complete April
○ Move Leeds Processing to Sheffield.			Consult April to Sept	Implement April to Sept
• Develop logistics infrastructures in the SE and North to support planned consolidations in the regions.		Plan	Implement	Ongoing
• Operational improvement programme linked to consolidation.		Plan	Implement	Complete end Q1
• Replenishment model – improvements to the distribution of blood components to hospitals and NBS stock holding units.		Plan and begin pilot	Implement	Ongoing
• Estates optimisation - improvements in space utilisation.		Commence Vacate Aztec West	Ongoing	Complete Aug 2011
3b) Initiatives which contribute to delivering 'compliance' targets.				
• Reinforce a compliance culture through increased self-inspection resource to identify and correct problems in advance, ensuring all major non-compliances are managed effectively and within defined timescales.		Recruit and train staff Increase internal inspection	Ongoing	Ongoing
• Plan for non-compliance - to reduce the percentage of external non-compliance with overdue actions from c14% to 0% in line with the targets above.	Plan	Implement / 0%	Ongoing / 0%	Ongoing / 0%
3c) Implementation of improved service to hospitals.				
• Develop process maps for all NBS / hospital service interactions and identify improvements that add value to the customer.		Process maps Q1 Implement quick wins	Ongoing Improvem ents	Ongoing Improvem ents
• Improve hospital customer satisfaction scores with respect to NBS decision making and strength of partnership through a programme of pro-active interactions with key customers.		Establish and begin programme	Ongoing	Ongoing
• Implement initiatives to improve performance related to the level of component ordering/despatch errors demonstrated through a reduction in complaints and an improvement in the top box score for accuracy of delivered orders.		Complete audit implement improve ments	Ongoing	Ongoing
• Increase hospital satisfaction with service from non NBS drivers – initiate a pilot of platelet issue via NBS drivers and define customer centric performance measures for the courier contract.		Define measures Complete pilot	TBD	TBD
• Provide hospitals with comparative data sets on red cells, platelets and frozen components to assist hospitals in meeting CMO BBT3 and compliance requirements.		Every 6 months Refine and develop datasets	Every 6 months Refine and develop datasets	Every 6 months Refine and develop datasets

Planned Initiatives	2007/08	2008/09	2009/10	2010/11
BSC4 NHSBT will reduce the residual risk of transfusion through continued implementation of agreed blood safety initiatives.				
4a) Ongoing implementation of blood safety initiatives:				
• Continued implementation of expanded platelet production by component donation (baseline production at 60%).	Agree funding for 80%	80% by March	80%	80%
• NHSBT will continue to lead the CMO's BBT initiatives introducing new steps to: ○ Reduce inappropriate use of blood components ○ Reduce inappropriate usage of O negative red cells ○ Reduce inappropriate use of Platelets and FFP	RC demand (1.820m) -3% -3%	RC demand -3.0% (1.765m) -3% -3%	RC demand -2.3% (1.724m) -3% -3%	RC demand -1.4% (1.700m) -3% -3%
• Reduction in errors resulting in ABO incompatible red cell transfusions reported to SHOT by continuing education, training and audit; exploring new approaches to error reduction in conjunction with NPSA, NBTC and SHOT.	10 (2005)	10	9	8
• Develop new over-arching measure for monitoring of blood safety (including donor safety).		Develop	Implement	
• Extend the use of imported virus inactivated plasma from low risk BSE countries for the preparation of cryoprecipitate for children.	NCG funding and plan	10k units imported	Ongoing	Ongoing
4b) Ongoing evaluation of further potential blood safety plans (see paragraphs 26/27 below):				
• Implications of red cell prion filtration – NHSBT will continue to participate in the UK Blood Services Prion Reduction Working Group.	Ongoing	Option appraisal to SaBTO April Ongoing evaluations	Ongoing evaluations plus other actions agreed with the DH	Ongoing evaluations plus other actions agreed with the DH
• Implications of a licensed test for vCJD - NHSBT will continue to participate in the UK Blood Services Prion Assay Working Group	Ongoing	Option appraisal to SaBTO by 30 April Ongoing evaluations	Ongoing evaluations plus other actions agreed with the DH	Ongoing evaluations plus other actions agreed with the DH
• Further testing and processing initiatives to reduce TRALI	Screening of female potential platelet donors	Production of male donor cryo Option appraisal of PAS vs. testing of platelet donors	100% male FFP and suspend 100% platelet pools in male plasma	Ongoing
• Evaluate whether bacterial screening or pathogen inactivation should be implemented	Ongoing	Clinical study Paper to SaBTO	Actions as agreed with the DH	Actions as agreed with the DH

26. We will work with the DH ESOR department to ensure appropriate briefings to the Board and the Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) on the above blood safety matters.

27. It should be noted, that there is no provision (financial or otherwise) for implementation of any of these additional safety interventions, which we could be required to implement during this planning cycle. If implementation is mandated by the DH for one or all of them, then an assessment will be required to establish the impact of pursuing an initiative against the achievement of other objectives within this plan.

b) Specialist Services

Strategic Objective: To move Specialist Services towards financial sustainability, while maintaining quality, service provision and compliance standards.

28. NHSBT Specialist Services comprises a varied portfolio. Some activities provide essential support to the blood component supply chain and / or the organ donation supply chain, while others are effectively stand-alone patient-facing services.

29. Demand for many of these specialist services continues to grow, however, they are currently subsidised by income from the provision of blood component products in the region of £24m.

30. Our challenge for the future is to ensure the provision of key services while achieving financial sustainability, thereby reducing the level of inappropriate cross-subsidy from blood component income.

31. Against this backdrop, we will continue to pursue initiatives within four Specialist Services (SS) strategic activities to effectively deal with the challenges outlined above.

    a) SS1 - implement appropriate funding and pricing strategies to eliminate inappropriate cross-subsidies,

    b) SS2 - expand in areas of anticipated high growth without increasing capacity unnecessarily,

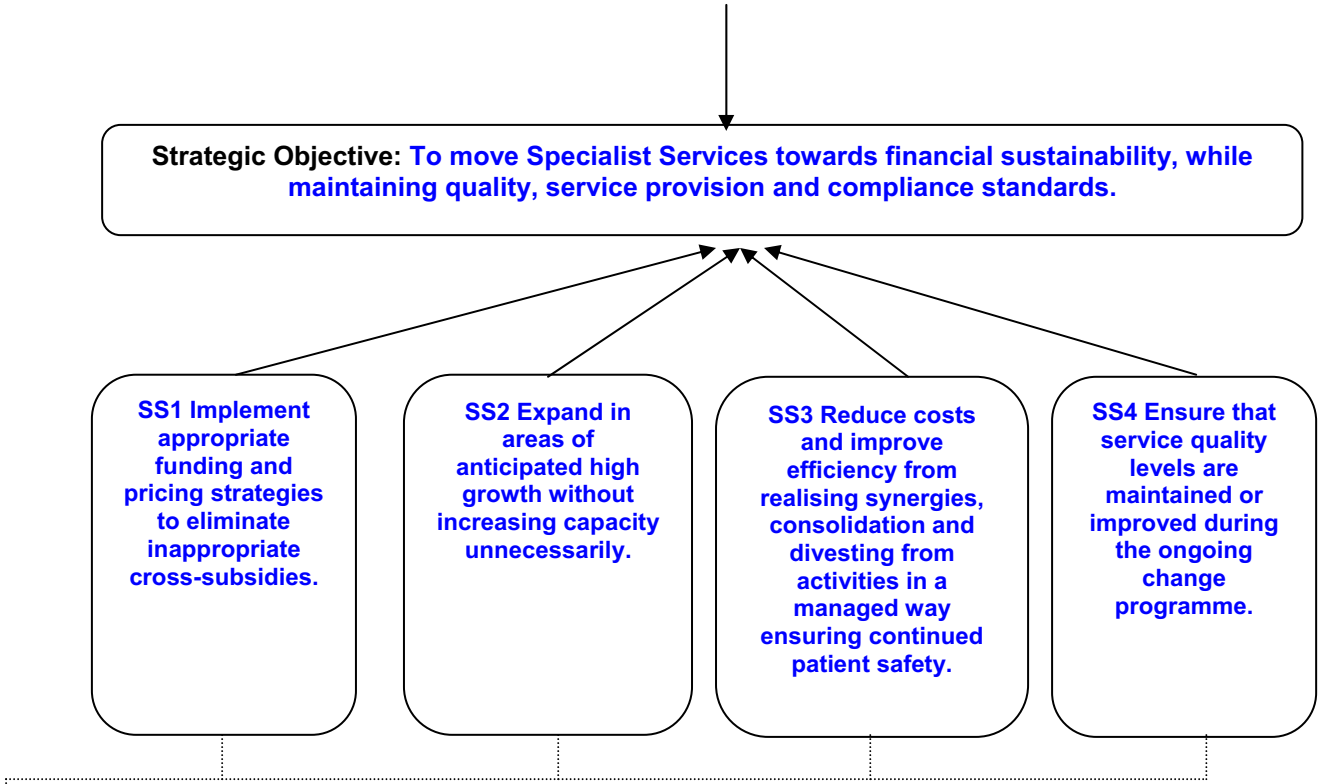
    c) SS3 - reduce costs and improve efficiency from realising synergies, consolidation and divesting from activities in a managed way ensuring continued patient safety,

    d) SS4 - ensure that service quality levels are maintained or improved during the ongoing change programme.

32. In 2007/08 the consolidation of the Cambridge Platelet Immunology (PI) and the Bristol Platelet and Granulocyte Immunology (PGI) services into Bristol was completed; with the consolidation of Tissue Services into Liverpool, Red Cell Immunohaematology from Southampton to Bristol and Reagents from Birmingham to Liverpool well progressed. BBMR donor numbers remained ahead of target and performance exceeded service levels in Histocompatibility and Immunogenetics and in Ante-Natal.

33. The following pages outline the high-level activities, key outcome measures and initiatives planned over the 2008/11 period that will build on this level of progress.

Strategic Objective measures and targets (level 1)	2007/08	2008/09	2009/10	2010/11
Overall Specialist Services funding gap	£23.7m	£17.6m	£13.4m	£10.3m
Number of 'critical' regulatory non-compliances	0	0	0	0
Please note this includes an R&D funding gap of £3m and IBGRL research activities				



Strategic Activity measures and targets (level 2)	2007/08	2008/09	2009/10	2010/11
SS1 Contribution to reduced funding gap (pricing)		£5.4m	£1.4m	£1.4m
SS2 Contribution to reduced funding gap (growth)		£0.0m	£0.8m	£0.7m
SS3 Contribution to reduced funding gap (cost reduction)		£0.7m	£2.0m	£1.0m
Total Contribution 1+2+3 (£m)		**£6.1m**	**£4.2m**	**£3.1m**
SS4 Maintenance of service quality				
4.a Percentage of external non-compliances with overdue actions	7%	0%	0%	0%
4.b SLA Compliance (RCI)	95.0%	95.0%	95.0%	95.0%
4.c Tissues: orders met on time in full (OTIF)	96.0%	98.5%	98.5%	98.5%

Planned Initiatives	2007/08	2008/09	2009/10	2010/11
SS1 Implement appropriate funding and pricing strategies to eliminate inappropriate cross-subsidies.				
• Implement RCI Reference price increase (20%).	0%	6.7%	6.7%	6.6%
• Implement H&I Immunogenetics price increase (20%).	0%	6.7%	6.7%	6.6%
• Implement H&I Support for Stem Cells price increase (20%).	0%	6.7%	6.7%	6.6%
• Implement H&I Support for Solid Organs price increase (15%).	0%	3.6%	5.7%	5.7%
• Implement RCI Reagents price increase (20%).	0%	7.8%	6.1%	6.1%
• Implement Stem Cells price increase (40%).	0%	8.0%	16.0%	16.0%
• Implement Tissues price increase (25%).	0%	10.0%	10.0%	5.0%
• Implement BBMR price increase (20%).	0%	13%	3.5%	3.5%
• Obtain GIA funding from DH to cover full costs of BBMR.	£0k	£326k	£10k	£10k
• Obtain GIA funding from DH to cover full costs of CBB.	£0k	£1,068k	£70k	£30k

Planned Initiatives	2007/08	2008/09	2009/10	2010/11
SS2 Expand in areas of anticipated high growth without increasing capacity unnecessarily.				
• Increase H&I referrals to support the increase in solid organ and stem cell transplantation.	Baseline	5%	5%	5%
• Increase Clinical Stem Cell procedures through increased business development.	Baseline	5%	5%	5%
• Increase the number of Cord Blood units held in stock	10,000	12,500	14,500	16,500
• Increase the proportion of Black and Minority Ethnic (BME) Cord Blood units held in stock.	39.6%	41%	42%	43%
• Increase Tissue sales through increased marketing and product development.	Baseline	5%	5%	5%
• Introduce foetal genotyping from maternal blood.		Plan	10,000pa	40,000pa

Planned Initiatives	2007/08	2008/09	2009/10	2010/11
SS3 Reduce costs and improve efficiency from realising synergies, consolidation and divesting from activities in a managed way ensuring continued patient safety.				
• Consolidate RCI reference services.				
○ Southampton to Filton.	Move to Southmead Complete	Move to Filton		
○ Manchester to Liverpool.		Plan	Complete move by October	
○ Plan alternatives for Cambridge (Addenbrookes or Colindale).		Plan	Implement	Complete move by April
• Consolidate Reagent services.				
○ Birmingham to Liverpool.	Underway	September		
○ Cambridge to Liverpool.	Underway	September		
• Consult with hospitals affected by divestment of routine ante natal services, and plan alternatives for each. Complete by 2010/11.		Consult	Commence divestment	Complete divestment April
• Consolidate BBMR, H&I, SCI and CBB services in one location. ○ Transfer Cord Blood Bank (CBB) from Edgware to Filton. ○ Donor-facing H&I activities from Colindale to Filton.	Develop business case	Plan and consult	Co-location of Services	Complete move by April
• Alignment of H&I and RCI services into a single diagnostics function.		Concept paper Early implementation	Further phased changes	Completion of restructure
• SCI efficiencies and growth.				
○ Transfer SCI Cambridge to Addenbrookes Hospital.	Plan	Complete		
○ Embed Manchester SCI in Liverpool.		Plan	Complete	
• H&I efficiencies and growth.		Review logistics for PGI		
• RCI efficiencies and growth.		Develop work-force plan; clarify benefits of extended working day		

Planned Initiatives	2007/08	2008/09	2009/10	2010/11
SS4 Ensure that service quality levels are maintained or improved during the ongoing change programme.				
• Percentage of hospitals satisfied with overall service (RCI - top two boxes)	57%	57%	60%	63%
• Achieve RCI turnaround targets.	95%	95%	95%	95%
• Achieve H&I turnaround targets.	80%	80%	80%	80%
• Achieve SCI turnaround targets.	90%	90%	90%	90%

c) Organ Donation

Strategic Objective: To identify and refer increasing numbers of potential donors and to increase the number of actual donors, enabling an increase in the number of transplants.

34. NHSBT is one of a number of NHS organisations involved in the commissioning and provision of UK transplant services. Our current role includes maintaining the register of organ donors, encouraging organ donation, facilitating the development of organ allocation policies and operating these to match available organs to recipients. We also provide a statistical audit and analysis function, covering all aspects of organ donation and transplantation.

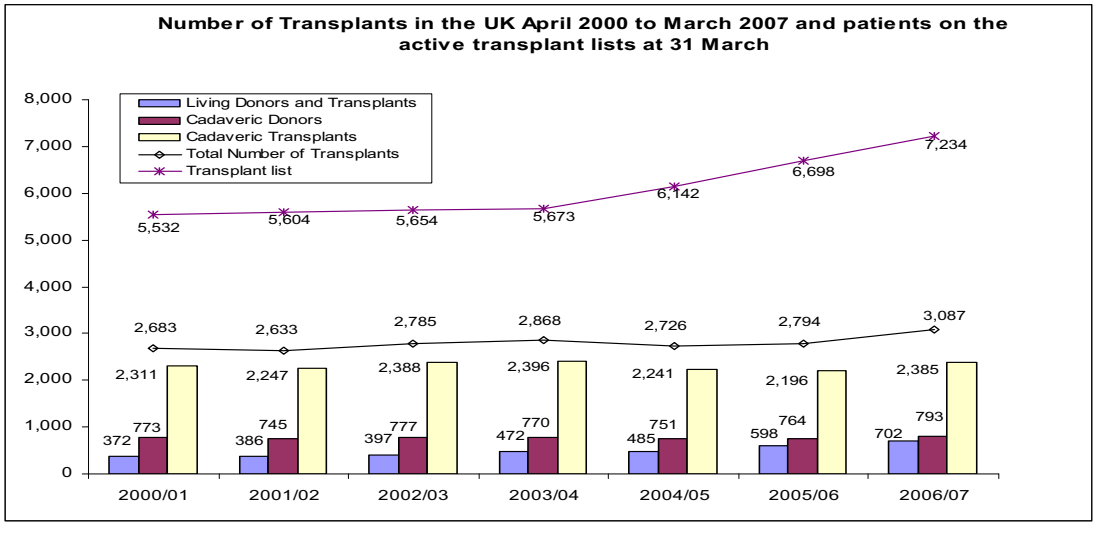
35. Since 2001/02 there has been a 17% increase in transplantation rates, 26% increase in kidney transplants, 279% increase in non heart-beating donation and an 82% increase in living donation. The number of transplants exceeded 3,000 for the first time in 2006/07; this represented a 10% increase on the previous year.

36. The NHS Organ Donor Register (ODR) currently has over 15.0 million names, representing nearly 25% of the UK population, who have registered their wish to donate organs after their death. Approximately one million names have been added to the ODR in the last year and it is encouraging that over 90% of the public are in favour, in principle, of organ donation.

37. In addition, organ donation activity has benefited from integrated corporate services within NHSBT, the existing organ donor co-ordinator network has been strengthened and exploratory work has begun on closer working with the Authority's tissue co-ordinator network.

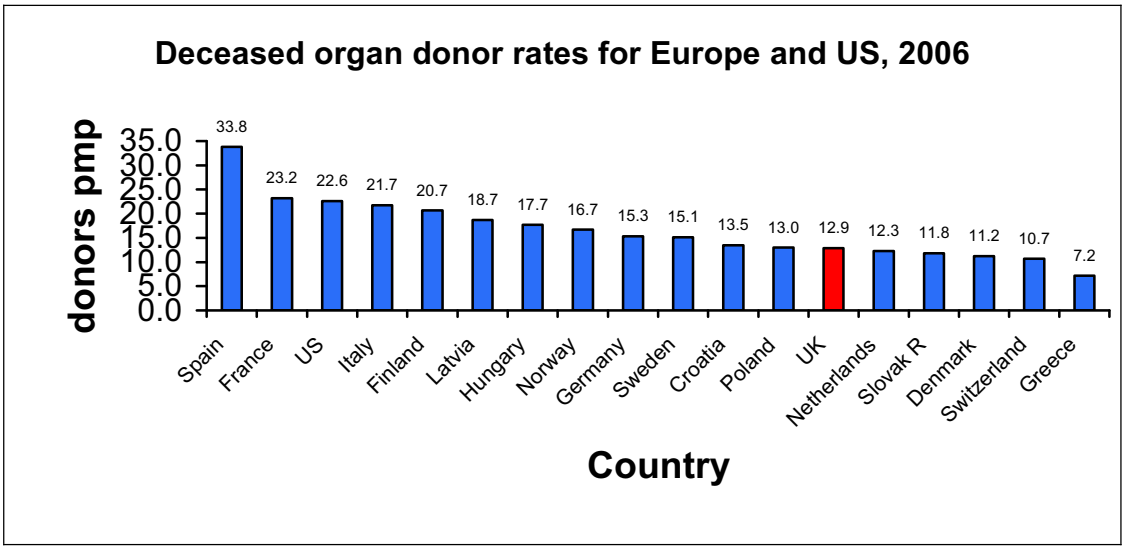
38. However, despite this record of achievement there are currently more than 7,500 people in the UK who need a transplant and this total continues to rise despite the significant effort being made to increase the number of donors (see figure two). The changing demographic profile within the UK is also likely to drive the demand for organs upwards.

Figure two – Number of Transplants in the UK



39. In addition, UK organ donation rates are significantly below those of some other major European countries including Spain and France. Spain has the highest organ donation rate in Europe at 34 per million of population (pmp). The UK has one of the lowest rates at c13 pmp (see figure three).

Figure three – Deceased Organ Donor Rates, Europe and US



40. To achieve a position significantly above the current UK level, other countries have adopted a systematic approach to addressing the barriers to organ donation.

41. Within the UK, the DH Organ Donation Taskforce (ODTF) has recently reviewed all of the stages in organ donation and has made fourteen recommendations. NHSBT has played a significant role in support of the Taskforce, and subsequently we have been asked by the DH to take forward a number of the recommendations.
A copy of the detailed ODTF report can be accessed at the following location: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082122.

42. These recommendations, if successfully implemented, are expected to enable a c50% increase in the number of organ donors and subsequently organ transplants, by the end of a five-year period, through the:

- Systematic removal of existing barriers to organ donation,
- Development of robust donor co-ordination and organ retrieval arrangements,
- Improved promotion and public recognition of organ donation.

43. The impact of these recommendations, as they relate to us, has been incorporated into plans for 2008/11 and are described in the work-plan below.

44. Some of the ODTF recommendations fall outside our remit and the successful delivery of the overall benefits will require effective integration and oversight of the entire work programme through an over-arching NHS framework. It has recently been announced that Professor Sir Bruce Keogh, NHS Medical Director, will have overall responsibility for implementation of the ODTF findings.

Strategic Objective measures and targets (level 1)	2007/08	2008/09	2009/10	2010/11
Number of Organ Donors	1,620	1,630	1,668	1,754
Cumulative percentage increase in deceased organ donation Please note: future year targets 2011/12 = 35% & 2012/13 = 50%	0%	2%	8%	20%
Number of Organ Transplants	3,202	3,235	3,401	3,665
Number of Cornea Donors	1,880	1,950	2,250	2,250
Number of Cornea Transplants	2,470	2,730	3,000	3,000

Strategic Objective: To identify and refer increasing numbers of potential donors and to increase the number of actual donors, enabling an increase in the number of transplants.

OD3 Develop and implement a flexible, robust and sustainable organ retrieval service that delivers viable organs to transplant units.

OD2 Maximise the conversion of potential donors into actual donors by developing and implementing a robust, sustainable donor co-ordination service.

OD1 Remove the obstacles to organ donation and effectively performance manage the identification and referral of potential donors.

OD4 Develop and implement a robust, sustainable cornea donation service.

OD5 Implement methods to publicly recognise the act of donation and actively promote donation to the public.

Strategic Activity measures and targets (level 2)		2007/08	2008/09	2009/10	2010/11
OD1 Percentage of patients where Brain Stem Death (BSD) is a possible diagnosis that following identification, testing and referral are suitable donors		70%	76%	78%	80%
OD2 Percentage of HB donor families approached that consent to / authorise donation within the ICUs		61%	63%	66%	69%
OD3 Number of transplantable organs per donor	Heart-beating	3.91	3.91	3.95	3.95
	Non Heart-beating	2.35	2.35	2.40	2.45
OD4 Percentage of corneas that is sufficient to meet demand		84%	91%	100%	100%
OD5 Number of people registered on the Organ Donor Register (ODR)		15.0m	15.7m	16.3m	16.9m

Planned Initiatives	2007/08	2008/09	2009/10	2010/11
OD1 Remove the obstacles to organ donation and effectively performance manage the identification and referral of potential donors.				
• Implement clinical "Donor Champions" and an Organ Donation Committee within donating hospitals (ODTF 4).	0 / 0%	51 / 19%	155 / 58%	195 / 73%
• Implement effective performance management within all donating hospitals (ODTF 6).	0%	0%	100%	100%
• Implement financial reimbursement to all hospitals for the additional costs incurred when facilitating a potential or actual donor (ODTF 8).		100%	100%	100%
OD2 Maximise the conversion of potential donors into actual donors by developing and implementing a robust, sustainable donor co-ordination service.				
• Implementation of a centrally employed Donor Transplant Co-ordinator network (ODTF 9).		4 teams in place (not fully operational)	12 teams in place, 4 teams fully operational	All 12 teams in place and fully operational
• Improve, and streamline, the process of donor registration through the introduction of an electronic (web-based) system (ODTF 9).		Pilot system by March		
• Maintain and increase the current level of investment in Living Donor schemes (Live Donor Co-ordinators).	26	30	30	30
OD3 Develop and implement a flexible, robust and sustainable organ retrieval service that delivers viable organs to transplant units.				
• Implement nationally commissioned Organ Retrieval Teams (ODTF 10).		Prepare and deploy framework Develop capability	7 teams part year effect	7 teams full, 2 'new' teams part year effect
OD4 Develop and implement a robust, sustainable cornea donation service.				
• Review eye retrieval units - performance manage each against a target of retrieving 70% of all donated corneas by 2011/12, whilst achieving an annual quality indicator of 70% retrieved corneas suitable for transplantation.		3 Units	6 Units	8 Units
OD5 Implement methods to publicly recognise the act of donation and actively promote donation to the public.				
• Develop and implement a national public awareness campaign.		Plan and develop	Implement	
• Promote organ donation and the "gift of life" to the general public via targeted marketing campaigns (ODTF 13).		Ongoing	Ongoing	Ongoing
• Promote organ donation and the "gift of life" specifically to the BME population via targeted marketing campaigns (ODTF 13).		Develop and implement campaigns	Ongoing	Ongoing
• Promote public recognition of individual organ donors through national memorials, local initiatives and personal follow up to all donor families (ODTF 12).		Commission research	Implement	Ongoing

d) Fractionated Products

Strategic objective: To achieve financial viability while continuing to meet all quality, service provision and compliance standards.

45. NHSBT manufactures and supplies a number of blood products to the NHS and to overseas markets (via its Operating Division, BPL). BPL operates in competitive national and international markets. The global market for plasma products has a direct impact on the local, national market in terms of overall supply of plasma and products, and on prices. BPL operates in a particular environment that is defined by:

    - The requirement to source its raw material (plasma) from the US, due to the risk of vCJD in the UK population. This has a significant impact on the cost of goods and on output volumes,

    - A requirement to supply the domestic market preferentially and ensure sufficiency of supply in times of national product shortages,

    - Restricted opportunity to maximise the revenue generation from its finished products due to barriers of entry in the higher priced markets such as the major Western European countries and the US.

46. As a result, in recent years, we have had to rely on direct funding from the DH. The level of funding required has decreased significantly as we have secured access to other markets and achieved price increases in our main product lines comparable to higher priced markets. During the 2006/07/08 period we reduced our planned level of central funding by 58%, increased sales by the same percentage and delivered significant efficiencies.

47. The continuing challenge for us is to build on the significant level of progress made and operate efficiently, on a financially self sufficient and sustainable basis.

48. Against this backdrop, we will pursue initiatives within four Fractionated Products (FP) strategic activities to effectively deal with the challenges outlined above:

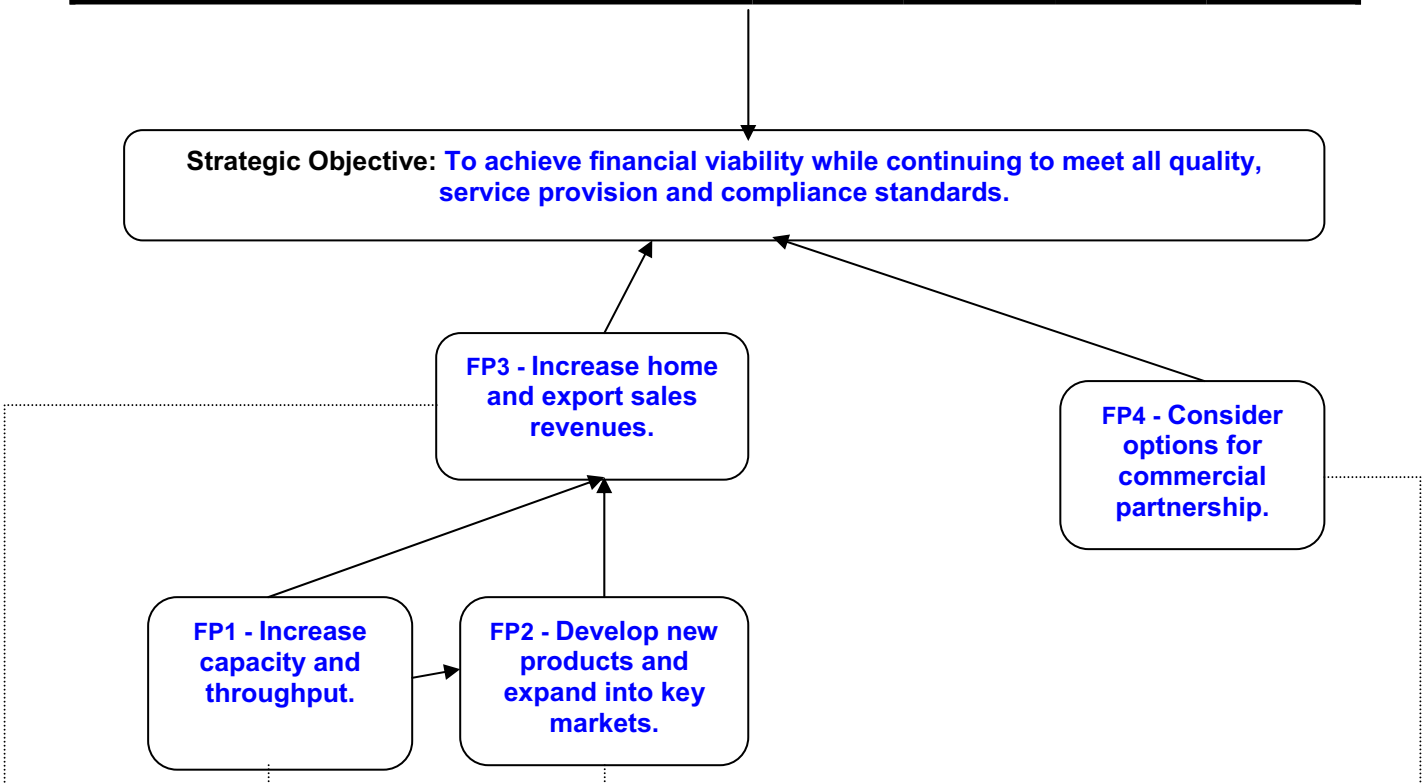
    a) FP1 - Increased capacity and throughput,

    b) FP2 - Develop new products and expand into key markets,

    c) FP3 - Increase home and export sales revenues,

    d) FP4 - Consider options for commercial partnership.

Strategic Objective measures and targets (level 1)	2007/08	2008/09	2009/10	2010/11
Cumulative reduction in central funding / grant in aid requirements (from a 2007/08 planned baseline)	-	41%	73%	100%
Number of 'critical' regulatory non-compliances	0	0	0	0



Strategic Activity measures and targets (level 2)	2007/08	2008/09	2009/10	2010/11
FP1 - Cumulative percentage increase in annual fractionation capacity	-	4%	9%	16%
FP2.1 - Launch new products	Full scale Optivate sales UK and Brazil	Optivate and Replenine sales in Europe	Gammaplex sales Factor X named patient	Optivate VWD sales Factor X sales
FP2.2 - Contract fractionation and licensing out IP	Kazpharm (LO)	Gammacan (CFr) Recombinant Anti –D (LO)	Secure small scale contract fractionation	Secure large scale contract fractionation
FP3 - Cumulative percentage increase in sales revenues	£82.7m	£93.4m / 13%	£103.9m / 26%	£113.3m / 37%
FP4 - Consider Options for Commercial Partnership	OBC complete	Plan response to OBC review	TBC	TBC

Planned Initiatives	2007/08	2008/09	2009/10	2010/11
FP1 Increase capacity and throughput.				
• Increase annual fractionation capacity.	464k L	483k L	505k L	540k L
• Average batches per week.	1.70	1.75	1.83	1.96
• Recurring revenue investment (or reduction).	0	£120k	£120k	£240k
• Capital Investment.	£5m	£6.5m	£6m	£6.5m
• Budgeted WTE.	429	432	432	435
FP2 Develop new products and expand into key markets.				
• Launch new products.	Full scale Optivate sales UK and Brazil	Optivate and Replenine sales in Europe	Gammaplex sales Factor X named patient	Optivate VWD sales Factor X sales
• Launch Date.	Sept 2007	Jan 2009	Aug 2009	May 2010
• Non-recurring revenue.	£2.9m	£2.9m	£3.0m	n/a
• Capital Investment.	n/a	n/a	£0.5m	n/a
• Contract fractionation (CFr) - Licensing out BPL IP (LO).	Kazpharm (LO)	Gammacan (CFr) Recombinant Anti –D (LO)	Secure small scale contract fractionation	Secure large scale contract fractionation
• Contracts Signed.	Sept 2007	Apr 2008	Apr 2009	2010
FP3 Increase home and export sales revenues.				
• Home sales revenues.	£60m	£68.5m	£76.9m	£84.9m
• Year on Year increase in home sales revenues.	£5.1m	Inc £8.5m	Inc by £8.4m	Inc by £8m
• Export sales revenues.	£21.6m	£23.7m	£25.8m	£28.4m
• Year on Year increase in export sales revenues.	£3.6m	£2.1m	£2.1m	£2.6m
FP4 Consider options for commercial partnership.				
• Respond to the outcome of ministerial review of the OBC on ownership options.	OBC complete	Plan response to OBC review	TBC	TBC

e) NHSBT: An organisation fit for purpose

Strategic objective: To establish NHSBT as an acknowledged, effective and efficient provider of products and services, focused on service to donors and customers, flexible to meet changing needs and ambitious to succeed.

49. The formation of NHSBT has facilitated the provision of additional management support and other resources to support our work on organ donation and fractionated products. However, it is clear that the size and scope of the changes to the delivery of front line services, as laid out above, will necessitate the transformation of our organisational structure and culture in order to enable successful delivery of our strategy and to better reflect the fact that such activities are now being undertaken within a single organisation.

50. In addition, despite the level of support required to deliver key plans and the progress made to date in streamlining support services by providing them on a 'group' basis, initial analysis would suggest there is significant scope to improve the level of productivity and efficiency within support functions and consequently reduce costs, further consolidating the benefits from the 2005 merger.

51. As a result, we will fundamentally review our organisational arrangements during 2008/11, reviewing and developing structures, systems and governance arrangements. These changes will ensure we are fit for purpose for future clinical and organisational challenges. During 2008/11 we will:

    - EA1: Ensure NHSBT corporate structures enable effective and efficient delivery of its strategy through the provision of appropriate organisational structures and systems.

52. Furthermore, effective and timely engagement with stakeholders is also an essential pre-requisite to the development, understanding and achievement of all aspects of activity within this plan and the underpinning work-plans. During 2008/11 we will:

    - EA2: Build support for the NHSBT strategy through a programme of proactive engagement with internal and external stakeholders.

53. The strategic review and ongoing planning process have identified that a significant risk to delivery of plans is a lack of capacity and capability to effectively lead and manage multiple strategic change programmes. In addition, development of a more performance led culture will be a critical enabler to the successful implementation of our strategic plan. As a result we will:

    - EA3: Improve NHSBT's capacity and capability to deliver strategic change through the deployment of appropriate resource, leadership and skill, supported by the development of appropriate performance management systems.

54. The following pages outline a summary of the plans within each of these areas.

Planned Initiatives	2007/08	2008/09	2009/10	2010/11
EA1 Ensure NHSBT corporate structures enable effective and efficient delivery of its strategy through the provision of appropriate organisational structures and systems.				
• NHSBT: Implementation of a revised organisation structure that integrates the new Organ Donor Organisation and demonstrates further synergies across its total supply chain.		Organisational development plan agreed	Continue to roll out restructure	
• NHSBT: Review of Group Services - planning delivery of cost reductions and efficiencies in support service functions in line with external benchmarks.		Begin January 2009	Implement action plan	
• In addition complete the realignment of support team sub-structures to enable successful delivery of strategic plans.				
○ Clinical: Develop an R&D strategy that recognises the need for succession planning, the opportunities presented by the creation of the National Institute for Healthcare Research and includes proposals for structuring of development.		Develop plan	Implement plan	Implement plan
○ Clinical: Review the current structure of the Clinical Directorate in the light of organisational restructure.		New structure in Place	Complete implementation	
○ HR: Implement a reorganisation of the HR Function to provide a more effective and responsive general HR and recruitment service.		Complete		
○ Finance: Continue the restructure / development of Finance to improve support to the development & delivery of strategy.		Complete		
○ IT: Implement the IT organisational change to deliver the structure outlined in the IT Strategy.		Planned Q2 underway Q3	Complete	
Communications & Public Affairs – restructure CPA: ○ Development and introduction of a single internal communications function across NHSBT, ○ Development and introduction of a single professional and responsive press and media function across NHSBT – with one integrated on-call team, ○ Recruitment of staff with relevant experience to build a Public Affairs function.		Complete restructure and Staff recruitment Develop single NHSBT magazine	Complete development of a single intranet site for the organisation	
• Review and develop NHSBT's Governance systems.				
○ NHSBT: Maintenance and development of an effective emergency preparedness infrastructure and framework.		Flu pandemic readiness assessment New SLA DH antidote service Review EP	Stock pile key consumables	
○ DSM: Development of an action plan in response to NHSBT's NHSLA and Standards for Better Health Self-assessments.		Agree & implement		
○ DSM: Implementation of the findings from the review of risk management systems and processes.		Plan & Implement		
○ DSM: Development of an integrated NHSBT Sustainable Development Action Plan.		SDAP by December	Implement	
○ Finance: complete benchmarking analysis with NHS SBS and develop an action plan.		Complete by March	Implement action plan	
○ Clinical: Review Clinical Governance arrangements, including Clinical Audit, with a view to improving the integration of Clinical Governance issues within NHSBT's management arrangements.		Review complete Implement changes		

Planned Initiatives	2007/08	2008/09	2009/10	2010/11
EA1: Ensure NHSBT Corporate structures enable effective and efficient delivery of its strategy through the provision of appropriate organisational structures and systems.				
• Review and develop NHSBT's systems in support of key strategic deliverables.				
○ IT: Pulse database consolidation and move to new hardware.		Completed by mid-year		
○ IT: Continue to renew the components of PULSE with business support.		Complete Pulse 16.1 live	Pulse 17.1 live	Pulse components completely renewed
○ IT: Replacement of the telecommunications system.		Procured & 50% deployed	Complete	
○ IT: Implement the new standardised Laboratory Information Management System (Hematos) in line with project milestones		Conversion of H&I labs BBMR CBB & SCI	Hematos fully deployed	
○ IT: Session infrastructure replacement.		Replaced		
○ IT: Filton infrastructure - Enterprise print management system procured and deployed.		Completed		
○ IT: NBS Data warehouse.		Developme nt and deployment commences	Complete	
○ IT: ODO system commissioned and deployed.		Initial deployment	Ongoing	Ongoing
○ IT: Secure corporate data on NHSBT laptops and removable media.		Complete		
○ IT: Upgrade core IT infrastructure components - Active Directory, Data centre SAN, Microsoft Exchange and Core Network, Web Services Components.		Active Directory complete Other activities commence	SAN, Microsoft Exchange, Web services and core network complete	
○ IT: & UKT: Development of a system for the 35 outstanding transplant-related datasets.		Initial Analysis	Complete	
○ Finance: Upgrade Oros ABC software to SAS ABM to enable improved performance reporting, drill down access, improved model automation and data integration. Complete ABC iteration 4 including UKT.		Implement upgrade Output by October	Qtrly Production	Qtrly Production
○ Finance: implementation of Intelligent invoice processing.		Complete Feasibility study	Implement	Ongoing use
○ Finance: Integration of core systems into billing processes / completing the review of Debtors processes.	Ongoing	Complete September	Ongoing use	Ongoing use
○ Finance: Progress ESR Benefits Realisation.		Implement E-expenses Oct & ADI upload Dec	Complete Rostering Pilot	Implement Managers self-service
Level 3 performance measures:				
• Maintain the availability of key IT services (% availability).		≥99.95%	≥99.95%	≥99.95%
• Maintain customer satisfaction with services offered at the desktop.		≥70%	≥70%	≥70%
• Better Payment Practice Code by volume and value.		≥92.00%	≥92.00%	≥92.00%
• Number of debtor days.		20	20	20

Planned Initiatives	2007/08	2008/09	2009/10	2010/11
EA2 Build support for the NHSBT strategy through a programme of proactive engagement with internal and external stakeholders.				
• HR: continued development of more effective consultative structures and an effective policy framework, developed in partnership.		First phase revisions in place	Ongoing policy review	Ongoing policy review
• HR: increase the response rate for the staff survey.		45% response	55% response	60% response
• HR: implement a new single Equality scheme.		Scheme adopted	Ongoing	Ongoing
• Communications & PA: Build on progress made in strategic stakeholder engagement on NBS review and launch of ODTF report so that this becomes part of business as usual across NHSBT.	Engage ment plans in place	Developed	Embedded	
• Finance: Ensure that sufficient funding is generated, effectively managed and made available in line with planned requirements. This includes support to the NCG for Blood process and submission of revenue, brokerage and capital GIA bids in line with the DH planning timetable.	NCG Autumn Fin Plan Mid Dec 2007	NCG Autumn Fin Plan Mid Dec 2008	NCG Autumn Fin Plan Mid Dec 2009	NCG Autumn Fin Plan Mid Dec 2010
• Finance: Continued delivery of a supplier development programme.	6 key suppliers	10 key suppliers	15 key suppliers	20 key suppliers
• DSM: establish process for self-regulation in line with DH gateway arrangements.		Complete		
• DSM: Effective development and deployment of an NHSBT planning framework, working within DH guidelines and frameworks.		DH Planning Deadline achieved	DH Planning Deadline achieved	DH Planning Deadline achieved
• Clinical: Engage stakeholders on the implementation, success monitoring and roll out of BBTIII and relevant and influential clinical audit outcomes and systematic reviews.		Ongoing	Ongoing	Ongoing
• Clinical: Engage with clinical colleagues in NHS Hospital Trusts involved in transplantation, to help ensure the successful implementation of the Organ Donation Taskforce recommendations.		Appoint to key clinical posts within NHSBT	Ongoing	Ongoing
• E&L: Develop an outline Estates and Logistics strategic plan in line with 'internal' stakeholder requirements.		Initial plan By March		Updated by September
○ E&L: Survey estates utilisation, suitability, cost and condition against internal stakeholders' needs.		Complete survey	TBD	TBD
○ E&L: Develop and implement 5 year estates investment plans to meet internal stakeholders' needs.		Commence	Ongoing	Ongoing
○ E&L: Review warehouse operations models against internal stakeholders' needs and propose improvements.		Complete review	TBD	TBD

Planned Initiatives	2007/08	2008/09	2009/10	2010/11
EA3: Improve NHSBT's capacity and capability to deliver strategic change through the deployment of appropriate resource, leadership and skill, supported by the development of appropriate performance management systems.				
• HR: Continued support for strategic workforce change to ensure successful implementation of change projects.		Ongoing	Ongoing	Ongoing
• HR: To develop more effective HR structures and systems, supported by the development of a system of KPIs.		KPIs in place	Ongoing improvement	Ongoing improvement
• HR: In conjunction with relevant directors, implement programmes to achieve a significant and sustainable reduction in areas with high absence levels. Particular target areas within Donor Services and Estates & Logistics.		DS 1.25% E&L 2% Baseline reductions	DS 2% E&L 3%	DS 2.5% E&L 4%
• HR: To implement a revised appraisal and PDR process and achieve 85% penetration of this system by 2011.		New system in place	70%	85%
• HR: Implement improved control and monitoring systems for the management of agency / temporary staffing.		Controls in place		
• HR: to ensure that an effective Leadership and Management Development programme is designed and implemented in support of strategic priorities.		New programme in place	Ongoing	Ongoing
• IT: Continue to ensure that effective programme management structures are available to support business change in all operating divisions, including the provision of appropriate resources, standards and governance frameworks.		Ongoing	Ongoing	Ongoing
• IT: Continue to ensure that suitable and sufficient Project Management resources are available to deliver NHSBT initiatives, and that appropriate project management standards and methods are developed and deployed.		Ongoing	Ongoing	Ongoing
• DSM: Development of improved performance management systems, frameworks and processes.		Phase 1 complete. Begin implementation	Implementation complete	
• Clinical: Review Clinical Directorate workforce requirements and geographical spread in light of NBS strategy review – appoint to new clinical posts, and joint posts in Transfusion Microbiology (with HPA), Tissue Services (Wrightington Hospital), and in Nottingham, Liverpool, Kings and St Mary's London. Review arrangements in Birmingham and Manchester. Implement new contract for non-consultant grade doctors in line with national agreements and develop.		On-going	On-going	On-going
• Clinical: Provide support for the replacement of the Chair of UK JPAC, and assist with the review of JPAC modus operandi.		Appoint new Chair of JPAC	Complete review	New arrange-ments in place

Section Three: Financial Overview, Performance and Assurance

NHSBT Financial Summary - Revenue Account

55. Overall, this strategic plan outlines a balanced income and expenditure position over the 2008/11 period, in line with our statutory requirement to demonstrate a break-even position. The table below summarises the key movements in income and expenditure over the 2008/11 period.

NHSBT Revenue Statement Key movements	2008/09 £m	2009/10 £m	2010/11 £m	Total £m
Opening Expenditure Position (2007-08 plan)	**463.0**	**491.8**	**520.6**	**463.0**
Estimated cost pressures and developments	36.3	42.9	32.8	112.1
Estimated one time costs / Transition costs	7.3	1.2	(12.3)	(3.8)
Estimated cost reduction programme	(14.9)	(15.3)	(22.1)	(52.3)
Net expenditure (reduction) / increase	**28.8**	**28.8**	**(1.6)**	**56.0**
Estimated Total Expenditure [A]	**491.8**	**520.6**	**519.0**	**519.0**
Opening Income Position	**463.0**	**491.8**	**520.6**	**463.0**
Baseline Cash Limit [GIA] (reduction) / increase	(6.4)	(2.9)	(2.7)	(12.0)
ODTF Funding	7.7	21.4	11.2	40.3
One time costs / Transition cost funding	7.3	1.2	(12.3)	(3.8)
Movement in income from devolved administrations	0.0	0.1	0.1	0.2
Movement in income from product and service sales	20.1	9.1	2.2	31.4
Net income (reduction) / increase	**28.8**	**28.8**	**(1.6)**	**56.0**
Estimated Total Income [B]	**491.8**	**520.6**	**519.0**	**519.0**
Net Income & Expenditure position [A-B]	**(0.0)**	**(0.0)**	**(0.0)**	**(0.0)**

Revenue Investment Plans

56. The financial plan outlines growth in revenue funding totalling £56.0m over the 2008/11 period. This includes additional revenue funding in support of our strategic activities with the following areas of material investment:

- Organ Donation - £41.0m investment over the 2008/11 period

  This is predominantly (£40.3m) attributable to phased revenue expenditure to commence the programme of work to deliver those recommendations of the ODTF that we have been asked by the DH to take forward. The table below summarises this over the 2008/11 period.

Organ Donation Planned Initiatives	2008/09	2009/10	2010/11
• OD1: Implement clinical "Donor Champions", Organ Donation Committees and effective performance management (ODTF 4&6)	£0.6m	£3.2m	£4.0m
• OD1: Implement financial reimbursement to all hospitals for the additional costs incurred when facilitating a potential or actual donor (ODTF 8)	£2.4m	£2.6m	£3.0m
• OD2: Implementation of a centrally employed Donor Transplant Co-ordinator network (ODTF 9)	£1.9m	£8.9m	£12.8m
• OD3: Implement nationally commissioned Organ Retrieval Teams (ODTF 10)	£0.3m	£9.7m	£19.4m
• OD5: Promote organ donation and identify appropriate methods of public recognition (ODTF 12&13)	£1.0m	£4.1m	£0.4m
• EA1: Establish a UK wide Organ Donor Organisation (ODTF 1&2)	£1.5m	£0.6m	£0.7m
TOTAL INVESTMENT	**£7.7m**	**£29.1m**	**£40.3m**

- Fractionated Products - £18.4m increase in costs over the 2008/11 period

  This relates to growth in costs to enable an increase in sales of c37%. The value of sales planned in excess of these costs will enable NHSBT to eliminate our grant in aid funding requirement for fractionated products by the end of this three-year planning cycle.

- Blood Components and Specialist Services – net cost reduction of £3.4m

  The impact of cost reduction plans over the 2008/11 period (£40.3m – see strategic activities BSC2 and SS3) plus an overall reduction in the level of non-recurring costs in baseline (£3.8m) offsets the impact of forecast cost pressures and developments (£40.7m).

  We will require significant levels of non-recurring funds, prudently estimated at £39.0m over the 2008/11 period, to cover the potential cost of reorganisation, change management support and other non-recurring costs associated with delivery of the strategic change programmes within these areas. The table below outlines our approach to funding these costs

Transition funding plan	2007/08 (X)	2008/09	2009/10	2010/11 (Y)	Movement (X-Y)
Expenditure	£9.0m	£16.3m	£17.5m	£5.2m	-£3.8m
Funded via:					Total 2008/11
• Prices	£9.0m	£9.0m	£4.0m	£3.0m	£16.0m
• Brokered funding		£7.3m	£13.5m	£2.2m	£23.0m
TOTAL		£16.3m	£17.5m	£5.2m	£39.0m

Capital Investment Plans

57. During 2008/11, we are planning to deliver a capital investment programme totalling £61.8m. These plans are largely centred on the consolidation plans within the blood supply chain, BPL's ongoing capital investment plan, plus rolling equipment replacement and renewal programmes.

Capital Expenditure Plan	2008/09	2009/10	2010/11
• BSC: Complete the South West Regional Restructuring - Bristol Filton New Build	£7.8m	£0.6m	-
• BSC: South West Regional Restructuring - minor equipment	£4.2m	-	-
• Specialist Services – replacement LIMS	£0.2m	-	-
• Fractionated Products (BPL) Capital Programme	£6.5m	£6.5m	£6.5m
• Minor Capital Programme – equipment replacement and estate works	£8.7m	£10.8m	£10.0m
TOTAL	**£27.4m**	**£17.9m**	**£16.5m**

58. The appropriate level of capital charges on our fixed asset base, in the form of interest and depreciation, are included within the Income and Expenditure account.

59. We will be working closely with our DH partners to progress and deliver this capital programme in a timely manner, with plans being progressed in conjunction with the DH Business Support Unit and Capital Investment Branch where necessary.

Arm's Length Bodies Review Targets

60. The level of cost reduction and efficiency savings planned demonstrates that we are on track to significantly exceed the overall cost reduction objectives set by the Arm's Length Bodies Review (ALBR).

61. ALBR targets to be achieved by 2008/09 (from a baseline of the 2005/06 plan) are as follows:

- A reduction in baseline grant in aid funding of £11.0m.

  £23.1m will have been achieved by the end of 2008/09
  (£7.1m 2006/07, £9.6m 2007/08 and £6.4m in 2008/09).

- Total cost reduction savings of £27.0m.

  £65.0m will have been achieved by the end of 2008/09
  (£32.3m 2006/07, £17.8m 2007/08 and £14.9m in 2008/09).

- A reduction in funded establishment of 153 WTE.

560 WTE will have been achieved by the end of 2008/09
(284 WTE 2006/07, 183 WTE 2007/08 and 93 WTE in 2008/09).

Performance and Assurance

62. We adopt an integrated approach to planning, performance, governance and assurance. This means that each strategic objective has been subject to risk evaluation and assessment and that supporting activities and work plans (and their respective controls) have been developed to mitigate the risks of failing to achieve these objectives. Such risks are captured within our Strategic Risk Register and this forms a key aspect of the Authority's Assurance Framework (appendix three).

63. Progress against delivery of this plan will be reported each month to the NHSBT Executive Management Team and NHSBT Board, using the Authority's Performance Scorecard (see page 31 below) as the basis of an exception report. This will be supplemented by a full review of progress against the detailed work-plan at the end of each quarter.

64. These quarterly reviews of progress against the work plan will form the basis for the Authority's formal accountability review arrangements with DH sponsors.

65. Major risks to delivery of plans, which arise in-year, are captured within our Programme Governance arrangements and as part of each Functional Management Team's ongoing review of performance and management of risk. Risks are escalated, as appropriate, for resolution via the performance review process.

66. This work is subject to scrutiny by the Governance and Audit Committee (GAC), the Board Programme Assurance Committee (B-PAC) and the Authority's Internal Auditors. As part of the planning process the GAC provides an opinion on the robustness of the Assurance Framework, and its alignment with the activities within this strategic plan.

67. Our integrated planning, performance and governance system, and its associated frameworks and scorecards, are managed on behalf of the CEO by the Directorate of Strategy Management(DSM).

NHSBT 2008/09 Performance Scorecard

		Level	Description	2007/08	2008/09
Blood Components	Sufficient Supply	Objective	Percentage of Product requests met	>99.9%	>99.9%
		Objective	Number of weekdays where red cell stocks (for any blood group) are below the three day alert level	c7 days / month	0
		Objective	Number of days where platelet stocks are 100 below agreed stock level	c2 days / month	0
	Modernise Blood Collection	BSC1a	Percentage of blood collection target achieved	100%	100%
		BSC1b/1c	Percentage of blood donors very / totally satisfied	63%	65%
	Cost Reduction and Efficiency	Objective	Unit price of red cells	£133.99	£139.72
		BSC2	Income and expenditure position (cost reduction target reflected within financial plan)	£0m (£10.5m)	£0m (£10.2m)
	Capacity to process to required standards	Objective	Number of 'critical' regulatory non-compliances	0	0
		BSC3a	Productivity within Processing and Testing - number of red cell (equivalent) units per WTE	5,200 / WTE	5,300 / WTE
		BSC3b	Percentage of external non-compliances with overdue actions	14%	0%
		BSC3c	Percentage of hospitals very / totally satisfied with overall service	50%	53%
	Blood Safety	BSC4	Year on year reduction in red cell issues	1.820m	1.765m (-3.0%)
		BSC4a	Increase platelet production by component donation	60%	80%
Specialist Services	I&E Gap	Objective (SS1-3)	Overall Specialist Services funding gap - managed through delivery of the financial plan	£23.7m	£17.6m
	Service quality maintained	Objective	Number of 'critical' regulatory non-compliances	0	0
		SS4	Percentage of external non-compliances with overdue actions	7%	0%
		SS4	SLA Compliance (RCI)	95.0%	95.0%
		SS4	Tissues: orders met on time in full (OTIF)	96.0%	98.5%
Organ Donation	Organ Donation	Objective	Number of Organ Donors	1,620	1,630
		Objective	Cumulative percentage increase in deceased organ donation	-	2%
		Objective	Number of Organ Transplants	3,202	3,235
		OD1	Percentage of patients where Brain Stem Death (BSD) is a possible diagnosis that following identification, testing and referral are suitable donors	70%	76%
		OD2	Percentage of Heart-beating donor families approached that consent to / authorise donation within the ICUs	61%	63%
		OD3	Number of transplantable organs per donor – Heart-beating	3.91	3.91
		OD3	Number of transplantable organs per donor - Non Heart-beating	2.35	2.35
		OD5	Number of people registered on the Organ Donor Register (ODR)	15.0m	15.7m
	Cornea Donation	Objective	Number of Cornea donors	1,880	1,950
		Objective	Number of Cornea transplants	2,470	2,730
		OD4	Percentage of corneas that is sufficient to meet demand	84%	91%
Fractionated Products	I&E Gap	Objective	Cumulative reduction in central funding / grant in aid requirements (from a 2007/08 planned baseline)	-	41%
		FP1	Cumulative percentage increase in annual fractionation capacity	-	4%
		FP3	Cumulative percentage increase in sales revenues	£82.7m	£93.4m / 13%
	Compliance	Objective	Number of 'critical' regulatory non-compliances	0	0

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Appendix 1 NHSBT Work-Plan 2008/09
Strategic Objective a) Blood Components

PM = Programme Management (resource needed)
BAU = Business As Usual (no additional resources)

Strategic Activity BSC1 NHSBT will ensure the collection of sufficient red cells and platelets to meet current and future demand by modernising blood collection activities.	**Resp Dir.**	**PM / BAU**	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
1a) Redress the decline in blood collection focusing on targeted donor marketing and communications activities:						
○ Implement short-term initiatives focused on retention and frequency - cumulative reduction in potential "do nothing" shortfall • Improved planning of marketing and communication activities to be more effective in attracting and retaining donors • Retained / maintained frequency of 3 times donors through a specific marketing campaign. (Increase in the number of donors donating three times in the year) • Conversion of new donors into second donation by differentiating the service and communications. (Number of new donors who donate for a second time within six months of first donation) • Sending SMS or e-mail appointment reminders. (Proportion of donors from target group for who we hold the relevant information) • Tracing donors lost due to change of address (Proportion off "lost donors" that we have tried to trace)	CRo	PM	11K	14K	12K	13K
○ Achieve whole blood collection target 1.890m in 2008/09	CRo	BAU	476k	482k	461k	471k
○ Medium to long-term initiatives focused on defined sections of the donor population and areas where collection rates are currently poor (London and North West) – plan segments and target areas	CRo	PM	Planning and evaluation			Feasibility assessed
1b) Increase donor satisfaction through improved session convenience, increasing the percentage of blood donors very / totally satisfied from 63% to 65%						
○ Plan Decoupling panels	CRo	PM				Plan & specification written
○ Plan revised opening times and more accessible locations	CRo	PM				Plan & approach signed off
○ Pilot collection centre sited with retail partner – Boots in Poole	CRo	PM			Site in Poole operational	Ramp up Collections
○ Double dose red cells	CRo	PM		Evaluate requirement & feasibility		

Appendix 1 NHSBT Work-Plan 2008/09
Strategic Objective a) Blood Components

Strategic Activity BSC1 NHSBT will ensure the collection of sufficient red cells and platelets to meet current and future demand by modernising blood collection activities.	Resp Dir.	PM / BAU	Quarter 1	Quarter 2	Quarter 3	Quarter 4
1c) Increase operational productivity (& improve donor experience) through the implementation of a donation operational improvement programme – redesign and pilot new processes The quarter 4 targets will be achieved In the areas where roll out has been completed	CRo	PM	Pilot/ evaluation	Commence Roll-out	Continue Roll-out	Continue Roll-out Reducing total queuing time by 20% and end-to-end donation time by 15% Collect to target
1d) Develop plans to import red cells as an important aspect of NHSBT contingency planning – feasibility study	PAG	BAU	Report to EMT			

Appendix 1 NHSBT Work-Plan 2008/09
Strategic Objective a) Blood Components

Strategic Activity BSC2 NHSBT will avoid further significant increases in red cell prices by reducing costs and improving efficiency in line with expected falls in blood demand.	Resp Dir.	PM / BAU	Quarter 1	Quarter 2	Quarter 3	Quarter 4
The 2008/09 cost reduction programme (£10.2m) is reflected in baseline budgets. Delivery will be monitored via the cumulative income and expenditure position (including Group Services)			I&E to plan	I&E to plan	I&E to plan	I&E to plan
2a) Reductions in supply chain costs related to the continued decline in blood component demand - £4.6m	CRo	BAU				
2b) Reductions in cost and efficiencies from increasing capacity utilisation through consolidation and productivity improvements within processing and testing and by implementing best practice (linked to 3a) - £0.3m	CRo	BAU				
2c) Implementation of an operational improvement programme to deliver greater productivity in blood collection (linked to 1c) - £1.4m	CRo	BAU				
2d) Procurement savings - £2.5m	RB	BAU				
2e) Release of non-recurring safety funding in prices - £1.4m	CRo	BAU				

Appendix 1 NHSBT Work-Plan 2008/09
Strategic Objective a) Blood Components

Strategic Activity BSC3 NHSBT will ensure that the organisation has the appropriate level of capacity and capability to process blood to the standards required by modernising its production and testing infrastructure.	Resp Dir.	PM / BAU	Quarter 1	Quarter 2	Quarter 3	Quarter 4
3a) Increasing capacity utilisation through consolidation, productivity improvements and by implementing best practice (5,300 units of red cell (equivalent) per WTE productivity within P&T).						
○ Complete the consolidation in the South West on-time and to budget						
• Complete the new build at Filton	DD	PM	By Mid-June			
• Filton business readiness and occupation	CRo	PM	Planning	SCI, BITS and office moves into Filton	100% of Southmead and Aztec West	
• South West regional operations	CRo	PM	New Leadership Team in place			New SW service model in place
• Complete the relocation of Donation Testing into Filton	CRo	PM	Planning and staff consultation	Planning and staff consultation MHRA licensing	Routine Testing move into Filton	NAT move into Filton
• Complete reconfiguration of Issue (Hospital Services) facilities in the South West	CRo	PM	Planning and staff consultation	Planning and staff consultation MHRA licensing	Move Issue from Southmead to Filton	Implement action of new model
• Complete consolidation of Processing (manufacturing) into Filton	CRo	PM	Planning and staff consultation	Planning and staff consultation MHRA licensing	Move manufacturing from Southmead into Filton	Consolidation of manufacturing into Filton
• Complete logistics and supply chain reconfiguration in the South West	DD	PM	Planning	Planning	Planning	Implement new service model
○ Plan consolidation in the South East and North in advance of consultation beginning in 2009/10	CRo	PM	Planning			
○ Develop logistics infrastructures in the SE and North to support planned consolidations in the regions	DD	BAU	Planning			
○ Operational improvement programme linked to consolidation	CRo	PM	Planning			

Appendix 1 NHSBT Work-Plan 2008/09
Strategic Objective a) Blood Components

Strategic Activity BSC3 NHSBT will ensure that the organisation has the appropriate level of capacity and capability to process blood to the standards required by modernising its production and testing infrastructure.	Resp Dir.	PM / BAU	Quarter 1	Quarter 2	Quarter 3	Quarter 4
○ Replenishment model – improvements to the distribution of blood components to hospitals and NBS stock holding units	CRo	PM	Planning			Pilot
○ Estates optimisation - improvements in space utilisation – decommission Bristol Aztec West	DD	BAU			By December	
3b) Initiatives which contribute to delivering 'compliance' targets (zero 'critical non-compliances and 0% of external non-compliances with overdue actions).						
○ Reinforce a compliance culture through increased self-inspection resource to identify and correct problems in advance, ensuring all major non-compliances are managed effectively and within defined timescales - Recruit and train staff and increase internal inspection	CRo	BAU	Ongoing			
○ Plan for non-compliance - to reduce the percentage of external non-compliance with overdue actions from c14% to 0% in line with the strategic plan targets	CRo	BAU	Ongoing			
3c) Implementation of improved service to hospitals (53% of hospitals very / totally satisfied)						
○ Develop process maps for all NBS / hospital service interactions and identify improvements which add value to the customer • Implement quick win changes • Work with IT and supply chain managers to plan longer term initiatives for implementation 09/10	CRo	PM	Process maps complete by end June08	Develop & initiate promotional campaign to introduce foetal genotyping	Outline plan for longer term initiatives By Nov for Mid-Yr 2008/09	Develop & initiate promotional campaign NBS sci & tech training
○ Improve hospital customer satisfaction scores with respect to NBS decision making and strength of partnership through a programme of pro-active interactions with key customers Initiate face to face customer satisfaction survey completion with key accounts	CRo	BAU	Hospital key account visits complete	Initiate "customer value" visits with strategy teams	Define service standards for Specialist Services	3 percentage points increase in top 2 boxes
○ Implement initiatives to improve performance related to the level of component ordering/despatch errors demonstrated through a reduction in complaints and an improvement in the top box score for accuracy of delivered orders (baseline 25% top box satisfaction) ○ Undertake hospital audit of ordering substitutions	CRo	BAU	Complete audit of order substitutions	Implement service excellence with Issues & Logistics staff in SW	Implement service excellence with Issue & Logistics staff in L&SE & North	

Appendix 1 NHSBT Work-Plan 2008/09
Strategic Objective a) Blood Components

Strategic Activity BSC3 NHSBT will ensure that the organisation has the appropriate level of capacity and capability to process blood to the standards required by modernising its production and testing infrastructure.	Resp Dir.	PM / BAU	Quarter 1	Quarter 2	Quarter 3	Quarter 4
○ Increase hospital satisfaction with service from non NBS drivers ○ Initiate pilot of platelet issue via NBS drivers ○ Hospital Liaison to work with logistics to define customer centric performance measures in courier contract	CRo	BAU	Transport survey feedback to hospitals	Define customer values criteria for courier contract	Implement pilot of platelet issue	
○ Provide hospitals with comparative data sets on red cells, platelets and frozen components to assist hospitals in meeting CMO BBT3 and compliance requirements	CRo	BAU	Develop Business Objects queries	Issue Red cell datasets to RTCs	Issue platelet & frozen component datasets	Refine and review dataset format

Appendix 1 NHSBT Work-Plan 2008/09
Strategic Objective a) Blood Components

Strategic Activity BSC4 NHSBT will reduce the residual risk of transfusion through continued implementation of agreed blood safety initiatives.	Resp Dir.	PM / BAU	Quarter 1	Quarter 2	Quarter 3	Quarter 4
4a) Ongoing implementation of blood safety initiatives (reduction in red cell issues of 1.765m / 3%)						
○ Continued implementation of expanded platelet production by component donation increasing production to 80% by year-end	CRo	BAU	Plans developed and potential assessed	Roll out	Roll out	80%
○ NHSBT will continue to lead the CMO's BBT initiatives introducing new steps to:						
• Reduce inappropriate use of ORhD negative red cells through audit and provision of comparative data	CRo	BAU	Develop audit tool, consider how to facilitate inter-hospital transfers	Audit sent to hospitals for completion	Audit report issued to hospitals	Group ORhD neg constitutes <11 % of total red cell issues
• Reduce inappropriate use of FFP and platelets through audit and provision of comparative data, strengthening the evidence base through systematic literature reviews and clinical trials, and contribution to guidelines in areas of critical care, cardiac surgery and haematology	LW	BAU	Audit sent to hospitals for completion	Audit report issued to hospitals	Review comparative data with RTCs	<340,000 frozen components issued <214,000 platelets issued
○ Reduction in errors resulting in ABO incompatible red cell transfusions reported to SHOT by continuing education, training and audit; exploring new approaches to error reduction in conjunction with NPSA, NBTC and SHOT.	LW	BAU	2.5	2.5	2.5	2.5
○ Extend the use of imported virus inactivated plasma from low risk BSE countries for the preparation of cryoprecipitate for children	CRo	BAU	Stock building Import 2.5k units	Make product available Import 2.5k units	Import 2.5k units	Import 2.5k units
○ Develop new overarching measure for monitoring of blood safety (including donor safety)	LW	BAU	Ongoing	Complete by mid-year		

Appendix 1 NHSBT Work-Plan 2008/09
Strategic Objective a) Blood Components

Strategic Activity BSC4 NHSBT will reduce the residual risk of transfusion through continued implementation of agreed blood safety initiatives.	Resp Dir.	PM / BAU	Quarter 1	Quarter 2	Quarter 3	Quarter 4
4b) Ongoing evaluation of further potential blood safety plans						
○ Implications of red cell prion filtration – NHSBT will continue to participate in the UK Blood Services Prion Reduction Working Group	LW	BAU	Option appraisal to SaBTO by 30 April	Commence filter arm of Study A	Product for exchange transfusion	Plan for Study B
○ Implications of a licensed test for vCJD - NHSBT will continue to participate in the UK Blood Services Prion Assay Working Group	LW	BAU	Option appraisal to SaBTO by 30 April	Ongoing evaluations	Ongoing evaluations	Ongoing evaluations
○ Further testing and processing initiatives to reduce TRALI: screening of potential female platelet donors, manufacture of cryoprecipitate from male donors	CRo	BAU	Ongoing	Ongoing	Ongoing	Ongoing
○ Evaluate whether bacterial screening or pathogen inactivation of platelets should be considered for phased implementation	LW/ PAG	PM to BAU	Ongoing clinical study	Complete clinical study	Option appraisal to SaBTO	Plan for implementation as required

Appendix 1 NHSBT Work-Plan 2008/09
Strategic Objective b) Specialist Services

Strategic Activity SS1 Implement appropriate funding and pricing strategies to eliminate inappropriate cross-subsidies.	Resp Dir.	PM / BAU	Quarter 1	Quarter 2	Quarter 3	Quarter 4
○ Price and funding targets have been reflected in each service budget for 2008/09 – delivery will be monitored via the cumulative income and expenditure position for specialist services	PAG	BAU	I&E to plan	I&E to plan	I&E to plan	I&E to plan

Strategic Activity SS2 Expand in areas of anticipated high growth without increasing capacity unnecessarily.	Resp Dir.	PM / BAU	Quarter 1	Quarter 2	Quarter 3	Quarter 4
○ Increase H&I referrals to support the increase in solid organ and stem cell transplantation	PAG	BAU	2%	3%	4%	5%
○ Increase Clinical Stem Cell procedures through increased business development	PAG	BAU	2%	3%	4%	5%
○ Increase the number of Cord Blood units held in stock	PAG	PM	10,600	11,200	11.850	12,500
○ Increase the proportion of Black and Minority Ethnic (BME) Cord Blood units held in stock.	PAG	PM	40%	40.3%	40.7%	41%
○ Increase Tissue sales through increased marketing and product development	PAG	BAU	2%	3%	4%	5%
○ Introduce foetal genotyping from maternal blood	PAG	BAU	Continue validation at Southmead	Procure Equipment	Plan for implementation	Complete plan

Strategic Activity SS4 Ensure that service quality levels are maintained or improved during the ongoing change programme.	Resp Dir.	PM / BAU	Quarter 1	Quarter 2	Quarter 3	Quarter 4
○ Percentage of hospitals satisfied with overall service (RCI - top two boxes) – Maintenance of excellent communications and service during period of change	PAG	BAU	57%	57%	57%	57%
○ Achieve RCI turnaround targets	PAG	BAU	95%	95%	95%	95%
○ Achieve H&I turnaround targets	PAG	BAU	80%	80%	80%	80%
○ Achieve SCI turnaround targets	PAG	BAU	90%	90%	90%	90%

Appendix 1 NHSBT Work-Plan 2008/09
Strategic Objective b) Specialist Services

Strategic Activity SS3 Reduce costs and improve efficiency from realising synergies, consolidation and divesting from activities in a managed way ensuring continued patient safety.	Resp Dir.	PM / BAU	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Consolidate RCI reference services						
○ Complete the move of Southampton to Filton	PAG	PM	Plan	Complete		
○ Plan the move of Manchester to Liverpool	PAG	PM	Plan	Plan	Plan	Plan
○ Plan alternatives for Cambridge (Addenbrookes or Colindale)	PAG	PM	Plan	Plan	Plan	Plan
Consolidate Reagent services						
○ Complete the move of Birmingham to Liverpool	PAG	PM	Plan	Complete		
○ Complete the move of Cambridge to Liverpool	PAG	PM	Plan	Complete		
Consult with hospitals affected by divestment of routine ante natal services, and plan alternatives for each. Cessation by 2010/11.	PAG	PM	Appoint Project Team	Draft Business Case	Early consultation	Consultation complete
Consolidate BBMR, H&I, SCI and CBB services in one location.						
○ Transfer Cord Blood Bank from Edgware (CBB) to Filton	PAG	PM	Plan	Plan	Draft Business Case	Consultation
○ Donor-facing H&I activities from Colindale to Filton	PAG	PM	Plan	Plan	Draft Business Case	Consultation
Alignment of H&I and RCI services into a single diagnostics function	PAG	PM/ BAU			Draft Business Case	Early Implementation
SCI efficiencies and growth						
○ Transfer SCI Cambridge to Addenbrookes Hospital	PAG	BAU	Complete			
○ Embed Manchester SCI in Liverpool	PAG	PM	Plan	Plan	Plan	Plan
H&I efficiencies and growth	PAG	BAU				Review logistics for PGI
RCI efficiencies and growth	PAG	BAU	Develop workforce plan	Filton pilot extended working day		

Appendix 1 NHSBT Work-Plan 2008/09
Strategic Objective c) Organ Donation

Strategic Activity OD1 Remove the obstacles to organ donation and effectively performance manage the identification and referral of potential donors.	Resp Dir.	PM / BAU	Quarter 1	Quarter 2	Quarter 3	Quarter 4
○ Implementation of clinical "Donor Champions" and an Organ Donation Committee within 51 (c19%) donating hospitals (ODTF recommendation 4)	TM	PM	JDs and recruitment process			51 / 19%
○ Implement effective performance management with donating hospitals within all donating hospitals (ODTF recommendation 6)	TM	PM	Indicators for HCC standards	Indicators for HCC standards		
○ Implement financial reimbursement to all NHS Trusts for the additional costs incurred when facilitating a potential or actual donor (ODTF Recommendation 8)	TM	PM	Preparation	Q1 in July	Q2 in October	Q3 in January
Strategic Activity OD2 Maximise the conversion of potential donors into actual donors by developing and implementing a robust, sustainable donor co-ordination service (ODTF 9).						
○ Implementation of a centrally employed Donor Transplant Co-ordinator network in four teams	TM	PM	Commence recruitment of new staff			4 teams (not fully operational)
○ Improve, and streamline, the process of donor registration through the introduction of an electronic (web-based) system	TM	PM	Architecture developed	Application development underway	Application development complete	Pilot EOS system deployed
○ Maintain and increase the current level of investment in Living Donor schemes, through funding the deployment of 4 additional Live Donor co-ordinators	CRu	BAU	SLAs in place April	Funding new living donor schemes		30 live donor co-ordinators
Strategic Activity OD3 Develop and implement a flexible, robust and sustainable organ retrieval service that delivers viable organs to transplant units (ODTF 10).						
○ Implement nationally commissioned Organ Retrieval Teams (ODTF 10) - develop a framework within which the commissioning of Organ Retrieval Teams can be implemented in time for the 2009/10 financial year	TM	PM	Develop specification and model	Commiss'ng agreements for 2009/10	Deployed November	NHSBT commiss'ng capability
Strategic Activity OD4 Develop and implement a robust, sustainable cornea donation service.						
○ Review eye retrieval units - performance manage each against a target of retrieving 70% of all donated corneas by 2011/12, whilst achieving an annual quality indicator of 70% retrieved corneas suitable for transplantation	CRu	BAU				3 units
Strategic Activity OD5 Implement methods to publicly recognise the act of donation and actively promote donation to the public.						
○ Plan and develop a national public awareness campaign (implement in 2009/10).	HJ	BAU	Plan and develop			
○ Promoting organ donation and the "gift of life" to the general public, and specifically to the BME population, via targeted marketing campaigns (ODTF recommendation 13). This will include the commissioning of research through DH Research and Development funding	HJ	BAU		Develop marketing campaigns	Implement campaigns	Implement campaigns
○ Promoting public recognition of individual organ donors through national memorials, local initiatives and personal follow up to all donor families (ODTF recommendation 12)	TM	PM		Develop specification for commissioning research	Commission research	

Appendix 1 NHSBT Work-Plan 2008/09
Strategic Objective d) Fractionated Products

Strategic Activity FP1 Increase capacity and throughput.	Resp Dir.	PM / BAU	Quarter 1	Quarter 2	Quarter 3	Quarter 4
○ Increase annual fractionation capacity by 4%	JM	BAU				483k L
○ Average batches per week	JM	BAU				1.75
○ Capital Investment – cumulative expenditure	JM	BAU	£1.1m	£2.7m	£4.3m	£6.5m
○ Budgeted WTE	JM	BAU	432	432	432	432
Strategic Activity FP2 Develop new products and expand into key markets						
○ Launch new products	JM	BAU				
• Optivate sales in Europe			MHRA advice – clinical data refresh	MHRA expert report	January	Mutual recognition filing
• Replenine sales in Europe			MHRA advice – clinical data refresh	MHRA expert report	January	Mutual recognition filing
○ Contract fractionation (CFr) - Licensing out BPL IP (LO)	JM	BAU				
• Gammacan – contract signed (trial 2 – plasma dependant)			April	Clinical trial batches - 1	Clinical trial batch -2	
• Anti-D – contract signed			Preliminary contract discussion	TBA	TBA	TBA
Strategic Activity FP3 Increase home and export sales revenues						
○ Deliver home sales plan – year on year increase of £8.5m	JM	BAU	£17.1m	£34.3m	£51.4m	£68.5m
○ Deliver export sales plan – year on year increase of £2.1m	JM	BAU	£5.9m	£11.8m	£17.7m	£23.7m
Strategic Activity FP4 Consider options for commercial partnership						
○ Respond to the outcome of Ministerial review of the OBC on ownership options	LH &JM	BAU	TBC	TBC	TBC	TBC

Appendix 1 NHSBT Work-Plan 2008/09
Strategic Objective e) NHSBT Organisation and Enabling Activities

Strategic Activity EA1 Ensure NHSBT corporate structures enable effective and efficient delivery of its strategy through the provision of appropriate organisational structures and systems	Resp Dir.	PM / BAU	Quarter 1	Quarter 2	Quarter 3	Quarter 4
○ NHSBT: Implementation of a revised organisation structure that integrates formation of an Organ Donor Organisation and demonstrates further synergies across its total supply chain	LH	BAU	Outline structure agreed and four of the new posts advertised and selection completed	Top Team in place, Operational Divisions changes agreed. Board Development Plan in place	Organisational Development Plan agreed	
○ NHSBT: Review of Group Services - planning delivery of cost reductions and efficiencies in support service functions in line with external benchmarks	LH	BAU				Begin January
○ Complete the realignment of support team sub-structures to enable successful delivery of strategic plans						
• Clinical: Develop an R&D strategy that recognises the need for succession planning, the opportunities presented by the creation of the National Institute for Healthcare Research, and includes proposals for structuring of development.	LW	BAU	Gather information on development activities	Formulate plans for Research	Present plan to NHSBT Board	Commence implementation
• Clinical: Review the current structure of the Clinical Directorate in the light of NHSBT organisational restructure	LW	BAU	Option appraisal and development of job descriptions	Appoint to new structure	Further appointments	New structure in place
• Implement a reorganisation of the HR Function to provide a more effective and responsive general HR and recruitment service.	DE	BAU	Ongoing	Restructure complete		
• Finance: Continue the restructure / development of Finance to improve support to the development & delivery of strategy.	RB	BAU				By March
• IT: Implement the IT organisational change to deliver the structure outlined in the IT Strategy	AMcD	BAU			IT organisation blueprint agreed.	Security Mgmt, Business Systems Solutions Mgmt and Relationship Mgmt structures in place.

Appendix 1 NHSBT Work-Plan 2008/09
Strategic Objective e) NHSBT Organisation and Enabling Activities

Strategic Activity EA1 Ensure NHSBT corporate structures enable effective and efficient delivery of its strategy through the provision of appropriate organisational structures and systems	Resp Dir.	PM / BAU	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Communications & Public Affairs: • Restructure of the CPA Directorate (the subsequent activities are dependent on this) • Development and introduction of a single internal communications function across NHSBT • Development and introduction of a single professional and responsive press and media function across NHSBT – with one integrated on-call team • Recruitment of staff with relevant experience to build a Public Affairs function	HJ	BAU			Single NHSBT magazine Begin the process of developing a single NHSBT Intranet	
○ Review and develop NHSBT's Governance systems						
• NHSBT: Maintenance and development of an effective emergency preparedness infrastructure and framework						
Renewed SLA DH Antidote service in place	CRo	BAU	Signed SLA in place			
Flu pandemic plans in place and mechanism for regular review.	CRo	BAU	Develop assessment tool in collaboration with DH.	Gap analysis.	Report on Flu Preparedness	
Review EP management arrangements	CRo	BAU	Report for NBS SMT	Business case(s) if required		
• DSM: Development of an action plan in response to NHSBT's NHSLA and Standards for Better Health self-assessments	TM	BAU	Action Plan agreed & Implemen'd	Q2 update report	Q3 update report	Actions complete Q4 report
• DSM: Implementation of the findings from the review of risk management systems and processes	TM	BAU	Recommendations and actions agreed	Implementation	Implementation	Actions complete
• DSM: Development of an integrated NHSBT Sustainable Development Action Plan	TM	BAU	SDAP developed	Agreement & Implementation of actions	SDAP integrated to NHSBT Planning & Governance Processes by December	
• Finance: complete benchmarking analysis with NHS SBS and develop an action plan	RB	BAU				March

Appendix 1 NHSBT Work-Plan 2008/09
Strategic Objective e) NHSBT Organisation and Enabling Activities

Strategic Activity EA1 Ensure NHSBT corporate structures enable effective and efficient delivery of its strategy through the provision of appropriate organisational structures and systems	Resp Dir.	PM / BAU	Quarter 1	Quarter 2	Quarter 3	Quarter 4
• Clinical: Review Clinical Governance arrangements, including Clinical Audit, with a view to improving the integration of Clinical Governance issues within NHSBT's management arrangements	LW	BAU	Clinical Audit Workshop, Medicines Mgt, Infection Control	Adverse events, medical records.	Present proposals to the Board	New arrangements in place
○ Review and develop NHSBT's systems in support of key strategic deliverables						
• IT: Complete the consolidation of Pulse onto new hardware and a single database	AMcD	PM	New hardware fully validated and in place and migration plans agreed with stakeholders	Migration complete		
• IT: Continue to renew the components of Pulse, with business support	AMcD	PM		Version 15.3 & 15.4 live	Version 16.1 live	
• IT: Replacement telecommunications system procured and deployment underway	AMcD	PM		Award contract	25% complete	50% by year-end
• IT: Implement the new standardised Laboratory Information Management System (Hematos) in line with project milestones	PAG	PM	Ongoing	H&I BBMR HITS live	CBB & BBMR office	SCI live
• IT: With Donor Services support, IT Session infrastructure replacement.	AMcD	PM	Procurement underway. Rollout plans agreed with DS.	Procurement complete. Rollout ongoing.	Rollout meets targets agreed with DS.	Rollout meets targets agreed with DS.
• IT: Enterprise print management system procured and deployed in Filton.	AMcD	PM	Planning complete and procurement begins	Procurement complete and deployment begins	Deployment complete	
• IT: NBS Data Warehouse developed and deployment underway.	AMcD	PM		Begin development and procurement	Complete development and procurement	Deployment commenced
• IT: Plan and design the infrastructure for the UKT ODO	AMcD	PM		Planning and design work for ODO underway	Planning and design complete	Initial implementation

Appendix 1 NHSBT Work-Plan 2008/09
Strategic Objective e) NHSBT Organisation and Enabling Activities

Strategic Activity EA1 Ensure NHSBT corporate structures enable effective and efficient delivery of its strategy through the provision of appropriate organisational structures and systems	Resp Dir.	PM / BAU	Quarter 1	Quarter 2	Quarter 3	Quarter 4
• IT: Secure corporate data on NHSBT laptops and removable media	AMcD	PM	Procure encryption. Begin to implement	Implementation continues	Complete implementation	
• IT: Upgrade core IT infrastructure components - 1. Active Directory, 2. Data centre SAN, 3. Microsoft Exchange 4. Core Network, 5. Web Services Components.	AMcD	PM	1. deployment plan agreed. 4 design in progress. 5. Design and implementation plans developed .	1. deployment in progress 2. Detailed requirements complete 4. design requirements complete. 5. Procurement begins	1. deployment in progress 2. procurement 4. procurement 3. requirements complete 5. Procurement complete and deployment begins	1. deployment complete 2. Contract award deployment started 4. Contract award deployment started 3. procurement complete 5. deployment complete
• Function?: Development of a system for the 35 outstanding transplant-related datasets	CRu / AMcD	BAU	Initial analysis	Requirement Defined		
• Finance: Upgrade Oros ABC software to SAS ABM to enable improved performance reporting, drill down access, improved model automation and data integration	RB	PM	Ongoing	Complete		
• Finance: Complete ABC iteration 4 and 5 including UKT.	RB	BAU	Ongoing	Ongoing	October	
• Finance: Complete the feasibility study on Intelligent invoice processing	RB	PM				March
• Finance: Integration of core systems into billing processes / completing the review of Debtors processes completed	RB	BAU		September		
• Finance: Progress ESR Benefits Realisation – implement e-expenses and ADI upload	RB	PM			E-expenses Oct ADI upload Decr	
○ IT: Maintain the availability of key IT services (% availability)	AMcD	BAU	≥99.95%	≥99.95%	≥99.95%	≥99.95%
○ IT: Maintain customer satisfaction with services offered at the desktop	AMcD	BAU	≥70%	≥70%	≥70%	≥70%
○ Finance: Better Payment Practice Code by volume and value	RB	BAU	≥92.00%	≥92.00%	≥92.00%	≥92.00%
○ Finance: Number of debtor days	RB	BAU	20	20	20	20

Appendix 1 NHSBT Work-Plan 2008/09
Strategic Objective e) NHSBT Organisation and Enabling Activities

Strategic Activity EA 2 Build support for the NHSBT strategy through a programme of proactive engagement with internal and external stakeholders.	Resp Dir.	PM / BAU	Quarter 1	Quarter 2	Quarter 3	Quarter 4
○ HR: continued development of more effective consultative structures and an effective policy framework, developed in partnership	DE	BAU	Ongoing	Ongoing	First Phase Revisions in place	
○ HR: develop and implement a revised action plan in response to the 2008 staff survey and improve the response rate to the 2009 survey to over 45%.	DE	BAU	Action Plan agreed			Response rate improved to 45%
○ HR: develop and implement a Single Equality Scheme and associated Action Plan	DE	BAU	SES agreed and adopted			
○ Communications & PA: Build on progress made in strategic stakeholder engagement on NBS review and launch of ODTF report so that this becomes part of business as usual across NHSBT	HJ	BAU	Engagement Plans developed			
○ Finance: Ensure that sufficient funding is generated, effectively managed and made available in line with planned requirements	RB	BAU				
• Support to the NCG for Blood process				NCG1 July	NCG 2 November	
• Submission of revenue, brokerage and capital GIA bids in line with the DH planning timetable.					Mid December	
○ Finance: Continued delivery of a supplier development programme	RB	BAU	7 key suppliers	8 key suppliers	9 key suppliers	10 key suppliers
○ DSM: Establish process for self-regulation in line with DH gateway arrangements	TM	BAU		Agreed by Mid-year		Implement
○ DSM: Effective development and deployment of an NHSBT planning framework, working within DH guidelines and frameworks	TM	BAU	Review and agree process, update strategic direction by end of Q1	Outline plans 2009/12 to Nov Board Planning day and draft documents to the DH	Refine plans to reflect DH feedback and in-year performance	Board and DH approval by March
○ Clinical: Engage stakeholders on the implementation, success monitoring and roll out of BBTIII and relevant and influential clinical audit outcomes and systematic reviews.	LW	BAU	Workplan for Clinical Audit	Greater involvement through NBTC Executive sub-group	Take part in public awareness day	Ongoing

Appendix 1 NHSBT Work-Plan 2008/09
Strategic Objective e) NHSBT Organisation and Enabling Activities

Strategic Activity EA 2 Build support for the NHSBT strategy through a programme of proactive engagement with internal and external stakeholders.	Resp Dir.	PM / BAU	Quarter 1	Quarter 2	Quarter 3	Quarter 4
○ Clinical: Engage with clinical colleagues in NHS Hospital Trusts involved in transplantation, to help ensure the successful implementation of the Organ Donation Taskforce recommendations.	LW	BAU	Develop job descriptions for clinicians to lead	Appoint to clinical lead posts within NHSBT	Activities as part of ODO plans	Activities as part of ODO plans
○ E&L: Develop an outline Estates and Logistics Strategic Plan in line with 'internal' stakeholder requirements	DD	BAU				By March
• Survey estates utilisation, suitability, cost and condition against internal stakeholders' needs	DD	BAU		Commence survey	Complete survey and report	
• Develop and implement 5 year estates investment plans to meet internal stakeholders' needs	DD	BAU				Propose draft Plans
• Review warehouse operations models against internal stakeholders' needs and propose improvements	DD	BAU		Complete review		

Appendix 1 NHSBT Work-Plan 2008/09
Strategic Objective e) NHSBT Organisation and Enabling Activities

Strategic Activity EA3 Improve NHSBT's capacity and capability to deliver strategic change through the deployment of appropriate resource, leadership and skill, supported by the development of appropriate performance management systems	Resp Dir.	PM / BAU	Quarter 1	Quarter 2	Quarter 3	Quarter 4
○ HR: Provide effective support to key strategic organisational changes, in particular; • Completion of the Filton and South West project • Implementation of the Organ Donation Taskforce recommendations • Transformational change within Donor Services	DE	BAU	Ongoing	Ongoing	Ongoing	Ongoing
○ HR: Introduce a new system of HR KPIs which will allow more effective workforce management by line managers	DE	BAU	Ongoing	KPIs Introduced		
○ HR: In conjunction with the relevant Directors, ensure a significant reduction by year-end in absence levels in areas with high absence rates. Key target areas - Donor Services and Estates/Logistics, as follows: E&L – 2% reduction by year end Donor Services – 1.25% reduction by year end	DE	BAU	Revised absence policy implemented	New monitoring system in place	Targeted action	Target reductions achieved in key areas
○ HR: Develop and implement a new Appraisal and Personal Development Review Process, linked to E-KSF.	DE	BAU			Consultation on new system	New system launched
○ HR: Implement improved control and monitoring systems for the management of Agency/temporary staffing.	DE	BAU	Controls in place			
○ HR: To ensure that an effective Leadership and Management Development programme is designed and implemented in support of strategic priorities	DE	BAU	Priorities identified	Programme spec developed	Resource identified /tender process completed	Revised programme in place
○ IT: Continue to ensure that effective programme management structures are available to support business change in all operating divisions, including the provision of appropriate resources, standards and governance frameworks	AMcD	BAU	Roll-out of new lifecycle & associated templates continues	Roll-out of new lifecycle & associated templates complete		
○ IT: Continue to ensure that suitable and sufficient Project Management resources are available to deliver NHSBT initiatives, and that appropriate project management standards and methods are developed and deployed	AMcD	BAU		Extend / replace the contract to provide project managt support to the change programme.	Ensure project managt support is commensur ate with NHSBT strategic needs	Ensure project managt support is commensur ate with NHSBT strategic needs

Appendix 1 NHSBT Work-Plan 2008/09
Strategic Objective e) NHSBT Organisation and Enabling Activities

Strategic Activity EA3 Improve NHSBT's capacity and capability to deliver strategic change through the deployment of appropriate resource, leadership and skill, supported by the development of appropriate performance management systems	Resp Dir.	PM / BAU	Quarter 1	Quarter 2	Quarter 3	Quarter 4
○ DSM: Development of improved performance management systems, frameworks and processes	TM	PM		Recommendations and actions agreed	Begin to implement	
○ Clinical: Review Clinical Directorate workforce requirements and geographical spread in light of NBS strategy review – appoint to new joint posts in Transfusion Medicine (with HPA), Tissue Services (Wrightington Hospital), and in Nottingham, Liverpool, Kings, and St. Mary's London. Review arrangements in Birmingham and Manchester. Implement new contract for non-consultant career grade doctors in line with national arrangements and develop.	LW	BAU	Finalise JDs, and advertise tissues, epidemiology, Kings, Nottingham	Finalise JDs and advertise St. Mary's	Review arrangements in Birmingham and Manchester	Plan for Liverpool
○ Clinical: Provide support for the replacement of the Chair of UK JPAC, and assist with the review of JPAC modus operandi	LW	BAU	Develop JD for Chair of JPAC	Appoint Chair of JPAC	Review JPAC modus operandi	Implement changes

NHS
Blood and Transplant

PLAN 2008/09
CONSOLIDATED
REVENUE STATEMENT

	Plan 07/08 £k	Forecast 07/08 £k	Plan 08/09 £k
Income			
Baseline Revenue Cash Limit	33,732	29,842	27,354
ODTF Revenue Funding	0	0	7,702
Inter Year Flexibility in	20,000	20,000	23,000
Divisional Income	427,456	422,284	447,537
Contribution from devolved administrations	1,813	1,813	1,863
Sub-total Income	**483,001**	**473,939**	**507,456**
Inter Year Flexibility out	(20,000)	(23,000)	(15,700)
Total Income	**463,001**	**450,939**	**491,756**
Expenditure			
NBS Operating Division	247,707	245,207	257,341
BPL Operating Division	91,490	88,488	97,024
UKT operating Division	9,422	9,422	15,439
Total Operating Division	**348,619**	**343,117**	**369,804**
Chief Executive and Board	933	933	957
Communications & Public Affairs	3,713	3,713	3,543
Estates & Logistics	54,506	54,479	55,919
Finance	7,042	7,026	7,103
Human Resources	7,305	7,442	7,432
Information Technology	18,719	18,719	18,963
Clinical Directorate	9,792	9,792	10,831
Directorate of Strategy Management	854	854	927
Reserves & Other	11,518	1,864	8,978
Brokered Transition Fund	20,000	23,000	23,000
Sub-total Group Support Services	**134,382**	**127,822**	**137,652**
Inter Year Flexibility out	(20,000)	(23,000)	(15,700)
Total Group Support Services	**114,382**	**104,822**	**121,952**
Surplus/(Deficit)	**0**	**3,000**	**0**

NHS
Blood and Transplant

PLAN 2008/09
CONSOLIDATED BALANCE SHEET

	Forecast 07/08 £k	Plan 08/09 £k
Fixed Assets	346,945	368,002
Current Assets		
Stocks	57,965	58,384
Trade Debtors	20,590	20,119
Prepayments	6,219	5,600
Other Debtors	2,993	4,166
Bank and Cash	70	70
	87,837	88,339
Less:-		
Current Liabilities		
Trade Creditors	15,411	13,411
Accruals	12,401	13,680
Inter Authority Loan	0	0
Others	2,689	4,925
	30,501	32,016
Net Current Assets	57,336	56,323
Provisions	3,088	3,088
Total Net Assets	**401,193**	**421,237**
Represented by:-		
Department of Health Funding		
General Reserve	401,193	421,237
Revaluation Reserve		
Total Dept of Health Funding	**401,193**	**421,237**

CONSOLIDATED CASH FLOW FORECAST
PLAN 2008/09

NHS
Blood and Transplant

	Apr-08 £k	May-08 £k	Jun-08 £k	Jul-08 £k	Aug-08 £k	Sep-08 £k	Oct-08 £k	Nov-08 £k	Dec-08 £k	Jan-09 £k	Feb-09 £k	Mar-09 £k	Total £k
Opening bank balance	70	8,578	11,131	13,686	16,240	18,793	21,347	20,810	20,272	19,736	18,821	17,528	70
Income													
Debtors & Other Receipts	37,450	37,450	37,450	37,450	37,450	37,450	37,450	37,450	37,449	37,450	37,450	37,451	449,400
Revenue Cash Limit	10,295	4,341	4,341	4,340	4,340	4,341	4,341	4,341	4,342	4,341	4,341	4,352	58,056
Inter year flexibility out												-15,700	-15,700
Capital Cash Limit	2,277	2,281	2,281	2,281	2,281	2,281	2,280	2,280	2,281	2,280	2,281	2,281	27,365
Total income	50,022	44,072	44,072	44,071	44,071	44,072	44,071	44,071	44,072	44,071	44,072	28,384	519,121
Expenditure													
Staff Expenses	16,871	16,871	16,871	16,871	16,871	16,871	16,974	16,974	16,973	17,168	17,365	17,374	204,054
Other Revenue costs	19,277	19,277	19,277	19,277	19,277	19,277	22,265	22,265	22,265	22,448	22,631	22,967	250,503
Capital Charges	3,089	3,090	3,088	3,089	3,089	3,089	3,089	3,089	3,089	3,090	3,088	3,220	37,199
Capital costs	2,277	2,281	2,281	2,280	2,281	2,281	2,280	2,281	2,281	2,280	2,281	2,281	27,365
Total costs	41,514	41,519	41,517	41,517	41,518	41,518	44,608	44,609	44,608	44,986	45,365	45,842	519,121
Closing bank balance	8,578	11,131	13,686	16,240	18,793	21,347	20,810	20,272	19,736	18,821	17,528	70	70

NHS
Blood and Transplant

PLAN 2008/09
CONSOLIDATED FUNDS FLOW STATEMENT

	Forecast 07/08 £k	Plan 08/09 £k
Surplus/(Deficit)	**0**	**0**
(Increase)/Decrease in stocks	(57,965)	(419)
(Increase)/Decrease in trade debtors	(20,590)	471
(Increase)/Decrease in prepayments and other debtors	(9,212)	(554)
Increase/(Decrease) in trade creditors & accruals	27,812	(721)
Increase/(Decrease) in other creditors	2,689	2,236
Increase/(Decrease) in Inter Auth Loan	0	0
Increase/(Decrease) in provisions	3,088	0
Increase/(Decrease) in working capital	**(54,178)**	**1,013**
	(54,178)	**1,013**
Opening cashbook balance	114	70
Closing cashbook balance	70	70
Increase/(Decrease) in cash	**(44)**	**0**

Appendix 2 (e)

NHS
Blood and Transplant

PLAN 2008/09
CAPITAL EXPENDITURE PLAN

	2008/09 £m
South West Regional Restructuring - Bristol Filton New Build	7.815
South West Regional Restructuring - minor equipment	4.207
Specialist services system replacement	0.191
Minor Capital Programme	8.652
BPL Capital Programme	6.500
Total NHSBT	**27.365**

Appendix 3 NHSBT Assurance Framework April 2008

Objective (a)	Blood Components									
	What do we want to do?	*How will we know? What will be different in 2008/09/10/11?*	*What will stop us?*	*How is the risk controlled*	*How do we know the risk is controlled?*	*What are the gaps in managing the risk*	*What should we do about the risk gaps*		*Following quarterly review, has the risk moved up, down or stayed the same?*	
Blood Supply Chain (BSC)	**Principal corporate objective**	**Success criteria / end outcome and expected dates**	**Constraints / risks to meeting the objective**	**Control**	**Assurance**	**Gaps identified**	**Priorities for actions from risk, control, assurance, gaps**	**Risk rating**	**Movement in risk rating**	**Lead**
	To provide a sustainable supply of blood component products and services that meet all safety, quality, service provision and compliance standards, as efficiently as possible, via the modernisation of the blood component supply chain.	**BSC1a** Blood collection target achieved (100% -2007/08 / 100% -2008/09 and onwards) **BSC 1b / 1c** Blood donor satisfaction levels increase (63% - 07/08 / 65% - 08/09 / 68% - 09/10 / 73% - 10/11)	**BSC1** Turnover in donors - active donor database declining at a faster rate than the decline in demand. **BSC1** Blood collection model not providing the right environment for donors - blood stocks are falling below optimum levels.	**BSC1** Ensure the collection of sufficient red cells and platelets to meet current and future demand by modernising blood collection activities.	BSC – Overall progress overseen by NHSBT Board and Executive Management Team. (Minutes of Meetings) Quarterly and Monthly Performance Reports At a Divisional Level, overseen by NBS SMT. Also:- Donor Services SMT Minutes Process, Testing and Issues SMT minutes	None	None			CRo
		BSC 2 Cost reduction target - £10.5m - 07/08, £10.2m - 08/09, £11.1m - 09/10, £15.4m - 10/11	**BSC 2** Stakeholder pressure to reduce costs and stabilise previously rising prices. **BSC 2** NHSBT behind European counterparts on efficiency and productivity benchmarks.	**BSC2** Avoid further significant increases in red cell prices by reducing costs and improving efficiency in line with expected falls in blood demand.						CRo
		BSC 3a Productivity within Processing and Testing no of red cell (equivalent) units per WTE - 5,200/WTE 07/08, 5,300/WTE 08/09, 6,300 WTE 09/10 & 7,000/WTE 10/11. **BSC 3b** Reduction in external non-compliances with overdue actions – 14% - 07/08, 0% - 08/09 - 10/11 **BSC 3c** % of Hospitals satisfied with overall service (Top Box) 50% - 07/08, 53% - 08/09, 56% - 09/10, 60% - 10/11.	**BSC 3a** Significant over capacity exists and will grow if not addressed. **BSC 3b/c** Product and service infrastructure will not meet future regulatory and safety requirements without corrective action.	**BSC3** Ensure that the organisation has the appropriate level of capacity and capability to process blood to the standards required by modernising its production and testing infrastructure.						CRo
		BSC 4 Year-on-year reduction in red cell issues 1.820m in 07/08 1.765m (-3.0%) in 08/09 1.724m (-2.3%) in 09/10 1.700m (-1.4) in 10/11	**BSC 4** Some blood component products continue to cause adverse reactions in patients.	**BSC4** Reduce the residual risk of transfusion through continued implementation of agreed blood safety initiatives.						CRo/ LW

Appendix 3 NHSBT Assurance Framework April 2008

Objective (b)	Specialist Services									
	What do we want to do?	**How will we know? What will be different in 2008/09/10/11?**	**What will stop us?**	**How is the risk controlled**	**How do we know the risk is controlled?**	**What are the gaps in managing the risk**	**What should we do about the risk gaps**		*Following quarterly review, has the risk moved up, down or stayed the same?*	
Specialist Services (SS)	Principal corporate objective	Success criteria / end outcome and expected dates	Constraints / risks to meeting the objective	Control	Assurance	Gaps identified	Priorities for actions from risk, control, assurance, gaps	Risk rating	Movement in risk rating	Lead
	To move Specialist Services towards financial sustainability, while maintaining quality, service provision and compliance standards.	Contribution to reduced funding gap: **SS1 (Pricing)** £5.4m -08/09, £1.4m - 09/10, £1.4m - 10/11	**SS1, 2 & 3** Ability to meet growing demand for many NHSBT specialist services.	**SS1** Implement appropriate funding and pricing strategies to eliminate inappropriate cross-subsidies.	SS – Overall progress overseen by NHSBT Board and Executive Management Team. (Minutes of Meetings) Quarterly and Monthly Performance Reports At a Divisional Level, overseen by NBS SMT. Also:- Specialist Services SMT Minutes	None	None			PAG
		Contribution to reduced funding gap: **SS2 (Growth)** £0.0m - 08/09, £0.8m - 09/10, £0.7m - 10/11	**SS1, 2 & 3** Some services do not fit with wider NHSBT supply chain.	**SS2** Expand in areas of anticipated high growth without increasing capacity unnecessarily.						
		Contribution to reduced funding gap: **SS3 (Cost reduction)** £0.7m - 08/09, £2.0m - 09/10, £1.0m - 10/11	**SS1, 2 & 3** Services are currently subsidised by income from the provision of blood component products.	**SS3** Reduce costs and improve efficiency from realising synergies, consolidation and divesting from activities in a managed way ensuring continued patient safety.						
		SS4 Maintenance of Quality a) Reduction in external non-compliances with overdue actions - 7% - 07/08, 0% - 08/09 to 10/11. b) SLA Compliance 95% 07/08 to 10/11 c) Tissues: orders met on time in full (OTIF) 96% - 07/08, 98.5% - 08/09 to 10/11	**SS4** Failure in quality levels could lead to harm / death to patients and loss of license / accreditation	**SS4** Ensure that service quality levels are maintained or improved during the ongoing change programme.						

Appendix 3 NHSBT Assurance Framework April 2008

Objective (c)	Organ Donation									
	What do we want to do?	*How will we know? What will be different in 2008/09/10/11?*	*What will stop us?*	*How is the risk controlled*	*How do we know the risk is controlled?*	*What are the gaps in managing the risk*	*What should we do about the risk gaps*		*Following quarterly review, has the risk moved up, down or stayed the same?*	
Organ Donation (OD)	**Principal corporate objective**	**Success criteria / end outcome and expected dates**	**Constraints / risks to meeting the objective**	**Control**	**Assurance**	**Gaps identified**	**Priorities for actions from risk, control, assurance, gaps**	**Risk rating**	**Movement in risk rating**	**Lead**
	To identify and refer increasing numbers of potential donors and to increase the number of actual donors, enabling an increase in the number of transplants.	**OD1** % of patients where BSD is a possible diagnosis that following identification, testing and referral are suitable donors - 70% - 07/08, 76% - 08/09, 78% - 09/10, 80% -10/11.	**OD1** Current structures and arrangements act as a barrier to organ donation. Organs are currently retrieved from 30%-40% of potential donors. **OD1** Organ donation is not effectively performance managed within the NHS.	**OD1** Remove the obstacles to organ donation and effectively performance manage the identification and referral of potential donors.	OD – Overall progress overseen by NHSBT Board and Executive Management Team. (Minutes of Meetings)	None	None			TM/ CRu
		OD2 % of HB donor families approached that consent to / authorise donation within ICU - 61% - 07/08, 63% - 08/09, 66% - 09/10, 69% - 10/11.	**OD2** Current donor co-ordination arrangements are fragmented and are not sustainable for the future.	**OD2** Maximise the conversion of potential donors into actual donors by developing and implementing a robust, sustainable donor co-ordination service.	Quarterly and Monthly Performance Reports					
		OD3 Number of transplants per donor - HB - 3.91 - 07/08, 3.91 - 08/09, 3.95 - 09/10, 3.95 - 10/11 N-HB - 2.35 - 07/08, 2.35 - 08/09, 2.40 - 09/10, 2.45 - 10/11	**OD3** Current organ retrieval arrangements are fragmented and are not sustainable for the future.	**OD3** Develop and implement a flexible, robust and sustainable organ retrieval service that delivers viable organs to transplant units.	At a Divisional Level, overseen by UKT SMT.					
		OD4 % no. of corneas that is sufficient to meet demand - 84% - 07/08, 91% - 08/09, 100% - 09/10 & 10/11.	**OD 4** Current eye retrieval arrangements are fragmented and are not sustainable for the future.	**OD4** Develop and implement a robust, sustainable cornea donation service.	Also Performance Reporting to DH around implementation of Organ Donation Taskforce Findings					
		OD5 People on ODR 15.0m - 07/08, 15.7m - 08/09, 16.3m – 09/10, 16.9m - 10/11	**OD5** There is an urgent need to address health inequalities particularly for people of Asian or Afro-Caribbean origin.	**OD5** implement methods to publicly recognise the act of donation and actively promote donation to the public.						

Appendix 3 NHSBT Assurance Framework April 2008

Objective (d)	Fractionated Products									
	What do we want to do?	*How will we know? What will be different in 2008/09/10/11?*	*What will stop us?*	*How is the risk controlled*	*How do we know the risk is controlled?*	*What are the gaps in managing the risk*	*What should we do about the risk gaps*		*Following quarterly review, has the risk moved up, down or stayed the same?*	
Fractionated Products (FP)	**Principal corporate objective**	**Success criteria / end outcome and expected dates**	**Constraints / risks to meeting the objective**	**Control**	**Assurance**	**Gaps identified**	**Priorities for actions from risk, control, assurance, gaps**	**Risk rating**	**Movement in risk rating**	**Lead**
	To achieve financial viability while continuing to meet all quality, service provision and compliance standards.	**FP1** Cumulative % increase in annual fractionation capacity - 4% - 08/09, 9% - 09/10, 16% - 10/11.	**FP1, 2 & 3** Plasma sourced from the US due to vCJD risk in the UK, increasing costs and constraining capacity to available plasma supply. **FP1, 2 & 3** Lack of overseas product licences (barriers to entry) hinders export sales and revenue, particularly for coagulation factors.	**FP1** Increase capacity and throughput.	FP – Overall progress overseen by NHSBT Board and Executive Management Team. (Minutes of Meetings) Quarterly and Monthly Performance Reports At a Divisional Level, overseen by BPL SMT.	None	None			JM
		FP2.1 Launch new products: Full scale optivate sales UK/Brazil – 07/08 Optivate & Replenine sales in Europe – 08/09 Gammaplex sales factor X named patient – 09/10 Optivate VWD sales, Factor X sales – 10/11 **FP2.2** Contract fractionation and licensing out IP Kazpharm (LO) – 07/08 Gammacan (CFr) Recombinant Anti-D (LO) – 08/09 Secure small scale contract fractionation – 09/10 Secure large scale contract fractionation – 10/11.		**FP2** Develop new products and expand into key markets.						
		FP3 Cumulative % increase in sales revenues - 13% - 08/09, 26% - 09/10, 37% - 10/11.		**FP3** Increase home and export sales revenues.						
		FP4 Consider Options for Commercial Partnership - OBC complete - 07/08, Plan response to OBC review - 08/09	**FP4** BPL is a relatively small player in a competitive global market, which impacts on plasma supply, product supply and prices.	**FP4** Consider options for commercial partnership.						

Appendix 3 NHSBT Assurance Framework April 2008

Objective (e)	NHSBT: An organisation fit for purpose									
	What do we want to do?	*How will we know? What will be different in 2008/09/10/11?*	*What will stop us?*	*How is the risk controlled*	*How do we know the risk is controlled?*	*What are the gaps in managing the risk*	*What should we do about the risk gaps*		*Following quarterly review, has the risk moved up, down or stayed the same?*	
NHSBT: An organisation fit for purpose	**Principal corporate objective**	**Success criteria / end outcome and expected dates**	**Constraints / risks to meeting the objective**	**Control**	**Assurance**	**Gaps identified**	**Priorities for actions from risk, control, assurance, gaps**	**Risk rating**	**Movement in risk rating**	**Lead**
	To establish NHSBT as an acknowledged, effective and efficient provider of products and services, focused on service to donors and customers, flexible to meet changing needs and ambitious to succeed.	Achievement of BSC, SS, OD and FP Objectives Further success criteria to be developed	**EA1** Current organisational structures and systems are not conducive to successful delivery of changes to front line services Some Group Service costs are in excess of external benchmarks.	**EA1** Ensure NHSBT corporate structures enable effective and efficient delivery of its strategy through the provision of appropriate organisational structures and systems.	EA – Overall progress overseen by NHSBT Board and Executive Management Team. (Minutes of Meetings)	Success criteria not fully developed and may limit clarity around performance management	All Group Service functions are developing detailed resource plans with success criteria to support delivery of the above objectives			LH
			EA2 Difficult to secure support for strategic plans from multiple stakeholders with conflicting interests.	**EA2** Build support for the NHSBT strategy through a programme of proactive engagement with internal and external stakeholders.	Quarterly and Monthly Performance Reports					
			EA3 Insufficient leadership skills, skilled resource and workforce capability in some areas to deliver a challenging change agenda. Lack of a performance led culture within NHSBT.	**EA3** Improve NHSBT's capacity and capability to deliver strategic change through the deployment of appropriate resource, leadership and skill, supported by the development of appropriate performance management systems.	At a Divisional & Group Services Level, overseen by NBS, BPL, UKT, Finance, HR E&L, IT, Clinical, PCA and SD SMTs.					

APPENDIX 4 - Emergency Preparedness

The NHSBT Emergency Planning System

NHSBT is a key health provider within the NHS. Without blood, transplantation, tissues and other services the NHS would rapidly find its capabilities significantly compromised. NHSBT services must not falter or fail. NHSBT therefore takes its responsibility for emergency preparedness (including business continuity) extremely seriously. NHSBT has a comprehensive and mature Emergency Planning System that has been developed to meet the needs of NHSBT within the wider healthcare system.

Central to the Emergency Planning System are cohesive and integrated crisis management arrangements based on a single, robust, national to local command and control structure. In addition to this over-arching system, there are detailed major incident supporting plans and continuity plans for each Operating Division / Function. Many key Group Services functions have detailed emergency plans that aim to support the wider organisation's emergency arrangements.

Governance

The NHSBT Chief Executive takes personal responsibility for Emergency Planning, exercising these responsibilities on behalf of the NHSBT Board, using an Emergency Planning Group structure which reflects the organisation as a whole. The NHSBT Board receives a report on Emergency Planning arrangements at least annually.

Standards

The following current legislation, guidance and standards are relevant to developing and maintaining Emergency Planning across NHSBT;

- Civil Contingencies Act (CCA) 2004 and its associated Guidance,
- Healthcare Commission Core Standard C24 – Major Incident Planning,
- NHS Emergency Planning Guidance 2005,
- UK Pandemic Influenza Planning Guidance 2007,
- Business Continuity Standard BS25999:1&2 – 2006/2007.

Although NHSBT does not currently have statutory obligations under the CCA, it is important as a public service provider that it continuously works toward ensuring that it's Emergency Planning System is aligned and consistent with all of the above regulations, standards and guidance.

Activities Within 2007/08

The main focus for the year was Pandemic Flu. Although scientific and medical understanding of the impact of Pandemic Flu is still evolving, NHSBT has made progress in the development and publication of its plans, both in terms of internal resilience and its response to wider healthcare pressures. By the end of 2007/08 business year, NHSBT will have completed its second full Pandemic Flu planning cycle updating its plans in light of the latest (2007) UK Government guidance.

Detailed areas of development for Pandemic Flu in 2007/08 have included;

- Infection control guidance,
- Staffing,
- Donor and Patient facing plans,
- Impact on Operations,

APPENDIX 4 - Emergency Preparedness

- Blood shortage plans,
- Supply chain assessment, including critical suppliers,
- Communication planning,
- IT and remote working.

NHSBT played an active part in 'Exercise Winter Willow', co-ordinating the UK Blood response and contributing to national feedback, as well as responding formally to the consultation on new draft UK Government plans. As a result, NHSBT services now have a profile in central UK plans which would otherwise not be the case. NHSBT also participated in 'Exercise Phoenix'. Areas for further Pandemic Flu plan development include completing the above items and developing an adjusted Command and Control system for deployment in the event of a prolonged Pandemic Flu outbreak.

In addition to Pandemic Flu, other Emergency Planning activities have included: keeping the system up to date, training, running necessary practices, monitoring the system and identifying learning points. In addition, relationships with other UK Blood Services and international collaborations to assist NHSBT's preparedness have been developed in 2007/08.

Planning against new Government fuel shortage guidance is also being undertaken and the NBS antidote service provision is being reviewed.

Activities Planned for 2008/11

Early 2008 will see the appointment, induction and development of the new Head of Emergency Planning as well as the continued use of expert external support services in this key area. There will therefore be an opportunity to review more fully the arrangements and strategic direction for NHSBT's Emergency Preparedness in 2008/09. This will, of course, be done without compromising existing arrangements.

Further development work will be required for Pandemic Flu (see above) and NHSBT will need to formally confirm its state of preparedness for this eventuality as will all other NHS organisations. Preparedness will be gauged against a planned NHS audit tool being developed by the Department of Health (DH). In addition, in 2008/09 we will bring forward proposals for stock-piling of flu specific consumables in 2009/10 (where relevant). The stated goal is for "all NHS organisations to have robust plans in place" (Secretary of State to House of Commons, Nov 22 2007). Planners at the DH are setting a deadline of end 2008 for the NHS to be "ready to implement", although stock-piling is expected to take until 2010 to complete.

Specific planned activities for 2008/09 also include;

- Completion of 2008 UK Capabilities Survey,
- Develop and deliver new training cycle for National Emergency Planning Managers,
- Closer integration of NHSBT EP system with Department of Health at EPD level,
- Improve pandemic preparedness through further training and exercising,
- Self assessment (HC Standard 24 - plus possible external HC assessment),
- NHS self audit on Pandemic Flu planning (plus possible NHS audit of NHSBT),
- Addressing gaps, actions and learning arising from above processes,
- Implement renewed SLA with DH on Antidote Service provision,
- Fulfil all obligations for practising, training and monitoring and learn from activations,
- Commence review of EP system against BS25999 (Business Continuity).

APPENDIX 5 - Sustainable Development Action Plan

Introduction

The document "Securing the Future – UK Government Sustainable Development Strategy" was issued in 2005 and updated the Governments previous strategy of 1999, which set out to help deliver a better quality of life through sustainable development. It outlines a number of requirements, targets and aspirations on sustainability, towards which all Government departments and executive agencies must work.

This paper is a high-level summary of the actions planned by NHSBT to meet and fulfil its obligations on Sustainable Development.

Background

Sustainable development is based on five key principles;

- Living within environmental limits,
- Ensuring a strong healthy and just society,
- Achieving a sustainable economy,
- Promoting good governance, and
- Using sound science responsibly.

Within these principles, there are currently four priority areas which agencies are being asked to address;

- Sustainable consumption and production,
- Climate change and energy,
- Natural resource protection and environmental enhancement, and
- Sustainable communities.

Although there is no current mandate for ALB's to meet new Government targets on sustainability, there are strong indications that these targets will be compulsory in the very near future.

NHSBT 2008/11 Plan

During 2008/09 NHSBT will develop a Sustainable Development Action Plan (SDAP) as part of the first steps to embedding sustainable development activities into the organisation over the 2008/11 period. This will include:

- Development of adequate structures and processes to manage the formulation, execution and performance management of the plan,
- Establishment of formal links with the DH lead on sustainable development and the Sustainable Development Commission,
- Implementation of appropriate communications and robust governance arrangements,
- Establishment of a baseline position against published targets for Sustainable Operations on the Government Estate (SOGE),
- Production of a Sustainable Procurement Strategy, and
- Integration of SDAP planning into the extant planning process and associated procedures.

Glossary of Terms

ABO	Major Blood Grouping system (Types A, B, AB, O)
ALBR	Arms Length Body Review
ABC/M	Activity Based Costing / Management
BBMR	British Bone Marrow Registry
BBT III	Better Blood Transfusion 3 (A DH initiative led by the CMO)
BME	Black and Minority Ethnic
BPL	Bio-Products Laboratory
BSE	Bovine spongiform encephalopathy
CBB	Cord Blood Bank
CMO	Chief Medical Officer
DH	Department of Health
ESOR	Economics Statistics & Operational Research (department within DH)
ESR	Electronic Staff record (National database initiative within NHS)
FFP	Fresh Frozen Plasma
GIA	Grant in Aid (Central cash-limit funding from the Department of Health)
Granulocyte Immunology	The science of antibodies directed against antigens on the surface of white blood cells. Granulocytes contain enzymes that digest micro-organisms
H&I	Haematology and Immunogenetics
HB	Heart-Beating (relating to organ donation)
IBGRL	International Blood Group Reference Laboratory
ICUs	Intensive Care Units
KSF	Key Skills Framework
LIMS	Laboratory Information Management System
NBS	National Blood Service
NBTS	National Blood Transfusion Committee
NCG	National Commissioning Group (Through which price of blood is agreed annually)
NHSBT	National Health Service Blood and Transplant, the new authority formed on October 1st, 2005, through the merging of NBA and UKT
NHSLA	NHS Litigation Authority
NPSA	National Patient Safety Agency
OBC review	Outline Business Case review
ODO	Organ Donation Organisation
ODTF	Organ Donation Task Force
PAS	Platelet Additive Solution
PDR	Personal Development Review
PGI	Platelet & Granulocyte Immunology
Plasma Fractionation	The extraction of a variety (over 700) of proteins from Human plasma which are of considerable therapeutic value

Glossary of Terms

Prion filtration	Abnormal prions (small proteinaceous infectious particles) can attack the brain, killing cells and creating gaps in tissue or sponge-like patches. The vCJD prion is the same prion found in cows with Bovine Spongiform Encephalopathy (BSE). Research companies are looking to develop abnormal prion reduction systems, (primarily filters) to remove prions from donated blood.
PTI	Processing Testing and Issue
R&D	Research and Development
RCI	Red Cell Immunohaematology
SaBTO	Advisory Committee on the safety of Blood, Tissues and Organs
SAS	Industry standard Business / Finance software
SBS	Shared Business Services
SCI	Stem Cell Immunotherapy
SDAP	Sustainable Development Action Plan
SHOT	Serious Hazards of Transfusion
SLA	Service Level Agreement
TRALI	Transfusion Related Acute Lung Injury
UKT	UK Transplant
VCJD	Variant Creutzfeldt-Jakob Disease
WTE	Whole Time Equivalent

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NHS
Blood and Transplant

REPORT TO LEEDS CITY COUNCIL HEALTH SCRUTINY BOARD

1.0 NHS Blood and Transplant

NHS Blood and Transplant (NHSBT) was established as a Special Health Authority in October 2005 – with the merger of the National Blood Service (NBS), UK Transplant and Bio Products Laboratory.

The organisation collects, tests and processes almost 2 million blood donations from volunteer donors every year to ensure a consistent supply of blood donations to hospitals. The organisation also makes some 5500 organ and cornea transplants possible every year. In addition, it retrieves and stores other tissues, such as skin and bone, ready for patient use. It manufactures a range of therapeutic products from blood plasma and provides a number of related specialist services, such as solid organ tissue typing and cord blood.

NHSBT is responsible for optimising the supply of blood, organs, plasma and tissues and raising the quality, effectiveness and efficiency of blood and transplant services.

2.0 National Blood Service Strategy

NHSBT published its strategy for the NBS in November 2006. It sought to address the main challenges which the service faces, namely the need to:

- meet the clinical need and demand for red cells and platelets and address the declining numbers of blood donors;
- ensure greater efficiency and flexibility in our processing and testing facilities to meet current and future clinical, safety and accreditation standards;
- provide a range of specialist (diagnostic) services which cover their costs and meet identified patient need;
- stabilise the price of red cells, supplying them to hospitals at a cost which represents value for money for the NHS.

The strategy proposed the consolidation of the existing 11 (processing) and 10 (testing) centres to three major centres based in Filton near Bristol, Colindale and Manchester. The number of blood issue centres at which blood is stored and from which it is dispatched to hospitals, was also to be reduced.

3.0 Review of National Blood Service Strategy

In July 2007, the Board of NHSBT commissioned a review of the NBS strategy. While the challenges identified in the strategy have not changed, concerns about some aspects of the strategy had been raised by staff, hospitals and other stakeholders. The review – undertaken between October and December 2007 – sought to address these.

3.1 Stakeholder Engagement

As part of the review, a series of meetings was held with hospitals and other stakeholders to discuss the challenges which the NBS faces and the proposed actions to address these.

These included 3 regional meetings held in November 2007 and a number of local meetings. Representatives from The Leeds Teaching Hospitals NHS Trust attended these meetings.

The main concerns expressed at these meeting focused on the following:

- The Red Cell Immunohaematology (RCI) reference service[1] should remain close to hospitals and patients;
- Blood should continue to be stocked and issued at Leeds;
- The location of blood processing and testing was less important than specialist services;

Having listened to stakeholders, NHSBT undertook further analysis to consider whether it should consolidate to a more geographically-balanced configuration of sites, retaining locally-based services for hospitals and patients - wherever possible - while still making the necessary changes to run a more efficient service.

3.2 Review Findings

The review findings, published in January 2008, confirmed the broad direction for the service set out in the original strategy, but made significant changes to the way in which it is to be implemented.

The review identified excess capacity in blood processing and testing facilities of 40% and 35% respectively. The decision was taken, therefore, to consolidate blood production to 6 processing and 5 testing centres over the next 3 years – as opposed to the 3 major centres proposed in the original strategy - retaining a good geographical spread across the country.

The 6 processing centres will be located at:

Brentwood
Colindale
Filton
Manchester
Newcastle
Sheffield

The 5 testing centres will be located at:

Colindale
Filton
Manchester
Newcastle
Sheffield

[1] This service investigates and provides blood for complex patients

3.3 Implications for the Leeds Blood Centre

Under the current implementation plan, testing services will move from the Leeds Centre by the end of 2009/10; processing services will move by the end of 2009/10.

Following these changes, processing and testing services will be provided by NBS blood centres at Sheffield, Manchester and Newcastle.

The following services will remain at the Leeds Blood Centre:

- The blood issue department will remain open and continue to supply local hospitals with blood as and when it is needed. The centre will continue to hold at least the same stock levels of blood and blood products as currently, including the requirement for short shelf-life components;
- The RCI reference service

In discussion with hospitals, the NBS plans to withdraw from routine antenatal screening across the country by the end of 2009/10. As the Health Scrutiny Board may be aware, two-thirds of the NHS currently uses antenatal screening services supplied by routine NHS pathology services (from outside the National Blood Service).

NHSBT anticipates that these changes will result in the reduction of around 70 posts at the Leeds Centre over the next 2 years. NHSBT is committed to making this reduction through non-compulsory means, wherever possible, including voluntary redundancy, staff turnover, redeployment and vacancy control.

11th July 2008

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Submission from AMICUS

Overall

Issues identified with the strategy as a whole

- The review is not transparent.
- Major errors in the calculations used to justify the decision as local senior managers were not involved in the production or checking of these figures.
- Weakens the healthcare provision in Leeds
- Fundamental problems with blood coming back to Leeds site, to go onto Sheffield or Newcastle to test and process, to come back to Leeds for issue. Why not just do it all at Leeds
- No review of support services until 2009, after the front line services have been removed. Maybe this should have been looked at prior to the decision to remove front line services
- No cohesion in the strategy with respect to frontline and backroom services
- The frontline services are being cut as opposed to backroom services. So in response to this vast overspend in the backroom they cut frontline jobs in an area that not only generates all the revenue for the service, but is filled with highly specialised, technically trained staff that cannot be replaced from the wider community.
- Net increase in cost to the wider NHS. The price of a unit stays the same whilst there is an increase in the cost of specialist services, such as crossmatch.
- The removal of antenatal services may result in the hospitals taking this on. Increase in the financial burden placed on the already pressurised PCTs
- In the previous quadrant strategy Leeds was “ideally placed” as it has the best transport links. Also it was chosen as one of the national Nucleic Acid Testing (NAT) laboratory sites, as again it was “ideally placed”. Now Leeds is seen as not ideally placed and no satisfactory reasoning has been shown.
- The McKinsey’s report cost £750 000 and is deeply flawed. Errors have been found in the evidence used to justify the plan. If these errors are present what more errors are not immediately apparent.
- Leeds was not formally visited by McKinsey’s and the area measured. Both Newcastle and Sheffield were.
- In Sheffield and Newcastle the overall area that was measured included garages, offices, laboratories in use and plant rooms. None of these was taken into account at Leeds giving a false impression.
- There are differences in the detailed numbers first presented and what is now being presented with no explanation.
- A 30% over capacity is actually a 30% contingency should one centre fail. i.e. Sheffield in June 2007
- There is no plan should one centre fail. The remaining sites do not have capacity to make up for shortfall.
- One of the strategic heads, Michelle Ashford, stated that “the most effective sites have P,T, and I together” so why are they removing P and T at Leeds and Brentwood
- Leeds City Council and other official bodies have not been informed of the planned change. There would be no discussion with the LCC if the staff had not made LCC aware. How can the strategy have been “discussed with the stakeholders” if the LCC were not aware
- Leeds has the lowest PTI sickness rate of anywhere in the country and is the most efficient centre

Processing Testing and Issue (PTI)

Issues identified within PTI

- Overnight hold is going to be used, the RBC’s are not reaching the current specification.
- Since 2002 there has been an overall reduction in staff in PTI whereas there has been a 50% increase in staff in HR, IT and Finance. Maybe look at these areas first.
- There are different models between the north and the south of the country.

- Leeds has the lowest rate of discarded units in the country. This is due to all departments working to the highest standards of quality.

Processing

Issues identified within Processing

- Performance has not been used as criteria. MHRA thinks our site is suitable and Leeds has been the best MHRA performer for the last few years.
- Leeds Processing and Issue have the best performance in the North with respect to process losses.
- The calculations used to justify the decision are nonsense. They vastly underestimate the capacity here at Leeds.
- A higher percentage of male Fresh Frozen Plasma is produced in Leeds than any other site. Other centres produce more female derived plasma, thereby increasing potential risk of TRALI
- Leeds uses 26% of its Whole blood collection to make Frozen components this is more than any other centre
- There is in place a 16 hour shift rota so we can vastly improve capacity.
- Specialist products such as Intra Uterine Transfusions (IUT's) and Platelets in additive solution are not available off the shelf and must be processed especially. At present this takes place in Leeds but will move to Sheffield or Newcastle. Sheffield floods and Newcastle and Manchester are not always reachable by road. Placing lives at risk. Leeds has the largest teaching hospital in Europe and a brand new regional oncology centre. It would be folly to move these near patient specialist services away from the patient

Testing

- Geographical spread – Leeds has Nucleic Acid Testing (NAT) and the facility was created in Leeds due to it being ideally placed geographically and had enough spare capacity to cope with the increase in workload. As the MHRA has asked, how can these skilled personnel, and their skills, be moved whilst maintaining a service? There has been no answer
- New and emerging technologies would create space in testing, further increasing capacity.
- Leeds has been the reprovisioning site for Sheffield or Newcastle 16 times in the last 12 months
- National figures show that the blood grouping machine run by Leeds specialist staff is the most efficiently machine in the country. This quality of service is due entirely to the staff and quality of their work.

Donor population

- The Leeds site has built excellent relationships with local stakeholders, donors, hospitals, businesses and the local community. This link would be fractured.
- Yorkshire blood for Yorkshire people, again we have excellent community links and the relationship between the NBS as a whole and its donors are already strained. Why potentially make it worse by shipping blood to Newcastle and Sheffield for processing, just to bring it back to Leeds.

It is no coincidence that Leeds is the best performing site in all these areas. We have staff with real understanding and ownership of GMP and the quality systems in place and a real commitment to the service.

Update for Scrutiny Board (Health) on changes to the National Blood Service – July 2008

The context of the changes was that the NBS was an Arms Length Body (ALB) which in 2005 merged with UK Transplant into a Special Health Authority, NHS Blood and Transplant (NHSBT), following the ALB review. NHSBT have been charged by the Arms Length Body Review with making substantial savings over the next few years and the NBS are using this process to reconfigure processes and upgrade their estate. In November 2006, a strategic plan NHSBT 2006-2010 was approved by the NHSBT Board which agreed changes to all three sections of NHSBT, the majority of which relating to the NBS by virtue of the relative size of this section of the organisation.

The changes take place against a background of increasing costs of blood relating to newer technologies, emerging threats (blood borne viruses and especially vCJD prions), falling donations, fixing of the price of blood in the UK, and the outsourcing of plasma from the USA. In addition the estate which NBS has inherited over the years was largely built during the Second World War, and is now in serious need of upgrading. This is of importance as the Medicines and Healthcare Products Regulatory Agency which inspects premises require standards ("Good Manufacturing Practice") to be the same as those of pharmaceutical industry premises and many of the NBS estates have been served notices for major, cost prohibitive renovation or closure.

In the autumn of last year there was a review of the plan due to a number of concerns including the lack of wider consultation, and Leeds PCT fed our concerns into that process. The new plan is considered to be robust and acceptable to the Regional Transfusion Committee and the local Blood Bank Managers and is summarised below:

- Leeds Blood centre will now retain its red cell immunology lab which had been threatened for closure and relocation. All back up support for difficult cases and emergencies will still be available locally and no problems are now forseen.
- By 2010, testing and processing will move to Sheffield or Manchester. This is essentially a back office change. Leeds will still collect and depot blood collections. The plans for this appear robust and no problems are foreseen.
- There will no longer be 3 megacentres for blood services in the UK. This is a good thing as more local services are being retained.
- By 2010 the NBS will pull out of routine antenatal screening services (blood group antibodies and microbiology screening) in a planned way with their support. A minority of hospitals use the NBS to provide this service. Leeds TH use their own in-house testing. Some of our neighbouring PCTs use the NBS for this but all are in the process or setting up themselves or sourcing local providers. The NBS has a commitment that it will not pull

any testing until a satisfactory local solution has been reached. The NBS will continue to do more complex antenatal issues.

- There will be some redundancies and relocation of staff inevitable as a consequence of the service modernisation.
- A big issue remains relating to blood donors. Leeds was one of the first in the country to have a blood donor programme in the 1930s. Donations are falling nationally and will have an impact on services if they continue to fall. Blood use in hospitals has been declining but has plateaued. The NBS is investing in a big donor recruitment investment programme including minority ethnic groups and non traditional donor groups to meet the changing needs of the population. There will be a big TV campaign shortly. Local 'blood drives' may be an option and there is a need to develop closer working between the NBS, LA and NHS locally to recruit donors and this is something the OSC may be able to assist with.

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 22 July 2008

Subject: Clinical Services Reconfiguration

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

1.0 Introduction

1.1 At its meeting on 13 March 2008, the Health Proposals Working Group (a working group formed under the former Health and Adult Social Care Scrutiny Board) considered the impact of the centralisation of children's inpatient services at Leeds General Infirmary (LGI).

1.2 Under the definitions of reconfiguration proposals and stages of engagement / consultation, the proposed changes where identified as 'significant' which required formal mechanisms to be established to ensure that patients, service users, careers and the public are engaged in planning and decision making.

1.3 The attached Leeds Teaching Hospitals NHS Trust (LTHT) report seeks to update the Board on the engagement and involvement process to date. The Director of Planning (LTHT) and the Executive Director of Strategic Development from Leeds Primary Care Trust (PCT) will attend the Board to present the report and address any questions identified by the Board.

2.0 Recommendations

2.1 The Board is requested to consider the information provided in the attached report and determine what, if any, further action is required..

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LEEDS TEACHING HOSPITALS NHS TRUST

REPORT TO LCC HEALTH SCRUTINY BOARD

22nd JULY 2008

CLINICAL SERVICES RECONFIGURATION AT LGI AND SJUH ENGAGEMENT & INVOLVEMENT PROGRESS UPDATE

1. INTRODUCTION

The Trust is working closely with the Leeds PCT on this work and has been reporting back to the Health Scrutiny Board sub group on both process and progress since the Minister for Health, Ann Keen, confirmed her support in autumn 2007 for centralisation of children's inpatient and critical care services at Leeds General Infirmary.

Members of the Health Scrutiny Board are asked to:

- Note the extensive engagement with public, patients and parents on developing proposals for new hospital facilities for children.
- Note the involvement of clinicians in developing the clinical aspects of the changes; and that the clinical models will be approved by the PCT's Professional Executive Committee and Children's & Maternity Clinical and Professional Network.
- Confirm that the engagement and involvement work to date meets their expectations for this kind of service change.

2. BACKGROUND

The Trust has been moving to a position where, for clinical governance reasons, the majority of inpatient services are to be located on the two acute main sites, LGI and SJUH and most specialties are centralised on one acute site or the other. The three remaining LTHT hospitals, Seacroft, Wharfedale and Chapel Allerton are becoming a mix of locality and specialist hospitals with ambulatory centres each developing a unique identity in addition to providing some outpatient services for their local populations.

Whilst a key facet of the Trust estate strategy is to move out of the oldest, most unsuitable estate, in particular the old parts of the LGI – intensive clinical use is planned for the two remaining wings at LGI **and** the five wings at SJUH. At the same time we must maintain and develop each acute site with appropriate clinical adjacencies and with each acute site being clinically complementary to the other.

The current distribution of specialties between sites since the centralisation of orthopaedic trauma, plastics and vascular surgery as part of the Acute Services Reconfiguration which completed at the end of 2006 and the centralisation of colorectal surgery as a result of the opening of the Bexley Wing shows that the LGI is becoming more the acute surgical 'hot' site and this is already reflected in the developing different functions of the two A&E departments.

A range of challenges are highlighted across children's services and older peoples / acute medicine. These can be summarised as follows:

Interdependent services for children and some related adult services are split across a range of sites and buildings which creates a potential clinical risk. This ranges from poor patient and family experience, to a complex patient pathway which lacks flexibility to cope with changes in demand. This clinical risk is evident through children being seen in inappropriate environments and the complexity of cross site transfers of inpatient

children. Furthermore the sub-optimal service disposition increases the difficulty of achieving national standards and split site working makes staffing more problematic.

Older patients are being admitted inappropriately because of the lack of suitable preventative facilities. The Leeds strategy for older people envisages a different approach with an emphasis on admission avoidance, early discharge and local rehabilitation through the use of developing community facilities.

Much current hospital care for older people/acute adult medicine is delivered in unsuitable accommodation, with few single room facilities and infection prevention being more difficult than necessary in a number of areas because of the less modern wards in which these patients are looked after.

3. THE PLAN

This is a clinically led plan to bring all children's inpatient services together at LGI and as an enabling move, - but again, clinically led - bring together all inpatient adult acute medicine and older people's medicine at St James's. The full document summarising the clinical changes is attached as an appendix to this paper but in summary:

3.1 Already at LGI are the children's inpatient specialties (each supported by A&E/Walk in facilities) of:

Respiratory Medicine*
Diabetes
Gastroenterology*
Rheumatology*
Dermatology
Neurology *
Cardiology *
General surgery (GI thoracic, urology) *
Acute general surgery *
Neonatal surgery *
Orthopaedic trauma
Orthopaedics *
Plastic surgery *
ENT/Oral maxillo facial including cleft lip & palate *
Dentistry
Endocrine*
Neurosurgery *
Cardiac surgery *
Critical care *

3.2 These will be joined by the children's inpatient specialties from SJUH of:

Diabetes
Gastroenterology*
Cystic Fibrosis*
General Surgery (GI thoracic, urology)*
Oncology / Haematology *
Renal and Liver medicine *
Ophthalmology
Transplantation *
Critical care *

* specialties with large numbers of non Leeds patients

3.3 Currently, childrens day case and outpatients take place at both sites (and some outpatients at Seacroft hospital), normally at the site at which the inpatient service is located. In future, outpatients will still be on both sites (and at Seacroft) but only complex day case surgery will be based at LGI; the less complex work will be undertaken at SJUH in a childrens day case surgery unit.

3.4 Currently, children's inpatients and critical care services are in two different parts of the city at St James's (SJUH) and LGI. Both are supported by an A&E service, although the one at LGI is dedicated for children whilst the one at SJUH is not.

Children referred by GPs and those taken by ambulance are already directed to the A&E on the side of the city which is supported by the relevant inpatient children's services. There are walk-in services for children on both sides of the city.

In the future, walk-in services for children will continue to exist on both sides of the city. With all children's inpatient services at LGI, children referred by GPs and those arriving by ambulance, will come to LGI, into the purpose built children's A&E.

Additionally, a new paediatric assessment unit is being built at LGI adjacent to the paediatric A&E and this will be part of the children's urgent care pathway. Prior to centralisation, the unit will be open 8.30am to midnight with the last admission at 9pm. A review of opening hours will take place at centralisation. The unit will be multi specialty and for patients requiring short stay (4-6 hours only). The ethos will be one of rapid turnaround and assessment/treatment by senior children's medical staff. It will be the hub for children's ambulatory outreach services. Rapid access clinics will be run from the unit daily.

3.5 Whilst adult acute medicine and older people's medicine outpatients will stay on their current sites, the acute medicine and older people's medicine wards at LGI will move across to SJUH into Gledhow Wing to join the wards already on that site.

The only adult outpatient department that will move is diabetes and endocrinology where much of the current outpatient work in the Trust will be moved by the PCT into primary care and so the current departments at LGI and SJUH will be combined at SJUH in Beckett Wing.

3.6 Gastroenterology is currently delivered on both sides of the city on an inpatient and an outpatient basis. The service is reviewing the options for centralising on either the LGI site, the SJUH site or remaining on the 2 sites.

4. ENGAGEMENT AND INVOLVEMENT

4.1 The proposals were devised by the Clinical Directors in childrens services and acute and older people's medicine and are strongly supported by consultant and nurse staff within the specialties. The work to develop the proposals is being led by the Clinical Directors.

4.2 The process of engagement and involvement in relation to staff, reflects the structure of the project. Therefore, the operational work to review the clinical models, the adjacencies and the design of areas that are going to be refurbished is being undertaken by multidisciplinary teams of staff (Primary Planning Groups) who work in the individual clinical areas. The terms of reference for these groups include the responsibility to share the information and ideas from the group with their colleagues in their respective clinical professions.

Similar processes operate in cross cutting areas such as radiology and anaesthetics that are likely to be affected by the changes in childrens and adult acute and older people's medicine.

Trust groups such as the Trust Consultation and Negotiation Committee (TCNC) are regularly briefed.

Twice monthly, staff open meetings are being held on both sides of the city which outline the proposals, describe the process and discuss issues raised by staff in the meetings and outside them.

Summary information is issued to all staff, via the Trust's GroupWise e-mail, covering all staff on all sites. The latest examples of this are the clinical plans for childrens services and those for acute and older people's medicine which have been circulated throughout the Trust to all levels and types of staff to stimulate debate.

Clinical Services Reconfiguration has its own site on the Trust intranet. All agendas, papers and notes of all planning meetings are posted on here as are the schedules of accommodation for each of the areas to be redesigned. In the next few weeks the architect's drawings will also be posted for information and comment.

4.3 The Trust is starting to engage and involve external groups for example

- We are now working with the Sick Childrens Trust (and parents) to create family accommodation where the child patient is very sick and/or the family lives a long way from Leeds.
- We are working with Education Leeds on the reprovision of education and learning facilities across LGI.
- A number of organisations have expressed an interest in becoming involved in supporting the reconfigured childrens services.
- Discussions have begun to engage with both social work and the ambulance service.

4.4 In relation to engagement of parents, carers and service users, a significant amount of work is underway. Matrons in children and adult specialties have a key responsibility for leading on patient and public involvement and training sessions have been run to support them in this work.

In childrens services Leeds has a long history of trying to bring services together, and whilst the current plan cannot deliver a Childrens Hospital, the parents who have supported our previous efforts have been very supportive of this current reconfiguration plan. As a result of parent's and staff - and children's - comments on the current service, a number of short term improvements (around childrens food, outpatient waiting areas, parents' rooms and an assessment unit) are being acted upon prior to centralisation.

We have built on the earlier support and involvement to take parent and user involvement forward across childrens services. We recognise what a major commitment it can be for parents/carers to become involved in this type of project (particularly when they are already looking after a sick child) and we are working on a range of different ways - with parents - that parents and carers can be involved.

- A parents forum takes place approximately every two months.

- A small core parents group meets with the Trust on a monthly basis to review and understand progress and any barriers that have appeared in much more detail than is possible with a larger group.
- Two parents have become 'parents champions' and are a link between any parents who would rather talk to another parent rather than a member of Trust staff about things that they would like to see.
- Parent representatives are involved in the planning team looking at the provision of parent and family accommodation.
- Separate specialty open meetings for parents are being held, run by clinical staff, focussing on the issues that concern parents of children attending specialties that are at SJUH and are moving to LGI - particularly childrens cancer, cystic fibrosis, liver and kidney problems and transplantation.
- Parents belonging to the parents forum are e-mailed/written to on an 'as and when' basis to let them know of particular developments in between regular meetings.
- Special meetings are to be held, once architect's drawings are available for the refurbished areas, specifically for parents to make their comments.

4.5 Involvement and engagement on the centralisation of adult services.

By their very nature, there isn't as much user/carer engagement in this area as in childrens services.

However, the involvement is growing, building on the city wide Forum for Older People, and a number of specialty patient support groups - such as that for patients with diabetes - and by the involvement of "expert patients" with the planning teams.

4.6 Example of Trust involvement/engagement meetings with parents, users and staff for both adults and childrens services reconfiguration (5 week period 30/6/08 - 1/8/08)

Monday 30th June	Education Leeds
	Theatres planning group
Tuesday 1st July	Paediatric Surgery planning group
	Pathology planning group
	Paediatric radiology planning group
Wednesday 2nd July	Core parents meeting
	Trust IT leads
	Childrens cancer planning group
	Acute medicine planning group
Thursday 3rd July	Childrens cystic fibrosis parents group open meeting
	Childrens Management/Clinical Directors
	Neonatal planning group
Friday 4th July	PICU/HDU planning group
	Childrens liver/renal/gastro planning group
	Diabetes and endocrinology planning group
Monday 7th July	Open meeting for staff
Tuesday 8th July	Staff theatre design meeting
Wednesday 9th July	Adult Medicine Project Operational Team
Thursday 10th July	PCT PEC
	Childrens Management/Clinical Directors
Friday 11th July	Teenage Cancer Trust
Monday 14th July	Sick Childrens Trust
	Adult radiology planning Group

Tuesday 15th July	Core parents group tour of LGI
	Accident & Emergency planning group
	Childrens radiology planning group
Wednesday 16th July	Acute medicine planning group
Thursday 17th July	Childrens oncology parents group open meeting
	Childrens Management/Clinical Directors
Friday 18th July	Staff theatre design meeting
	Childrens and maternity Network
	PICU/HDU planning group
Thursday 24th July	Staff acute medicine design meeting
	Paediatric surgery planning group
Friday 25th July	Staff older people's design meeting
	Childrens cystic fibrosis planning group
Tuesday 29th July	Staff childrens liver/gastro/renal design meeting
	Pathology planning group
	Paediatric radiology planning group
Wednesday 30th July	Staff open meeting
	Staff oncology design meeting
	Acute medicine planning group
Thursday 31st July	Childrens Management/Clinical Directors
Friday 1st August	Staff childrens medicine/cystic fibrosis design meeting
	PICU/HDU planning group
	Accident & Emergency planning group

Sylvia Craven
Director of Planning
3rd July 2008

APPENDIX

DESCRIPTION OF THE CHANGES TO CLINICAL SERVICES AS PART OF THE CLINICAL SERVICES RECONFIGURATION WITHIN LEEDS TEACHING HOSPITALS

1. CHILDREN'S SERVICES CENTRALISATION AT LEEDS GENERAL INFIRMARY (LGI)

1.1 Children's service philosophy

Whilst many of the children's services on the two sites are different, or are delivered differently, the philosophy governing children's services is the same for both sides of the city and has influenced the service models and service delivery models for a centralised children's service at LGI. The philosophy has been developed, consulted upon and agreed with staff and with service users and with parents and carers:

- Children should be seen as children first, recognising their needs and abilities as they become older, rather than as a disease process or problem.
- The needs of the child should always be the first consideration and should take precedence over (though not exclude) the needs of carers.
- Provision of the highest quality of clinical care, both to the local population and for specialist tertiary services in support of other hospitals in Yorkshire and beyond.
- Services will be evidence based wherever possible, taking into account national guidance including national service frameworks, specialty reviews, confidential enquiries, NIHCE guidance, Healthcare Commission reviews and Our Healthy Ambitions.
- Services will be provided on the basis of collaborative working between all the professional groups involved in the child's care, in partnership with the child's family and where appropriate, with the child him/herself.
- Services will be provided as close to home as safely, technologically and economically possible.
- Our aim is to make the interface between hospital and community based children's services seamless, strengthening community paediatrics and helping us keep more children out of hospital if appropriate, improving the quality of service for children as a result.
- Services will be provided in an environment which is welcoming to children, their families and carers, which is designed to support patients with disabilities.
- Further development of teaching and research is essential for all professionals through the integration of hospital services, improving the quality of clinical services.

1.2 DESCRIPTION OF CHILDREN'S SERVICES BY SPECIALTY.

1.2.1 Paediatric Accident and Emergency (A&E)

Current model

Currently, children's inpatients and critical care services are in two different parts of the city at St James's (SJUH) and LGI. Both are supported by an A&E service, although the one at LGI is dedicated for children whilst the one at SJUH is not.

Children referred by GPs and those taken by ambulance are already directed to the A&E on the side of the city which is supported by the relevant inpatient children's services. There are walk-in services for children on both sides of the city.

Future model
In the future, walk-in services for children will continue to exist on both sides of the city. With all children's inpatient services at LGI, children referred by GPs and those arriving by ambulance, will come to LGI, into the purpose built children's A&E.

Additionally, a new paediatric assessment unit is being built at LGI adjacent to the paediatric A&E and this will be part of the children's urgent care pathway. Prior to centralisation, the unit will be open 8.30am to midnight with the last admission at 9pm. A review of opening hours will take place at centralisation. The unit will be multi specialty and for patients requiring short stay (4-6 hours only). The ethos will be one of rapid turnaround and assessment/treatment by senior children's medical staff. It will be the hub for children's ambulatory outreach services. Rapid access clinics will be run from the unit daily.

1.2.2 Paediatric Secondary Medicine

Current model
Paediatric secondary medicine is currently based on both sites. These services include diabetes, gastroenterology, rheumatology, dermatology and respiratory medicine. Cystic fibrosis services are provided at SJUH.

Currently between the two sites there are 50 inpatient beds across 4 small wards, 2 of which at SJUH are used for CF patients to allow for separation of infected and non infected CF children.

The wards take a very small number of elective patients, but mainly receive patients acutely via A&E and patients admitted acutely from outpatient clinics. The cystic fibrosis day hospital is an essential part of the service, integrated with the cystic fibrosis inpatient service - although this is currently on a separate part of the SJUH site to the inpatient wards.

Future model
The number of beds in future will change because of changed service models and some relocation of gastroenterology beds, currently part of the secondary paediatric medicine bed base at LGI, into the new liver/gastro and renal ward at LGI. Therefore

- 6 beds will be replaced by the new assessment unit
- 4 gastro beds move into a different ward space
- 4 beds will not be required because of new ways of working/the efficiencies of bringing together a number of beds, previously in 4 wards, into 2 wards.

Particular changes have been made to take account of cross infection issues. There will be 24 single rooms, more with ensuite facilities than current, and 12 beds in shared bays with all the Cystic Fibrosis specific cubicles having ensuite toilets and showers. Additionally, 2 long term ventilation beds will be adjacent to and part of the paediatric medicine ward in Jubilee Wing. The 2 medical wards will be in 2 different wings (Clarendon and Jubilee), to ensure B Cepacia Cystic Fibrosis patients do not come into contact with non B Cepacia patients and the Cystic Fibrosis day hospital will be on the ground floor adjacent to one of the two paediatric medicine wards that will house 6 Cystic Fibrosis cubicles, again for infection control purposes. One ward will have a minimum 48 hour stay focus; one will have a potentially longer stay cohort

Outpatient child protection services will be based at SJUH with inpatient beds available for these children at LGI.

Paediatric medical day cases will be undertaken at LGI - some within the day

hospitals (Cystic Fibrosis and Oncology) and the remainder in a paediatric medical day case unit.

1.2.3 Paediatric Specialty Medicine

Current model

SJUH delivers paediatric oncology and haematology and renal and liver medicine. LGI delivers paediatric neurology and cardiology - neurology patients nursed along side neurosurgery and cardiology patients cared for along side cardiac surgery.

1.2.3.i Hepatology, Gastroenterology and Renal services

Current model

Currently hepatology has 10 beds (incorporating approximately 2 gastroenterology beds) in a dedicated ward at SJUH. There are 6 renal beds within an 18 bedded nephro-surgical ward at SJUH and there is a purpose built 5 station paediatric haemodialysis unit in the Lincoln Wing at SJUH separate from all other paediatric services. There are 4 additional specialty gastroenterology beds at the LGI within the general paediatric ward.

Hepatology and nephrology services, incorporating transplantation, will be relocated with the PICU.

Future model

In the future proposed model these specialties will be combined in a single ward with two separate identities: one for children's liver services and one for renal/gastroenterology services with the renal haemodialysis unit located alongside.

The split will be: hepatology – 11 beds; gastroenterology - 4 beds; renal - 6 beds; and a five station haemodialysis unit. Beds for children with inflammatory bowel disease (currently on ward 48a) will remain on that ward - not in the new ward.

1.2.3.ii Oncology, Haematology and Bone Marrow Transplant (BMT)

Current model

Currently at SJUH, 17 children's beds, 9/10 teenage, 1/2 BMT = total 28 beds. There is separation (different buildings) of inpatient and day cases/outpatients but this is not regarded as satisfactory.

The ward is currently hepa filtered as a result of the building work for Bexley Wing on site. There are 7 day case beds in the day hospital and anaesthetics are currently also given in the day hospital.

Future model

In the future there will be the same inpatient bed numbers, including 4 high dose therapy/BMT beds. There will be an additional 3 day case beds located in the oncology day hospital reflecting changing practice and increasing patient numbers.

The oncology inpatient ward will be adjacent to the day hospital.

1.2.3.iii Neurology and cardiology

Current model

As described elsewhere in this paper children in these specialties are nursed in the same wards as their surgical counterparts i.e. neurology and neurosurgery together and cardiology and cardiac surgery together.

Future model

The position of neurology and cardiology will not alter and both will remain in their current wards at LGI. However, they will be affected generally as all childrens inpatients services come together.

1.2.4 Paediatric General Surgery

Current model

Paediatric general inpatient surgery is delivered both at LGI and SJUH with acute surgery already centralised at LGI and consists of GI, thoracic and urology surgery. Day case surgery is delivered at both SJUH and LGI. Virtually all neonatal surgery is undertaken at LGI although on rare occasions babies with liver or urological problems are operated on at SJUH.

Future model

Inpatient general paediatric surgery and urology will be transferred from SJUH to the existing paediatric surgical wards in Clarendon Wing LGI.

1.2.5 Paediatric Specialty surgery

Current model

This encompasses trauma and orthopaedics surgery, plastic surgery, ENT and oral maxillo facial surgery (including cleft lip & palate), ophthalmology, dentistry, neurosurgery, cardiac surgery and transplantation.

Most of these surgical specialties currently use wards 48, 48a and 55 in Clarendon Wing LGI along with paediatric general surgery. Most of the associated day surgery goes through the dedicated day case ward also in Clarendon Wing. Ophthalmology, mainly a day case specialty, is delivered from Chancellor Wing at SJUH. Cardiac surgery and neurosurgery are sited in Jubilee Wing ward 10 at LGI and transplantation is based at SJUH in Lincoln Wing.

Future model

All these specialties are already at LGI, apart from ophthalmology and transplantation. The main change as highlighted earlier, will be the move of day case surgery to SJUH wherever possible. Ophthalmology, as mainly a day case service, will continue to be provided from SJUH. A very small number of ophthalmology children may require an overnight stay and will be transferred to LGI following surgery. Acute ophthalmology cases will be admitted via paediatric medicine to LGI. Transplantation will be delivered from the new hepatology and gastro/renal ward at LGI.

1.2.5.i Cardiac surgery

Current model

Cardiac surgery and cardiology share a ward in Jubilee Wing with 19 beds (ward 10) and currently have a dedicated critical care ward.

Future model

There is space for significant expansion on the ward at LGI but this has been reserved in the long term to ensure we have the appropriate accommodation for expansion of the service, as part of the bid to become the Northern Cardiac Centre. The dedicated critical care ward will be relocated adjacent to (rather than opposite) the general PICU ward to increase flexibility and efficiency.

1.2.5.ii Transplantation

Whilst virtually all these services are managed by the paediatric teams, transplantation surgery is performed by adult transplant surgeons who transplant kidneys and livers to adults and children. Adult transplant surgery will remain based at SJUH whilst the inpatient paediatric service will be at LGI.

There are models in the UK and Europe where transplant surgery is based on one site and the team travels to the other to perform transplants and support the transplant service on that site. However the separation of transplant surgery from inpatient paediatrics is contentious and is being worked through carefully to ensure that the quality of the service is not compromised by this move. Paediatric services are currently working closely with adult transplant services to ensure that this is achieved and there are a number of models currently being reviewed. The aim is to ensure that transplant expertise is maintained and developed within paediatrics.

1.2.6 Theatres & anaesthetics

Current model

Currently, children's inpatient and day case operating takes place across a number of sites, Lincoln Wing and Chancellor Wing at SJUH, Clarendon Wing and Jubilee Wing at LGI and at Seacroft hospital.

There are elective inpatient and day case sessions, of which 2 are used for the robotic surgery, in Lincoln Wing SJUH. Additionally, renal and liver transplantation takes place, as and when organs are available, in theatre 9 Lincoln Wing.

There is a mix of elective inpatient and day case surgery in Clarendon Wing LGI. Currently there are 4.5 acute sessions.

Children's neurosurgery, cardiac surgery, orthotrauma and plastic surgery operating is undertaken in Jubilee Wing LGI.

Community dentistry (a PCT led service) currently takes place at Seacroft hospital but will be moved, because of governance issues, to LGI prior to centralisation.

As well as for surgery, anaesthesia is required for children for the following procedures amongst others:
Bronchoscopy, biopsies, Endoscopy, Laser dermatology, MRI scans, interventional radiology, line insertion, lumbar punctures, joint injections and teenage dialysis fistula fashioning. Anaesthesia is occasionally required for urodynamics, CT scanning, angiograpy and radiotherapy and is generally undertaken at the site where the related specialty takes place.

Future model

In future, after centralisation, all **inpatient** children's surgery, elective and acute, will take place at LGI in either Clarendon Wing or Jubilee Wing with day cases probably in Chancellor Wing at SJUH.

In Clarendon Wing theatres, it is intended to run day long sessions to make most efficient use of theatres. Complex children's day surgery will take place at LGI. There may be some reconfiguration of schedules between the C floor Clarendon Wing and Jubilee Wing theatres to ensure the most efficient use of theatre space. An additional theatre will be built within the current 4 theatre Clarendon Wing complex. It is hoped to increase the number of acute sessions to 10 but this has not yet been agreed.

The plan is to locate as much day case activity as possible at SJUH with all simple day case activity taking place at SJUH with the creation of a children's surgical day case unit. The most complex day case surgery will be at LGI.

There is a significant number of different day case **procedures** as well as surgery which currently take place in a variety of settings: it is intended the majority of these will take place in the children's surgical day case unit at SJUH or in the specialty procedures children's area in Bexley Wing SJUH

1.2.7 Critical Care

Current model

There is critical care provision for children on both sites; a mix of high dependency (HDU) and intensive care (PICU) depending on need. However, 15 beds are funded at LGI and 2 at SJUH: there is flexibility between the sites so that on occasions for example, 13 beds are used at LGI if 4 are being used at SJUH. Specialty HDU beds are located on appropriate specialty wards.

Future model

The clinical benefit of bringing the 2 units together will be realised if all the 17 beds are on the same floor and are co-located into adjacent wards 2 and 3. The beds on C floor Jubilee wing within the 2 wards will be expanded to create 19 beds. These will be grouped into cardiac, HDU and ICU but with flexibility across the groupings. Additionally, two long term ventilation beds will be one floor above, co-located with paediatric medicine. Critical care beds will be accessed by all paediatric specialties as appropriate and necessary. Specialty HDU beds will continue to be located on appropriate specialty wards.

1.2.8 Ambulatory services

Current model

Diagnostics are provided on both sites although some of the rarer procedures are undertaken on one site or another supporting the inpatient services provided on the site. Day case surgery and medicine and outpatients are provided at both SJUH and LGI without outpatients also at Seacroft.

Future model

Diagnostics and outpatients will still take place on both sites. Where possible, diagnostics will support inpatients at LGI and outpatients at SJUH, although specialty outpatients will continue at LGI with appropriate support.

1.2.9 Adjacencies across children's services

In relation to adjacencies within paediatrics and within the sites, most inpatient services at SJUH are close together in Gledhow Wing. The key adjacency issues are

- That renal dialysis is accommodated in another wing entirely (Lincoln Wing) separated from a paediatric infrastructure.
- The Cystic Fibrosis inpatient service is in a separate building to the day hospital and children with Cystic Fibrosis are not able to be isolated one from the other, because of cross infection issues, as easily as they should be.
- The oncology/haematology day hospital is in an entirely separate building to the inpatient wards.
- The distance between children's wards and theatres and diagnostics, which are in a separate building.

At LGI all inpatient children's services are in Clarendon Wing apart from the PICU/HDU and the cardiac/cardiology ward which is fairly self contained. These are both in Jubilee Wing which is directly linked to Clarendon Wing through corridors at two levels.

1.2.10 Links of children's services with adult services

At the LGI site there are very strong links with adult services where the same surgeons operate on both children and adults: in trauma and orthopaedics, plastic surgery, Cleft lip & palate, ENT and oral maxillo facial surgery, dentistry, cardiac surgery, cardiology and neurosurgery. At SJUH there are strong links with adult services where the same surgeons operate on both children and adults in renal and liver transplantation surgery.

Transition services are developing across a range of specialties with transitional clinics generally being based with the adult service.

1.2.11 Links with Maternity and Neonates

Maternity services and neonatal medicine are currently on both sides of the city in the same wings as the bulk of children's services. Neonates provide the bridge between children's services and maternity services. The services based at SJUH are slightly smaller than that at LGI. The feto maternal medicine service is delivered from LGI and from SJUH.

1.2.12 Parents' accommodation

On both sites there is broadly the same amount of support for parents needing to stay with their children (45 beds at LGI; 43 at SJUH) but again it is provided differently. St James's has a separate purpose built unit where parents and siblings can be housed (mainly used by families of oncology and liver patients), but no parents accommodation is available adjacent to wards. A parent can of course stay by a child's bedside. At LGI some parents accommodation is available adjacent to the wards - as well as the opportunity to stay at the child's bedside - and there is also parent/family accommodation within the hospital, mainly taking parents of children using cardiac/cardiology or PICU services.

After centralisation the Trust will provide a portfolio of accommodation for parents:

- At the child's bedside, with shower facilities nearby (when a parent cannot leave a child).
- In single/double rooms with ensuite wash hand basin, shower and wc adjacent to the clinical area. The planning assumption for accommodation adjacent to wards is that at least one parents unit will be created per ward, possibly a sitting room, a shower room and a bedroom.
- In a separate building on site (where a child is in hospital for some time and either the parent, with siblings, needs to stay, or where parents cannot readily go home because they live too far away).

Apart from in an emergency and in the very short term, it is not considered appropriate for siblings to stay in parents' accommodation adjacent to clinical areas.

There will be equity of provision in that **all** specialties will have access to parents/family accommodation dependent upon need.

The Sick Children's Trust is working with the Trust to provide the new family accommodation at LGI opposite Clarendon Wing.

1.2.13 Education

The Trust has a service level agreement with Education Leeds that schooling will be provided to children who have been in hospital for 5 days or more- although many children are seen much earlier than this.

Discussions are ongoing with Education Leeds to agree how the most modern ways of teaching - including the use of Leeds Learning Network - will be incorporated across all the childrens wards at LGI with age appropriate environments for teaching and learning away from the bed side.

1.2.14 Office accommodation

Currently, offices are within, or adjacent to, clinical accommodation and many people have single offices. Whilst it is recognised as being ideal, it is not practical -

or equitable - and it is already recognised that in a number of areas administrative/office accommodation is displacing direct clinical requirements.

After reconfiguration, clinical space will be at a premium in the reconfigured service. Good quality accommodation will first and foremost be used for clinical purposes. Therefore, the principle is that there will be a generic office within each clinical area. There will then be a small number of generic offices within the two wings adjacent to the clinical areas. The remainder of the office accommodation for both staff already based at LGI as well as staff transferring from SJUH will be in an open plan "office block" created in Martin Wing in the middle of the LGI site.

Some specialties at SJUH currently carry patients' notes on the wards. Discussions are in progress with medical records to look at stopping this practice and to have a discrete paediatric medical records department on A floor Clarendon Wing, adjacent to childrens services, following centralisation.

2. ADULT ACUTE MEDICINE AND OLDER PEOPLES MEDICINE

2.1 Philosophy and aims

- Provision of the highest possible quality of care making best use of human and other resources.
- Focus on patient safety and dignity and achievement of excellent clinical outcomes.
- Become the acute medical service of choice for patients, commissioners and all levels of staff.
- A well managed service able to respond quickly and flexibly to external changes and pressures.
- Early senior input to the care of acute medical admissions.
- Early input from appropriate specialists where necessary.
- No unnecessary steps in the patient pathway.
- Ambulatory patients managed as outpatients whenever possible.
- Focus on getting patients home or out of hospital as soon as possible.
- Build closer working relationships between, for example, acute medicine and A&E.
- Compliance with all national and local clinical standards, guidelines and directives.

2.2 Description of current service by specialty

2.2.1 Adult Accident & Emergency

Current model

Currently Emergency Departments (ED) are on both sides of the city at SJUH and LGI. There is a major Walk in Centre integrated with the ED at LGI. There are minor injuries/walk in facilities at WGH and the St Georges Centre run by the Trust. There is also a Walk in Centre in the LIGHT building in the centre of Leeds (not run by the Trust).

Since the centralisation of trauma, plastics and vascular in 2005/06, the nature of the two EDs in the Trust has changed to match the changing clientele of the hospitals with each department having patients streamed to them where the inpatient service is based on one site. Both sites continue to see large numbers of ambulance borne and walk in patients with the A&E at LGI becoming more the acute surgical 'hot' site.

Future model
All x-city GP referrals for acute assessment or admission for those specialties with beds on the SJUH site will be focussed on the SJUH site. On the SJUH site there will be a Medical or Multi speciality receiving department and a minor injuries unit as a minimum.

The LGI site will have a large ED including Resuscitation and Majors. There will also be an ambulatory care area (minor and moderate illness and injury), Paediatric ED, CDU and observation facility. This facility will take all 999 calls within the Trust (with the exception of some well defined longstanding exceptions such as Delivery Suite). This model will require sustainable arrangements to ensure that all GP admissions (except those who are critically ill) are managed in facilities outwith the ED.

Aside from the clinical reconfiguration outlined in this paper, future requirements for all seriously ill and injured patients to be assessed rapidly by 'senior clinical decision makers' in the ED are set out in the Yorkshire and Humber 'Healthy Ambitions' review. Delivering this important quality and patient safety initiative will require consolidation of Emergency Medicine services onto a single site.

In view of the close proximity of the city centre WiC to LGI it may be sensible to relocate the LGI WiC to the St James's site. Further developments may be possible with this model if the 'Darzi practice' is based near or on the St James's site.

2.2.2 Medicine for older people

Current model
This service is on both sites, SJUH and LGI with 5 wards in Martin Wing at LGI plus an acute admission ward and an older people's stroke ward at LGI on the old main site. At SJUH there are 4 wards in Beckett Wing, plus an acute admission ward in Chancellor Wing. There is a stroke ward at CAH which will move to Beckett Wing SJUH in September 2008. There is also an elderly care ward at WGH which operates as a step down/rehabilitation facility. Outpatients are located at CAH, LGI, WGH and SJUH.

Future model
Outpatients will remain as current. The older people's wards will move from LGI to SJUH and be co-located with other medical specialties in Gledhow Wing. Where clinically possible the wards will give a greater number of side rooms for maximisation of privacy and control of infection through the use of side rooms and doors on bed bays. It will also provide the opportunity to look at establishing single sex wards.

As a consequence of the move, the model of early senior medical assessment of each patient will allow maximum utilisation of community services facilitating people being able to stay in their own homes.

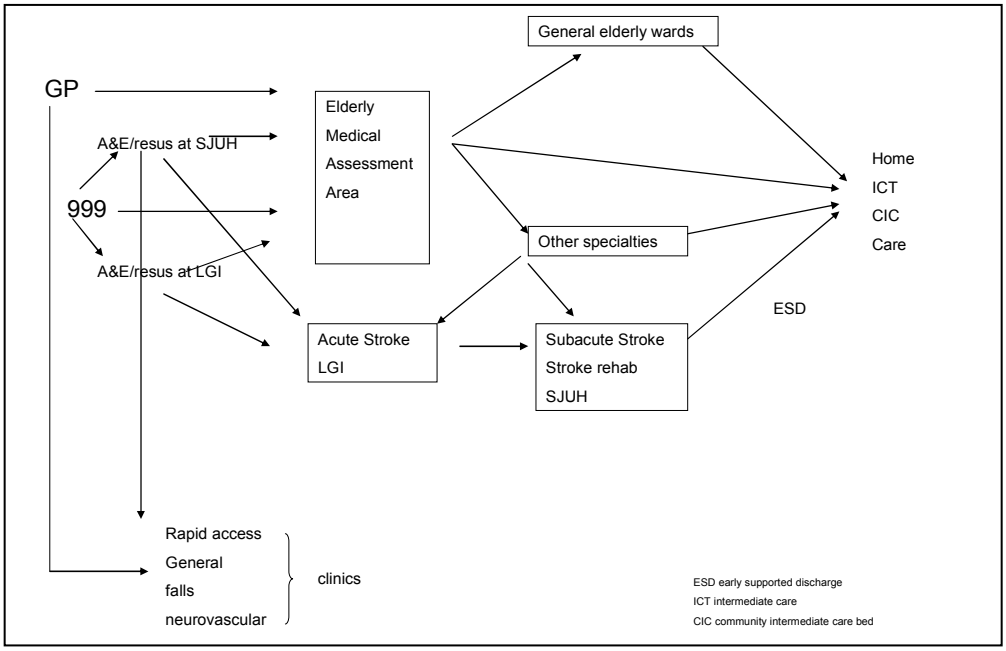
The hyperacute stroke ward will remain at LGI and be managed within neurology. A combined stroke unit will be established in Beckett Wing SJUH. Following their acute phase of care, patients requiring ongoing inpatient treatment will transfer to the stroke unit at SJUH or the neuro rehabilitation unit at CAH.

The SJUH wards will remain in Beckett Wing, but with the aim of moving them into Gledhow Wing should space become available.

The elderly care ward at Wharfedale will continue although in future it may be more

appropriate for it to be managed by the PCT - in a similar arrangement to that of V ward at Seacroft Hospital.

Flowchart describing future model of older people's hospital care.



2.2.3 Adult acute medicine

Current model

Adult acute medicine is currently based at SJUH and LGI within 4 wards on the old main site LGI and 2 wards in Chancellor Wing SJUH (wards included general medicine, diabetes & endocrinology). Outpatients are located at LGI, SJUH and WGH.

Future model

In future acute medicine inpatient care will be centralised at SJUH. The plan is to provide an improved and less complicated pathway which delivers a flexible and responsive service to patient and which GPs will find very easy to use. The service will be provided in facilities which are attractive and welcoming for parents and staff alike. There will be robust links with other medical specialties, including gastroenterology.

There will be telephone access for GPs direct to consultant/SpR to provide early service input and opportunity for admission. A medical receiving unit will be in place including resuscitation. The medical admission unit will function as currently but with systems in place to ensure patients do not stay longer than 24 hours. There will be a short stay ward for patients needing either a specialty bed or likely to go home fairly quickly. The focus on the inpatient wards will be on treatment and discharge.

Support to other specialties at the SJUH site will include gynaecology, thoracic surgery, upper GI surgery and the acute surgical take.

It is recognised as being essential that there is appropriate acute medical support to the LGI site through an on site SpR with specified consultant backup. Discussion is still ongoing with colleagues as to the best way to provide acute medical support particularly to vascular, orthopaedic trauma, ENT/oral max fax, plastics and hand surgery as will as the acute surgical take at LGI.

Pathways are being developed in relation to A&E and 999 patients.

2.2.4 Diabetes & Endocrinology

Current model

Both of these sub specialties are part of acute medicine and are outpatient based with endocrine clinics at LGI and diabetic clinics at WGH, SJUH and LGI. There are a number of special clinics for patients who have other conditions which may exacerbate, or be exacerbated by, their diabetes.

Future model

Commissioners are intending to pull out significant amounts of diabetic activity from the acute Trust into primary care and there will be less outpatient activity at the two acute sites. The two outpatient departments will therefore merge at the SJUH site in Beckett Wing.

2.2.5 Gastroenterology

Current model

Gastroenterology provides an inpatient day case and outpatient service on both the LGI and SJUH sites with endoscopy also at SJUH, LGI and WGH. The majority of the inpatients are acutely admitted.

Future model

Gastroenterology will still be delivered on both sides of the city. The question is whether it is appropriate to locate all the beds on one side of the city or not. There are benefits for gastroenterology patients in both scenarios. The key issues are the difficulty in providing two junior rotas for each side of the city for out of hours care if beds continue to be on 2 sites, the requirement to provide support to colorectal surgery patients who are at LGI and the need to have a Gastroenterology input into acute medicine at SJUH.

Therefore further work is continuing with colleagues in acute medicine.

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Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 22 July 2008

Subject: Performance Report

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

1.0 Introduction

1.1 At its meeting on 17 June 2008, the Board received an outline of the key priorities and targets for the Primary Care Trust (PCT), Leeds Teaching Hospitals NHS Trust (LTHT) and the Leeds Partnership Foundation Trust (LPFT).

1.2 As part of the discussion, the Board outlined a desire to be kept appraised of progress throughout the year, agreeing to consider the performance report presented to the PCT Board on a bi-monthly basis.

1.3 Attached to this report (Appendix 1) is the performance report scheduled to be discussed at the PCT Board meeting on 17 July 2008. The PCT's Director of Performance will attend the meeting to present the key issues highlighted by the report and to address any questions identified by the Board.

2.0 Recommendations

2.1 The Board is requested to consider the information provided in the attached report, identify any areas where further information is required and determine whether there are any specific matters that require more detailed scrutiny.

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Leeds NHS
Primary Care Trust

Performance Report

July 2008

Performance Report

Executive Summary

The report this month is presented in two parts:

- Part 1 – Process for performance reporting
- Part 2 – Performance against key priorities.

Part 1

The PCT Strategy 2008-2011 has been translated into an operating plan for 2008/09, with objectives set for the PCT towards achieving the Strategy.

These objectives include the six priorities, our commitment to the Local Area Agreement, Healthy Ambitions and statutory targets toward the delivery of the Annual Health Check. These are attached at Annex A.

It is proposed that the process for performance monitoring and reporting be as follows:

1. The performance team set up an internal process to monitor progress against all the objectives. This process is already advanced for the six priority areas (colour coded within Annex 1), but it will be extended to cover all objectives, many of which are different from previous targets.

2. The PCT Board receives summary progress updates, through the performance report, on all six priorities. The indicators associated with the six priority areas are:

   - **18 weeks standards**
     - 18 week referral to treatment waits; admitted and non-admitted
     - Diagnostic waits less than 6 weeks
     - Maximum wait time of 13 weeks for an outpatient appointment
     - Maximum wait time of 26 weeks for an inpatient appointment
     - Choose & Book rates

   - **Cancer wait times**
     - Maximum wait time of 14 days from urgent GP referral to first outpatient for suspected cancer
     - Maximum wait time of 31 days from diagnosis to treatment for all cancers
     - Maximum wait time of 62 days from urgent GP referral to treatment for all cancers
     - Breast cancer screening for women aged 53 to 70 years

   - **Health care associated infections standards**
     - MRSA levels sustained, with local stretch targets beyond the national targets

- C.Difficile reduction of 30% at national level, with local targets now agreed

➢ **Primary care access standards**
- Guaranteed access to a primary care professional within 24 hrs
- Guaranteed access to a GP within 48 hrs
- Number of GP practices offering extended opening hours

➢ **Sexual health programme standards**
- Chlamydia screening programme standard
- Access to a GUM service within 48 hrs

➢ **Urgent care**
- 4 hr A&E standard
- Ambulance response times: Cat A 9 min standard
- Ambulance response times: Cat B 19 min standard

The indicators are colour coded as follows –

18 weeks	Cancer	Primary care	Urgent Care	HCAI	Sexual Health

3. The PCT Board receives summary progress updates on any objectives where exceptions or non-delivery has occurred, or there is a risk of it doing so, i.e. where the status is Red.

4. The PCT Board are warned if an objective has moved from Green to Amber and a summary report will be produced next time to explain why there was a dip in performance.

5. The PCT Board choose to receive more detail on a few of the other objectives for presentation at the next meeting.

   The advantage of this approach is that whilst keeping the PCT Board abreast of performance on the six priorities, and any exceptions, there is a robust system in place to monitor performance on all the others, to allow the PCT Board to 'drill down' and secure assurance as required on other matters.

   The PCT Board should consider requesting progress on objectives and targets that are performing well or where there is a local or national interest.

   In addition to the motivational effect that this will have on service teams across the PCT, it would help to embed the performance regime across all PCT business.

6. As part of the Annual Health Check, we will also report on ratings given to the PCT and released during late October, to the November PCT Board meeting.

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Leeds NHS
Primary Care Trust

Part 2

Monthly Performance Report – July

Overview

The following charts use a traffic light system, with bars showing as green, amber or red, indicating whether performance is on track or not. Where possible, the traffic lights colours use the thresholds of the Healthcare Commission. This should provide a close guide on the likely performance outcome, as the year progresses.

18 weeks standards

18 week referral to treatment waits; admitted and non-admitted

Target:

Government operational targets of 90% of pathways where patients are admitted for hospital treatment; and 95% of pathways that do not end in an admission, should be completed within 18 weeks

Delivery of the referral to treatment (RTT) time standard is challenging for the PCT. The performance trajectory draws from the plan agreed with the SHA for delivery of the operational targets.

The PCT achieved the milestones that were set for March 2008 and continues to show performance exceeding trajectory. The charts show the latest validated data available.

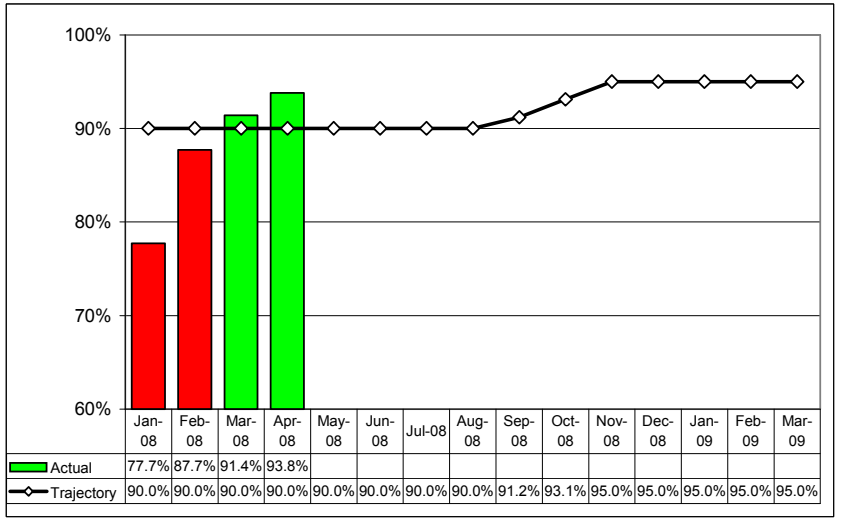
The target position for delivery of 18 weeks is now on track each month with work underway to deliver the higher level target by September 08. Early indications from LTHT are that they are more likely to achieve their elements of the target by October 08 but nevertheless there is a will and push for September.

A comprehensive capacity plan has been produced identifying which specialities have identified any risks and capacity gaps in the delivery of 18 weeks. Project leads have been identified to do further work at speciality level. Capacity required elsewhere in the system will be commissioned as a result of this with the aim of fully utilising IS capacity currently in the system.

Lead Executive Director: Matt Walsh
Management Lead: Nigel Gray
Operational Lead: Sue Hillyard

Ensure by March 08 most patients wait less than 18 weeks from referral to treatment

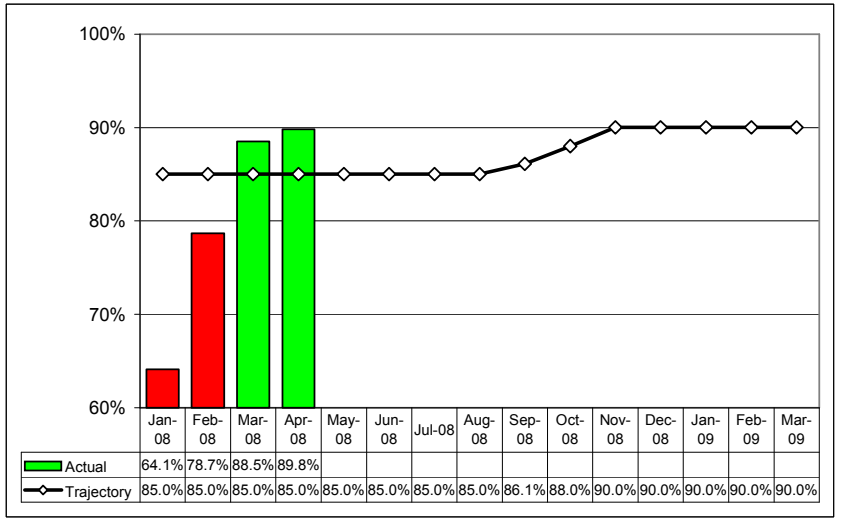
Percentage of patients seen within 18 weeks - non admitted



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	77.7%	87.7%	91.4%	93.8%											
Trajectory	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	91.2%	93.1%	95.0%	95.0%	95.0%	95.0%	95.0%

Ensure by March 08 most patients wait less than 18 weeks from referral to treatment

Percentage of patients seen within 18 weeks - admitted



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	64.1%	78.7%	88.5%	89.8%											
Trajectory	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	86.1%	88.0%	90.0%	90.0%	90.0%	90.0%	90.0%

18 weeks standards

Diagnostic waits less than 6 weeks

Target:

The number of patients waiting 6 weeks or more at the date of measurement for all diagnostic tests, should decrease to zero as rapidly as possible after March 2008.

6 week for direct access Audiology
Direct access audiology diagnostics is currently showing significant numbers of waiters over 6 weeks. However following a comprehensive validation process, the position is now on track to deliver 6 weeks in June. The reason for this has been the recent implementation of a diagnostics patient tracking list (PTL) which when initially became operational, comprised of a broader range of patients than should have been featured. This has now been rectified.

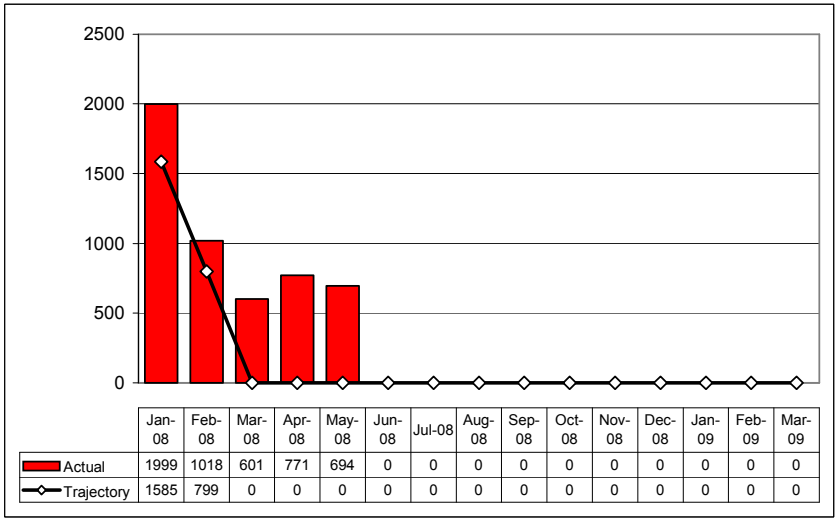
Hearing Aid fittings
This service is not currently 18 week compliant but significant work has been done to address this and overall improvements have been made. It is anticipated that through this work and increased capacity identified, delivery of target will be achieved by August. In addition waiting times for paediatric audiology are between 5 and 6 weeks.

Diagnostic waits
There remains a significant number of diagnostic waits over 6 weeks, Critical areas are endoscopy, colonoscopy and gastroscopy and work is ongoing to manage weekly performance delivery reports utilising the IS for additional capacity. In addition a modelling exercise is underway within each relevant CMT to identify what capacity is needed to deliver less than 6 weeks waits and then a further piece of work will model that delivery down to 2 weeks if necessary to sustain 18 weeks.

Lead Executive Director: Matt Walsh
Management Lead: Nigel Gray
Operational Lead: Sue Hillyard

Waits for diagnostics to be reduced to 6 weeks maximum

Number of patients waiting 6+ weeks for 15 key diagnostics



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	1999	1018	601	771	694	0	0	0	0	0	0	0	0	0	0
Trajectory	1585	799	0	0	0	0	0	0	0	0	0	0	0	0	0

18 weeks standards

Number of inpatients waiting longer than standard; Number of outpatients waiting longer than standard

Target:

That the maximum wait for a first outpatient appointment be no more than 13 weeks from GP referral and for an inpatient no more than 26 weeks after a decision to admit.

There continues to be sub speciality breach risks for 13 and 26 weeks in part as a result of the backlog of patients untreated earlier in the year. It is anticipated that these patients will be cleared in July for gastroenterology and August for the hands speciality. In addition there is further work being managed weekly through the task force to look at dermatology capacity and the utilisation of both the independent sector and primary care providers to address the current increase in demand.

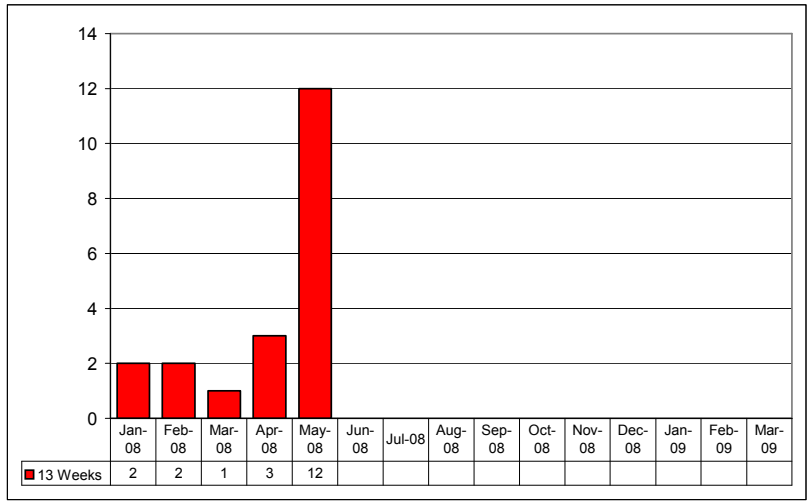
Neurosurgery and plastics also continue to be breach risks for 26 weeks due to the complex nature of a number of patients and therefore the reduced options for treatment in the IS. The impact of referrals from outside of Leeds also is also a key issue in these specialties therefore LTHT is particularly focussing a piece of capacity and demand work on these specialities with the greatest risk of breaching 13 and 26 weeks.

This will give a more comprehensive picture of capacity needed following the impact of free choice and the solutions needed to address these issues. This will report into the 18 week programme management arrangements for sign off.

Lead Executive Director: Matt Walsh
Management Lead: Nigel Gray
Operational Lead: Sue Hillyard

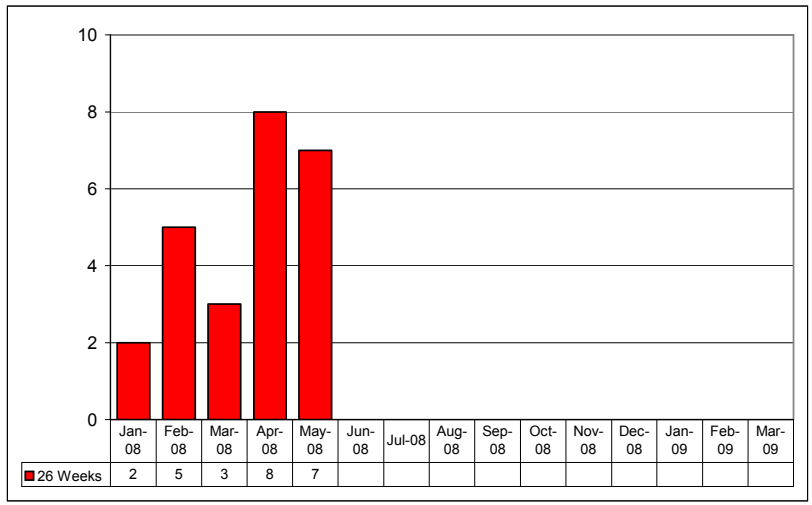
Ensure a maximum wait of 13 weeks for outpatients

Number of outpatients breaching 13+ weeks at each month-end



Ensure a maximum wait of 26 weeks for inpatients

Number of inpatients breaching 26+ weeks at each month-end



18 weeks standards

Maximise the use of the Choose & Book system

Target:

To be developed.

During May there was an increase in the rate of referrals using Choose & Book (C&B) from 18.57% to 19%. This is against a national average of 51%, a static figure for some time. The national average provides a realistic aim for achievement by March 2009. Further work on a more accurate "trajectory" to support this aim will confirm how this will be achieved.

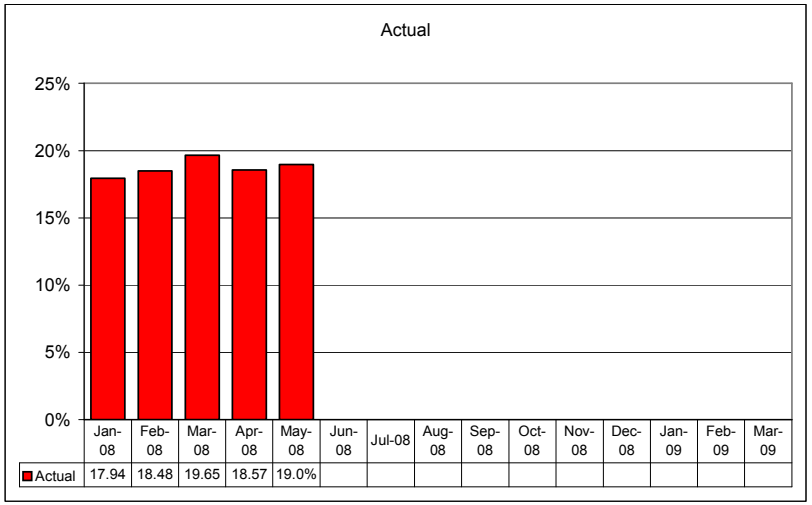
Statistics for the 4 months to December last year illustrate that only 17% of GPs use the C&B system to make more than 20% of their referrals. The main reason given for this is the lack of Directly Bookable Services that are live on the C&B system. Specialties that are not live account for up to 40% of all first referrals by GPs. The PCT is working to get these services available. The C&B team is also working with providers, including community services, to help facilitate their services going live on the system. The C&B system also now has further improved functionality and the ability to offer greater choice to the patient. GP engagement continues with visits being made to individual practices and GP consortia, following a sign up to use C&B by more than 95% of all GPs.

Additional actions being undertaken to improve the use of C&B include work being undertaken on helping practices with IT related queries; a review of the current PCT Referral Management System; and the improvement of governance and supporting systems underpinning C&B within the PCT.

Lead Executive Director: Lynton Tremayne
Management Lead: Rob Goodyear
Operational Lead: Rob Goodyear

Choose and Book

Percentage of outpatient bookings made using the Choose & Book system



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	17.94	18.48	19.65	18.57	19.0%										

Cancer wait times

Maximum wait time of 14 days from urgent GP referral to first outpatient appointment for suspected cancer

Target:

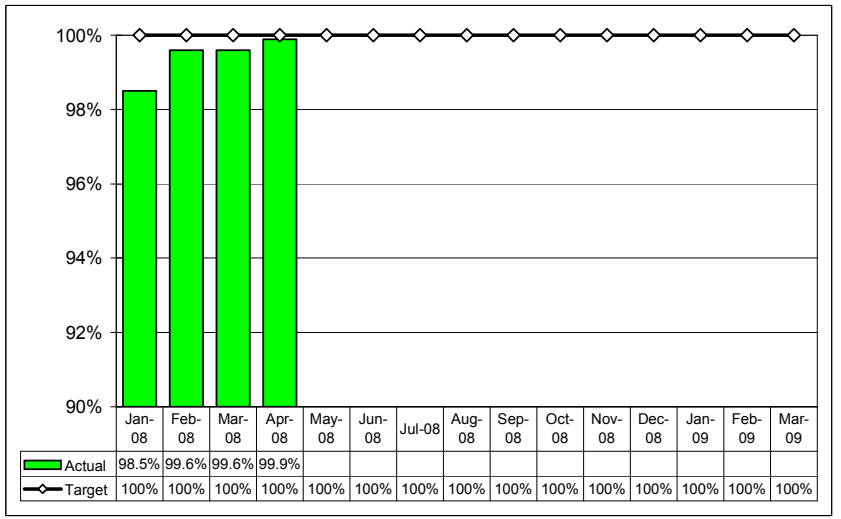
That there be a maximum wait time of 14 days from urgent GP referral to a first outpatient appointment for suspected cancer, with a target of 100% and an operational standard of greater than or equal to 97% patients seen.

The unvalidated position is that May and June targets appear to have been achieved, though this will not be formally confirmed until around six weeks after each month-end.

This wait time target has been consistently achieved within the operational standards.

Access to Cancer Services

Urgent GP Cancer Referrals received within 48 hours and seen within 14 days



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	98.5%	99.6%	99.6%	99.9%											
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Lead Executive Director: Matt Walsh
Management Lead: Nigel Gray
Operational Lead: Jayne Reeves

Cancer wait times

Maximum wait time of 31 days from diagnosis to treatment for all cancers

Target:

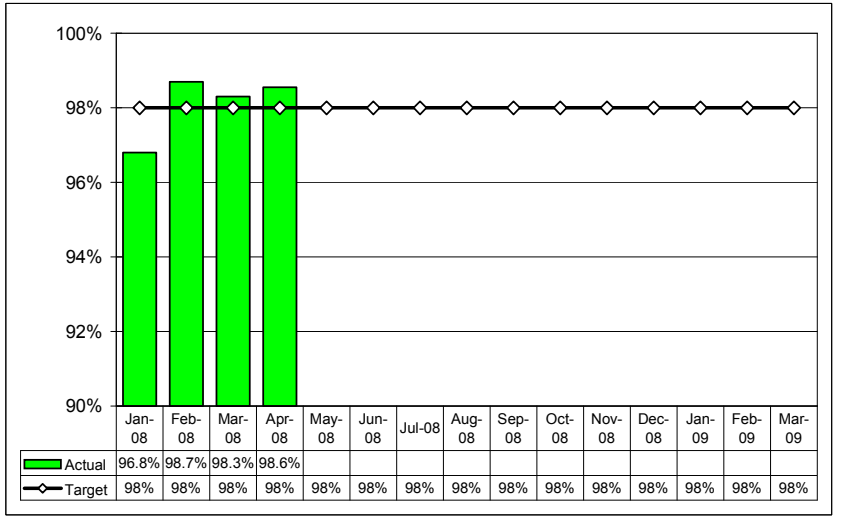
That there be a maximum wait time of 31 days from diagnosis of cancer to the beginning of treatment , with a target of 98% and an operational standard of greater than or equal to 96% of patients seen.

The unvalidated position is that May and June targets appear to have been achieved, though this will not be formally confirmed until around six weeks after each month-end.

This wait time target has been consistently achieved within the operational standards.

Access to Cancer Services

Percentage of patients receiving treatment within 31 days of diagnosis



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	96.8%	98.7%	98.3%	98.6%											
Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%

Lead Executive Director: Matt Walsh
Management Lead: Nigel Gray
Operational Lead: Jayne Reeves

Cancer wait times

Maximum wait time of 62 days from urgent GP referral to treatment for all cancers

Target:

That there be a maximum wait time of 62 days from urgent GP referral for suspected cancer to the beginning of treatment , with a target of 95% and an operational standard of greater than or equal to 93% of patients seen.

The unvalidated position is that May and June targets appear to have been achieved, though this will not be formally confirmed until around six weeks after each month-end.

There are continuing problems in lung cancer capacity which mean that early indications are that achievement of the target in July and possibly August look to be at risk.

There are several planned actions to address the problems in this area –

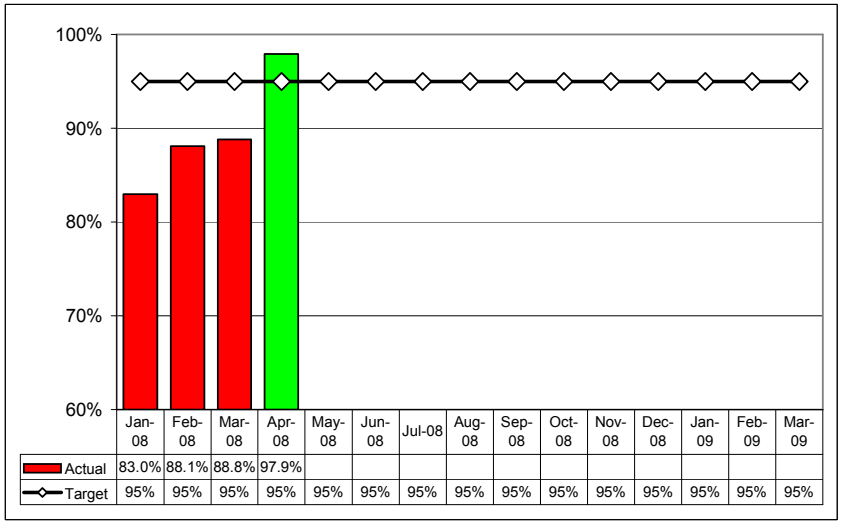
- A new locum has now started in post
- An extra all day list has been put in place

A plan is being developed to reduce backlog – early estimates suggest it may be up to September 08 before there is a return to steady state

The immediate action now is to reach agreement on the recovery plan and for all parties to ensure it is delivered.

Access to Cancer Services

Percentage of patients receiving treatment within 62 days of referral



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	83.0%	88.1%	88.8%	97.9%											
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Lead Executive Director: Matt Walsh
Management Lead: Nigel Gray
Operational Lead: Jayne Reeves

Cancer wait times

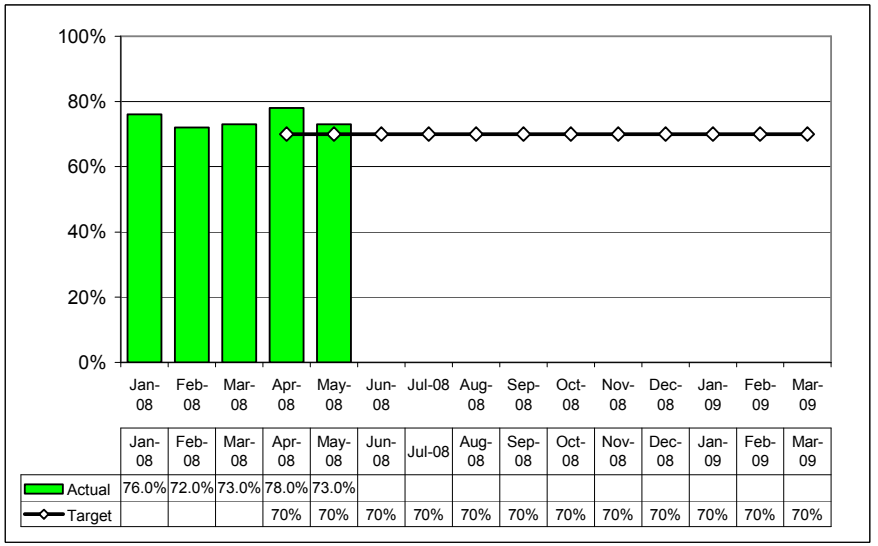
Breast cancer screening for women aged 53 to 70 years

Target:

That all women aged 53 to 70 years be invited for routine screening for breast cancer, based on a three-year screening cycle, with an operational target of 70% for uptake and 90% for round length cycle.

Access to Cancer Services

Women offered breast screening



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	76.0%	72.0%	73.0%	78.0%	73.0%										
Target				70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%

The data presented comes directly from the Breast Screening Unit and includes women eligible from 50-70 years of age. The minimum standard for uptake is set at 70%.

Uptake in Leeds has remained over the minimum standard of 70% since January 2008. The Leeds health economy previously struggled to meet the target for round length (> 90% of eligible women offered screen within 36 months of previous screen) and due to this it was felt that working to improve uptake could have a detrimental effect on round length. The Breast Screening Unit has now worked for 3 months within the round length target. Validated data for April 2008 shows 97% and yet to be validated data for May shows 98% achievement. Therefore, work has begun to promote breast screening in the target age groups and within the vulnerable groups across the city, working in partnership with the voluntary sector.

Leeds Breast Screening Unit, as with other units will be expected to implement an age extension programme of 47-73 (Date for this to be confirmed). Work is ongoing to model this planned age extension programme statistically and ensure that the local population increase is accounted for and built in to future business planning. This work is also mapping where uptake may be particularly low and work will be targeted in these geographical areas.

Lead Executive Director: Ian Cameron
Management Lead: Simon Balmer
Operational Lead: Kate Jacobs

Health care associated infections standards

MRSA levels sustained, with local stretch targets beyond the national targets

Target:

To maintain a maximum of not more than 6 cases per month.

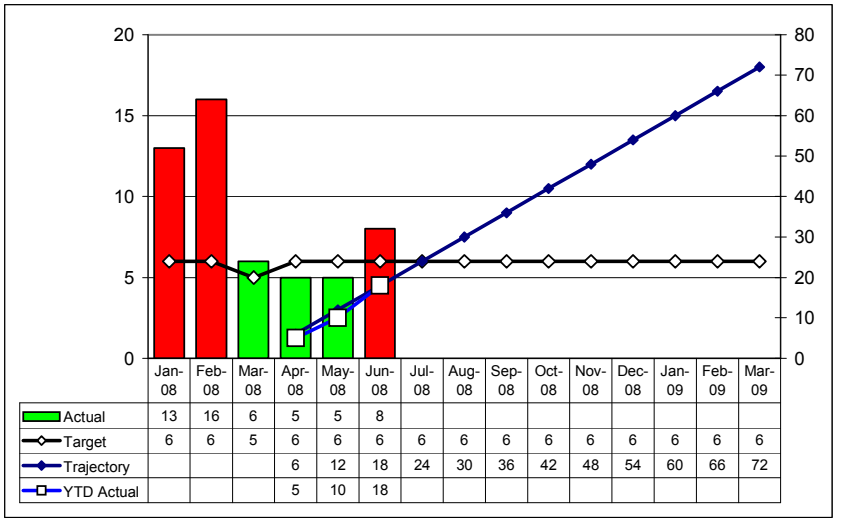
Unvalidated data for June is a total number of 8 cases for the month against a target of 6. The target has been breached for June by two cases, but over the 4 month period March, April, May & June, for which the SHA set a performance 'envelope', the target has been achieved overall to date.

LTHT and the PCT are currently working to renew efforts in reducing the number of cases. Further updates on this work will be given in the next performance report.

The degree of progress that LTHT have made in reducing the number of cases from that seen in September 2007 should be acknowledged, especially in the process of the detailed analysis of all individual cases that takes place. This focus has helped achieve the present position.

Health Care Associated Infections

Cumulative number of MRSA positive blood culture episodes



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	13	16	6	5	5	8									
Target	6	6	5	6	6	6	6	6	6	6	6	6	6	6	6
Trajectory				6	12	18	24	30	36	42	48	54	60	66	72
YTD Actual				5	10	18									

Lead Executive Director: Ian Cameron
Management Lead: Simon Balmer
Operational Lead: Bob Darby

Health care associated infections standards

Incidence of Clostridium Difficile

Target:

That the PCT work to contribute to a reduction of 30% in the number of cases at the national level, with a local target of 4.1 cases per 1000 admissions by 2010/11.

This target has been the subject of detailed discussions between the PCT and the SHA, which has resulted in an ambitious plan and trajectory, as part of the delivery of the national plan.

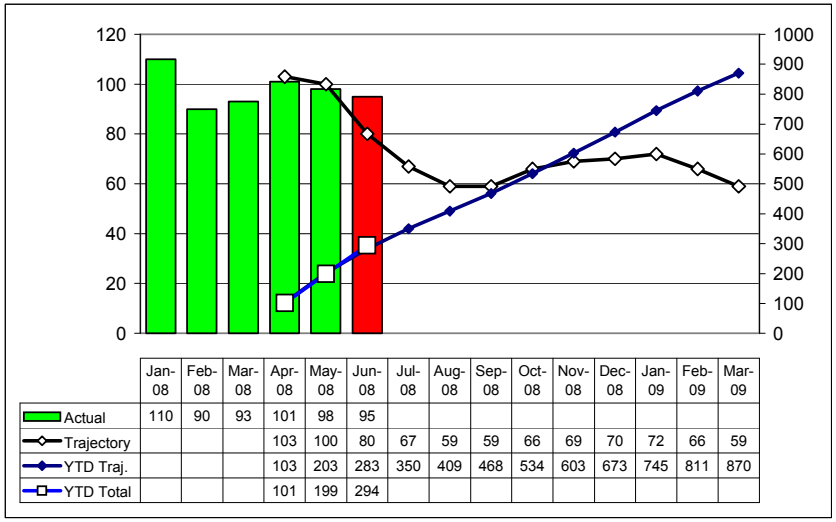
The new 3-year trajectory, a part of which can be seen on the chart opposite, now shows seasonal changes that are anticipated to affect the rate of cases through the year, though the overall projected trend is downwards. The chart has two scales, showing the monthly totals from the left hand side and the year to date information from the right.

Performance so far this year from April, has been reasonable, though slightly higher than planned. June data shows that the number of cases was higher than planned for, although the actual number is reduced from that seen in May. This higher figure for June pushed the total for the year to date over that anticipated and this represents an increased challenge for the remainder of the year.

Lead Executive Director: Ian Cameron
Management Lead: Simon Balmer
Operational Lead: Bob Darby

Health Care Associated Infections

C.Diff infections



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	110	90	93	101	98	95									
Trajectory				103	100	80	67	59	59	66	69	70	72	66	59
YTD Traj.				103	203	283	350	409	468	534	603	673	745	811	870
YTD Total				101	199	294									

Primary care access standards

Access to primary care

Target:

Patients are able to access a primary care professional within 24 hrs and a GP within 48 hrs and the PCT.

The Primary Care Access Survey, the data for which is presented in the charts opposite describes the results of the GP practice responses to questions on the availability of appointments. This survey is conducted quarterly and the next one is due to take place shortly.

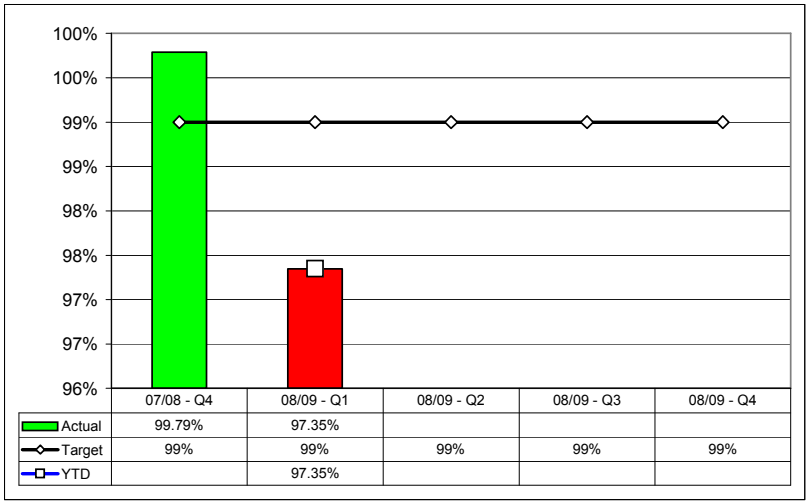
The latest data available is shown, which was also presented to the Board meeting in June.

The other element of the indicators on the delivery of the access standards is that drawn from the GP Patient Survey, which is conducted independently of the PCT. The Patient Survey is carried out annually and therefore cannot be represented in the chart data until results are released to the PCT. It is understood that this will be later this year.

Lead Executive Director: Matt Walsh
Management Lead: Damian Riley
Operational Lead: Emma Wilson

Primary Care Access

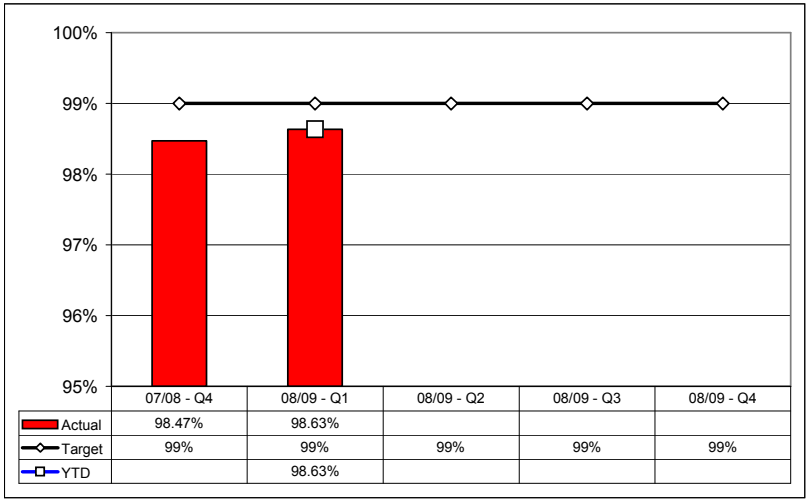
48 Hour Access to a GP



	07/08 - Q4	08/09 - Q1	08/09 - Q2	08/09 - Q3	08/09 - Q4
Actual	99.79%	97.35%			
Target	99%	99%	99%	99%	99%
YTD		97.35%			

Primary Care Access

24 Hour Access to a PCP



	07/08 - Q4	08/09 - Q1	08/09 - Q2	08/09 - Q3	08/09 - Q4
Actual	98.47%	98.63%			
Target	99%	99%	99%	99%	99%
YTD		98.63%			

Primary care access standards

Access to primary care

Target:

At least 50% of GP practices in the PCT offer extended opening hours by Dec 2008.

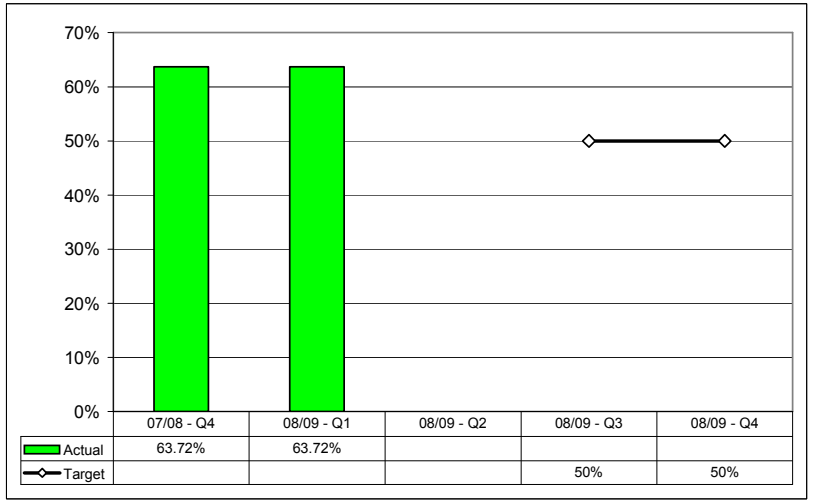
The target of 50% of practices offering extended opening hours in line with DH guidelines, by Dec this year has already been met. In June, the PCT was reporting that almost 64% of practices were meeting the requirements. This is planned to increase further during the year.

The chart shows quarterly data, which represents the reporting frequency.

Note: This indicator is also sometimes described using the term 'Family friendly hours'.

Primary Care Access

Family Friendly Hours



Lead Executive Director: Matt Walsh
Management Lead: Damian Riley
Operational Lead: Emma Wilson

Sexual health programme standards

Chlamydia screening programme standard

Target:

That 17% of the population aged 15-24 accept screening or testing for chlamydia in 2008/09

Narrative:

This indicator now includes screens carried out in primary care, a revision to previous practice. The number of these screens is presently being validated and is shown as a 'top-up' to the known validated number conducted within the national screening programme.

Complete data for Q1 (08/09) is not yet available, as the primary care screens outside the project can only be estimated at this stage based on last year's activity, therefore best estimates of activity have been included.

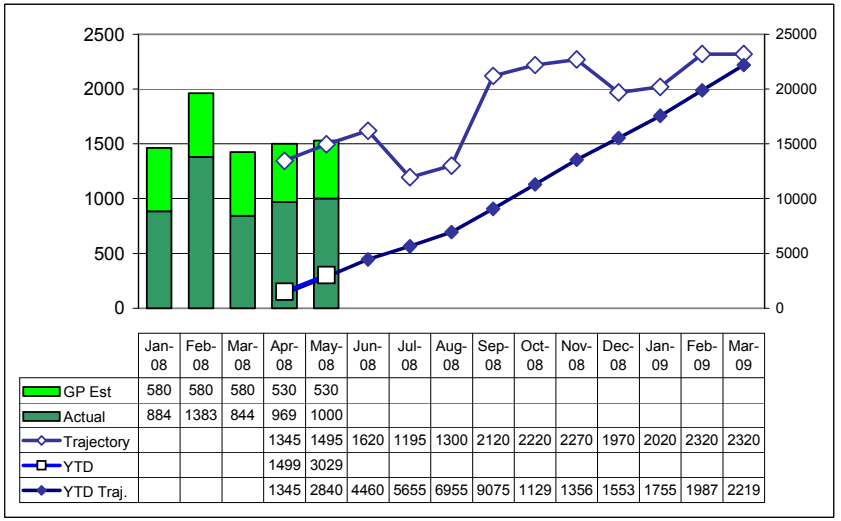
The chart shows the target trajectory will have been achieved up to June, with the inclusion of estimated data. In order to achieve the target rate of 17% of sexually active 15-24 year olds on 2008/09, screening activity will need to continue to increase.

Actions to ensure delivery include weekly meetings to monitor the agreed action plan and identify risks to achieving target. Key current risks are identified as within CaSH service and Prisons. Activity within both areas has fallen. This is being managed through discussion at senior level with PCT care services. Capacity has also been increased to manage key components of the project through matrix working. Capacity has been increased within the chlamydia screening team. A pharmacy campaign is planned for July/August, with Bond St Boots promoting postal testing kits. Workplace screening is also in progress and the PCT is working with FE colleges to implement registration screening.

Lead Executive Director: Ian Cameron
Management Lead: Jon Fear
Operational Lead: Victoria Eaton

Sexual Health

Chlamydia Screening



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
GP Est	580	580	580	530	530										
Actual	884	1383	844	969	1000										
Trajectory				1345	1495	1620	1195	1300	2120	2220	2270	1970	2020	2320	2320
YTD				1499	3029										
YTD Traj.				1345	2840	4460	5655	6955	9075	1129	1356	1553	1755	1987	2219

Sexual health programme standards

Access to GUM services

Target:

All patients should receive an offer of an appointment to be seen within 48 hrs of contacting the GUM service (not an offer made within 48hrs to be seen at a later date).

Narrative:

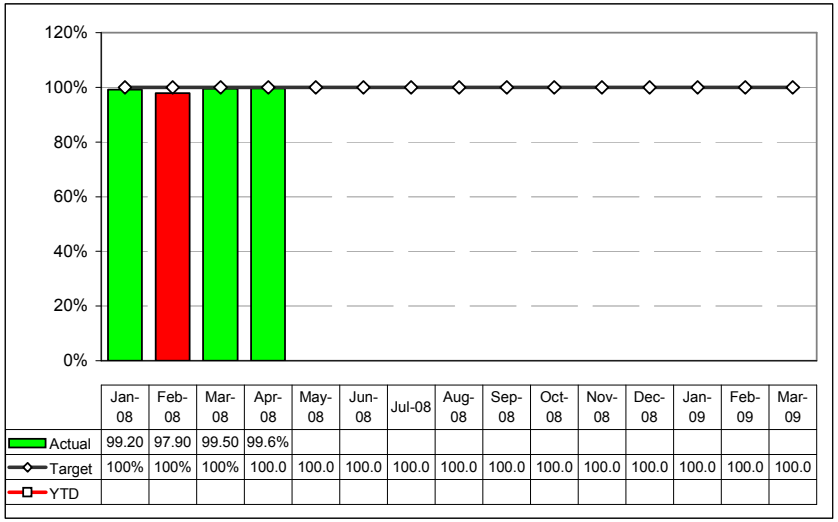
GUM have maintained the Healthcare Commission's 100% 'offered' target since March 2008 and continue to offer access to the service within 48 hours. Currently LTHT, as the main provider, have the capacity to continue to sustain this performance throughout the year.

Other positive news is that the new patient DNA rate has fallen since March from 14.77% to 10.4% in June.

The other indicator previously used, that of the rate of patients actually seen within 48 hours is the subject of debate and there is a strong national view within the service that patient choice is preventing achievement of the 95% threshold. An extension to the time period for the 'seen' indicator is being considered to take account of this. Further news on this will follow as it becomes available.

Improve access to genito-urinary medicine

Percentage of patients offered an appt for within 48 hrs of contacting GUM



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	99.20	97.90	99.50	99.6%											
Target	100%	100%	100%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
YTD															

Lead Executive Director: Ian Cameron
Management Lead: Jon Fear
Operational Lead: Victoria Eaton

Urgent care standards

4 hr A&E standard

Target:

That at least 98% of patients spend 4hrs or less in A&E, from arrival to admission, transfer or discharge.

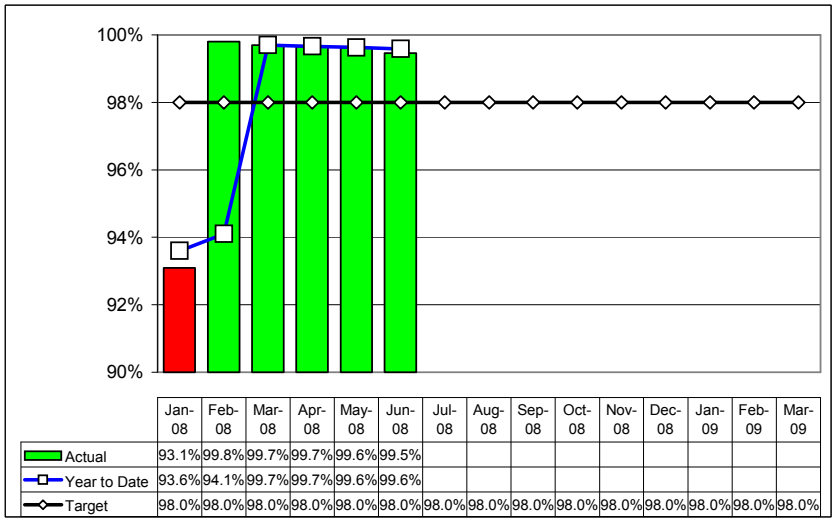
Year to date performance of 99.6% as at 2 July has been achieved. All sites at LTHT continue to achieve the target 98% daily, with rare exceptions.

This significant turnround is clearly due to successful implementation during March of a system of ward assessment and receiving areas, which is having a positive impact on patient flow through the A&E department. The culture shift required within LTHT, both within A&E and the inpatient teams, has now been shown to have the desired effect. The PCT and LTHT continue to meet with the SHA to be clear about the position going forward.

The activity from the Commuter Walk-in Centre in The Light is now contributing towards the 4hr target, and historical data since April 07 is being fed into the overall year-end return.

Maximum 4hr wait in A&E

Percentage of patients spending less than 4hrs in A&E



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	93.1%	99.8%	99.7%	99.7%	99.6%	99.5%									
Year to Date	93.6%	94.1%	99.7%	99.7%	99.6%	99.6%									
Target	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%

Lead Executive Director: Matt Walsh
Management Lead: Nigel Gray
Operational Lead: Laura Sherburn

Urgent care standards

Ambulance response times: Cat A 9 min & Cat B 19 min standards

Target:

A minimum of 75% of Cat A calls should receive an emergency response at the scene within 8 mins and 95% of Cat B calls should receive an emergency response at the scene within 19 mins.

Performance on these indicators is based on the whole ambulance service returns. On the Cat A 75% target, at 15th June 2008 the Yorkshire Ambulance Service (YAS) performance year to date stood at 62.6%. This is a key risk for the region in terms of Healthcare Commission ratings.

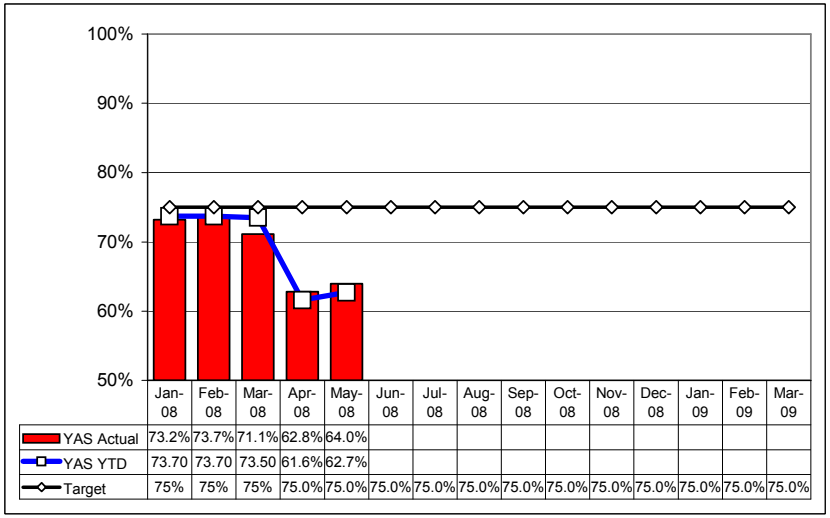
The recent marked decline in performance is acknowledged to be due to the impact of Call Connect. The performance management framework implemented by the SHA from April 08 with key actions for PCTs and NHS organisations is ongoing and includes trajectories to achieve the target. Going forward, the contract for 08-09 is currently being negotiated, and will look to move towards an activity-based contract funded through locally agreed tariff, with appropriate controls in place. The PCT is arranging to meet YAS at a future Board meeting to discuss performance trajectories and turnaround plans and we have offered to lead a workshop at the Directors of Performance network of Yorkshire and Humber to provide support and assistance to YAS in achievement of their plans.

On the Cat B target, YAS performance as a whole is 89.5% year to date. Ongoing contract negotiations for 08-09 and the SHA performance management action plan will address this going forward.

Lead Executive Director: Matt Walsh
Management Lead: Nigel Gray
Operational Lead: Laura Sherburn

Ambulance Response Times

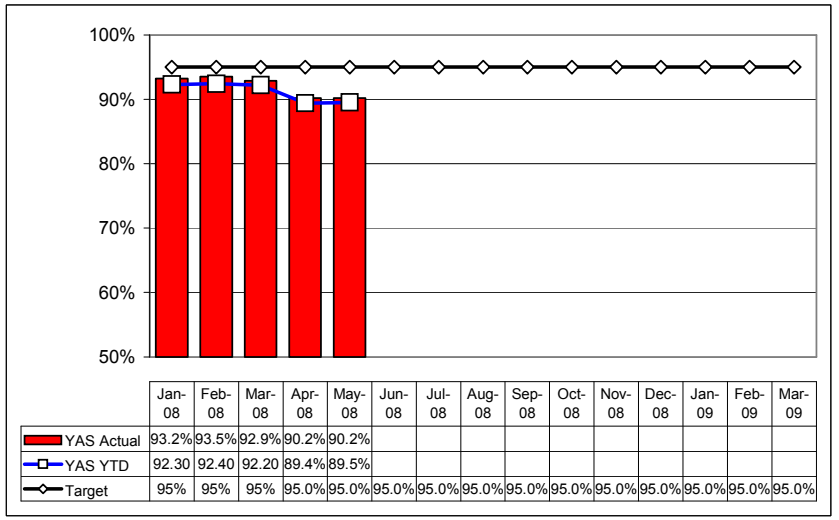
Category A calls receiving a first response within 8 minutes



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
YAS Actual	73.2%	73.7%	71.1%	62.8%	64.0%										
YAS YTD	73.70	73.70	73.50	61.6%	62.7%										
Target	75%	75%	75%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%

Ambulance Response Times

Category B calls receiving a first response within 19 minutes



	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
YAS Actual	93.2%	93.5%	92.9%	90.2%	90.2%										
YAS YTD	92.30	92.40	92.20	89.4%	89.5%										
Target	95%	95%	95%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

Leeds NHS
Primary Care Trust

Annex A – Full list of 2008/09 indicators, by PCT Directorate

Directorate	ED lead	PCT Top 6 Priority	Description of Objective / Initiative	Mngmt lead	Ops lead
Commissioning	MW	18 weeks	18 weeks maximum wait from referral to the start of treatment by Dec 2008	NG	SH
			Diagnostic Waits > 6 Weeks	NG	SH
			Maximum wait time of 13 weeks for an outpatient appointment	NG	SH
			Maximum wait time of 26 weeks for an inpatient appointment	NG	SH
			Patient reported measure of choice of hospital	NG	SH
			Percentage of Patients seen within 18 weeks for direct access audiology services	NG	SH
		Cancer	A maximum waiting time of one month from diagnosis to treatment for all cancers	NG	JR
			A maximum waiting time of two months from urgent referral to treatment for all cancers	NG	JR
			A two week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals	NG	JR
			Improving cancer services - Implementation of IOGs	NG	JR
			Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (radiotherapy treatments)	NG	JR
			Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment (surgery and drug treatments)	NG	JR
			Proportion of patients with breast symptoms referred to a specialist who are seen within two weeks of referral	NG	JR
			Proportion of patients with suspected cancer detected through national screening programmes or by hospital specialists who wait less than 62 days from referral to treatment	NG	JR
		Primary care	Guaranteed access to a primary care doctor within 48 hours	DR	EW
			Guaranteed access to a primary care professional within 24 hours	DR	EW
			Improvement in Family Friendly GP Hours (50% in PCT to offer extended opening)	DR	EW
			Patient reported measure of access to a GP	DR	EW
			Primary dental services, based on assessment of local needs with the objective of ensuring year on year improvements in the numbers of patients accessing NHS dental services	DR	SL
		Urgent Care	All ambulance Trusts to respond to 75% of Category A calls within 8 minutes	NG	LS
			All ambulance Trusts to respond to 95% of Category B calls within 19 minutes	NG	LS
			Four hour maximum wait in A&E from arrival to admission, transfer or discharge	NG	LS
			A maximum two week wait for Rapid Access Chest Pain Clinic	NG	PD
			All patients who have operations cancelled for non clinical reasons to be offered another binding date within 28 days, or the patients treatment to be funded at the time and hospital of the patient's choice	MW	NH
			Data quality on ethnic group (previously derived from SUS and MHMDS)	MW	NH/RW
			Number of people provided care closer to home	NG	
			Implementation of Stroke Strategy / Time to Treatment	NG	PD
			Emergency bed days (also used as proxy for VSC11: People with long-term conditions feeling independent and in control of their condition)	NG	PD
			Thrombolysis "call to needle" of at least 68% within 60 minutes, (where preferred local treatment for heart attack)/Primary angioplasty 'call to balloon' time	NG	PD
			Time to reperfusion for patients who have had a heart attack	NG	PD
			People with long-term conditions feeling independent and in control of their condition	CC	MiW
			A three month maximum wait for revascularisation	NG	PD

Directorate	ED lead	PCT Top 6 Priority	Description of Objective / Initiative	Mngmt lead	Ops lead
Public Health	IC	Cancer	Breast cancer screening for women aged 53 to 70 years	SB	KJ
		HCAI	All elective admissions screened for MRSA from 2008/09;	SB	BD
			All emergency admissions screened for MRSA as soon as possible in next three years	SB	BD
			C Diff reduction by 30% by 2011, SHA differential envelopes to deliver a 30% reduction nationally by 2011	SB	BD
			MRSA levels sustained, locally determined stretch targets taking us beyond the national target.	SB	BD
		Sexual Health	Chlamydia screening programme to be rolled out nationally (Year 1 (08/09) data to be used for prevalence indicator)	VE	SF
			Guaranteed access to a genito urinary clinic within 48 hours of contacting a service	VE	SF
			Prevalence of chlamydia (Year 1 will use existing AHC screening measure to set baseline)	VE	SF
			100% of people with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy	SB	KJ
			All Age All Cause Mortality Rate per 100,000	JF	JF
			All-age all cause mortality rate (target disaggregated to focus on narrowing the gap between most deprived 10% and the Leeds average)	JF	JF
			Children and young people's participation in high-quality PE and sport (NI 57)	DB	JB
			Healthy life expectancy at age 65	JF	JF
			Proportion of children who complete immunisation by recommended ages	SB	BB
			Reduce <75 Cancer Mortality Rate (20% by 2010)	JF	JF
			Reduce <75 CVD Mortality Rate (40% by 2010) (NI 121 Mortality rate from circularly diseases at ages under 75)	JF	LJ
			Reduction in gap between best and worst SOAs (CVD Mortality)	LJ	LJ
			Robust and up-to-date emergency planning	SB	BA
			Smoking prevalence (Quit Rates as presently reported)	HT	KH
			Stopping smoking - disaggregated to narrow the gap between 10% most deprived SOAs and rest of Leeds	HT	KH
			Tackling fuel poverty – People receiving income based benefits living in homes with a low energy efficiency rating (NI 187)	DB	DA
			COPD Prevalence	JF	HT
			Vascular risk	LJ	LJ

Directorate	ED lead	PCT Top 6 Priority	Description of Objective / Initiative	Mngmt lead	Ops lead
Strategic Development	**JC**	**Sexual Health**	**Teenage pregnancy rates per 1000 females aged 15-17 (NI 112 Under 18 conception rate)**	**SS**	**MF**
		Urgent Care	**Delayed transfers of care per 100,000 population**	**CC**	**MiW**
			Delayed transfers of care to be maintained at a minimum level	**CC**	**MiW**
			Number of drug users recorded as being in effective treatment (NI 40)	CC	TA
			Number of drug users successfully completing treatment	CC	TA
			% of women who have seen a midwife, or an appropriate healthcare professional, for health and social care assessment of needs and risk by 12 weeks of pregnancy	SS	MF
			Adults and Older people receiving direct payments and/or individual budgets per 100,000 population	CC	MiW
			All patients who need them to have access to crisis services, with delivery of 100,000 new crisis resolution home treatment episodes each year	CC	TA
			Breastfeeding continuation (prevalence 6-8 weeks)	SS	MF
			Carers receiving a 'carer's break' or a specific carers' service	CC	MiW
			Childhood obesity rate among primary school age	SS	MF
			Reduction in suicide and Undetermined injury mortality rate (20% by 2010) (Indicator to be used is AHC CPA 7 day follow up)	CC	TA
			Deliver 7,500 new cases (nationally) of psychosis served by early intervention teams per year;	CC	TA
			Effectiveness of CAMHS. % of PCTs providing a comprehensive service. (NI 51, Indicator under development; existing AHC Access to CAMHS indicator to be used as proxy for yr 1)	SS	MF
			Emotional and behavioural health of children in care (NI 58)	SS	MF
			Environment for a thriving third sector (NI 7)		LCC
			Number of vulnerable and socially excluded with mental health problems helped into settled into employment	CC	TA
			People supported to live independently	CC	MiW
			Percentage of vulnerable people achieving independent living (NI 141)	CC	LCC
			Rate of hospital admissions per 100,000 for alcohol related harm	CC	TA
			Stability of placements of looked after children: length of placement (NI 63)	SS	MF
			The extent to which older people receive the support they need to live independently at home (NI 139)	CC	MiW
			Timeliness of social care assessment (all adults) (NI 112)	CC	LCC
			Timeliness of social care packages following assessment (all adults) (NI 133)	CC	LCC

Directorate	ED lead	PCT Top 6 Priority	Description of Objective / Initiative	Mngmt lead	Ops lead	Code
Information	LT	18 weeks	18 week supporting indicator: Activity for 15 key diagnostic tests	AC		VSA05:10
			18 week supporting indicator: All first OP attendances (consultant led) - G&A	AC		VSA05:4
			18 week supporting indicator: First OP attendances following GP referral - G&A	AC		VSA05:3
			18 week supporting indicator: GP referrals for outpatient - G&A	AC		VSA05:1
			18 week supporting indicator: Non elective G&A FFCEs (excluding well babies)	AC		VSA05:9
			18 week supporting indicator: Other referrals for outpatient -G&A	AC		VSA05:2
			18 week supporting indicator: Planned elective daycase FFCEs	AC		VSA05:6
			18 week supporting indicator: Total elective G&A admitted FFCEs	AC		VSA05:7
			18 week supporting indicator: Total elective G&A daycase FFCEs	AC		VSA05:5
			18 week supporting indicator: Total planned G&A admitted FFCEs	AC		VSA05:8
			Choose & Book rates	RG		Local

Directorate	ED lead	PCT Top 6 Priority	Description of Objective / Initiative	Mngmt lead	Ops lead	Code
Workforce & Corporate	JGM		Compliance with Core Healthcare Commission standards	JL		AHC
			NHS Survey: Staff Satisfaction	JW		VSB17
			Patient and user reported measure of respect and dignity in their treatment	JW		VSC32 & AHC
			Percentage of people who believe people from different backgrounds get on well together in their area (NI 1)	JW		LAA
			Percentage of people who feel they can influence decisions in their locality (NI 4)	JW		LAA
			Self reported experience of patients/users/public	JW		VSB15 & AHC

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Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 22 July 2008

Subject: Scrutiny Inquiry: GP led Health Centres (Polyclinics) – draft terms of reference

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

1.0 Introduction

1.1 At its meeting on 17 July 2008, the Board agreed to undertake a scrutiny inquiry to consider the proposals for and implications of developing GP led Health Centres (Polyclinics) in Leeds. In this regard, draft terms of reference are attached at Appendix 1 for the Board's consideration.

1.2 A copy of the proposed terms of reference is attached for consideration by the Scrutiny Board.

2.0 Views of the Director and Executive Member

2.1 The Scrutiny Board Procedure Rules Guidance Notes require that, before embarking on an inquiry, the Board seeks and considers the views of the relevant Director and Executive Member. These views will need to be taken into account in finalising the terms of reference.

2.2 Initial views of the Director of Adult Social Services and Leeds Primary Care Trust (PCT) have been sought and are reflected in the attached draft terms of reference. The views of the Executive Board Member with portfolio responsibility for Adult Health and Social Care have been sought and will be reported to the meeting.

3.0 Recommendations

3.1 The Board is requested to agree:

3.1.1 The terms of reference for this inquiry, incorporating any amendments identified at the meeting.

3.1.2 The method for undertaking this inquiry, including the membership of any appointed Working Group.

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APPENDIX 1

SCRUTINY BOARD (HEALTH)

INQUIRY INTO GP-LED HEALTH CENTRES/POLYCLINICS

TERMS OF REFERENCE

1.0 Introduction

1.1 At its meeting on 17th June 2008, the Health Scrutiny Board resolved to undertake an Inquiry into proposals for a new polyclinic, or GP-led health centre, in Leeds. This was in response to a high level of media coverage and public interest in the issue.

1.2 The proposal stems from the interim report of the 'NHS Next Stage Review', currently being carried out by Lord Darzi. Lord Darzi was appointed as a Parliamentary Under-Secretary at the Department of Health in June 2007, and instructed to carry out a review of the NHS and advise on how the challenges of the next decade will be addressed. The interim report, published in October 2007, highlighted a number of concerns including

- Continuing and widening Health Inequalities
- Poor provision of GP surgeries in some areas
- Poor access to GP services among some sections of the community

1.3 In order to address these concerns, each PCT has been instructed to create a new GP-led health centre. It is proposed that these centres will have longer opening hours than traditional GP practices (8am – 8pm, 7 days a week) and will offer 'walk-in' services to enable patients who are not registered, to see a doctor. The centres could potentially be much larger than traditional GP practices (catering for up to 50,000 patients), with the possibility of other healthcare services being located within the same building.

1.4 In Leeds, the new health centre will cater for around 1000 patients (by the end of the first year) and is expected to be located in Burmantofts. A contract is expected to be awarded by December 2008, with the centre opening in January 2009.

1.5 Nationally, these proposals have been met with a negative response from some quarters, including some GPs, who feel that traditional practices will lose patients and funding as a result, and that the quality of care offered in a 'polyclinic' will not match that delivered by a smaller GP surgery.

2.0 Scope of the inquiry

2.1 The purpose of the Inquiry is to make an assessment of and, where appropriate, make recommendations on the following areas:

- The likely impact of Lord Darzi's interim report (NHS Next Stage Review) on healthcare in Leeds in the short, medium and longer term
- The impact which the proposed GP-led health centre will have on healthcare provision and Council Services (particularly Adult Social Care and Children's Services) in Leeds
- How the PCT can best manage the establishment of the new health centre in order to maximise the benefits for the population of Leeds and minimise any negative impact
- How the Council ought to approach the issue, and its overall role in managing public expectation

3.0 Comments of the relevant Director and Executive Member

3.1 In line with Scrutiny Board Procedure Rule 12.4 the views of the relevant Director and Executive Member have been sought and have been incorporated where appropriate into these Terms of Reference. Full details are available on request from the Scrutiny Support Unit.

4.0 Structure of the Inquiry

4.1 It is proposed that a range of approaches to evidence gathering are used in this Inquiry, including one or more of the following:

- A working group of the Scrutiny Board to consider some evidence and question key witnesses
- Full meetings of the Scrutiny board to consider some evidence and question key witnesses
- Discussion with key stakeholders
- Visits to selected establishments, as appropriate, to engage with service users and staff (for example, existing GP practices and health centres)

4.2 The Inquiry will conclude with the publication of a report, or statement, and recommendations by the Scrutiny Board that will be submitted to the appropriate forum.

5.0 Timetable for the inquiry

5.1 It is initially planned that the Inquiry will take place over three sessions with a view to issuing a final report or statement in October 2008.

5.2 The length of the Inquiry is subject to change.

6.0 Submission of evidence

6.1 The following formal evidence gathering sessions are scheduled:

6.2 **Site visits – dates to be confirmed**

6.3 **Session one – (date to be confirmed)**

The purpose of this session is to consider background information on the reasons why GP-led health centres are being introduced, including:

- The interim report of the 'NHS Next Stage Review'
- The response of the BMA and the King's Fund to the proposals, nationally

Towards the end of the session, consideration will be given to any further and/or specific information required as part of the inquiry.

6.2 **Session two - (date to be confirmed)**

The second session of the inquiry will focus on how the proposals will affect Leeds. Members will consider:

- Existing Primary Care arrangements in the city, including any gaps in provision
- The detailed proposals for the GP-led health centre, including the process by which the site and services were selected, the ways in which consultation was carried out, and the results/outcome of any consultation undertaken
- The effects which the new health centre may have on existing services in the city, including Council services
- GP-led health centres in Leeds in the longer term

Towards the end of the session, consideration will be given to any further and/or specific information required as part of the inquiry.

6.3 **Session three - (date to be confirmed)**

Subject to any additional information being identified, consideration will be given to the content and recommendations of a draft final report or statement.

7.0 Witnesses

7.1 The following witnesses have been identified as possible contributors to the Inquiry:

- Leeds PCT
- Leeds Teaching Hospitals Trust

- Leeds Partnerships Foundation Trust
- Leeds Local Medical Committee
- Leeds LINks (preparatory group)
- Local ward members
- Director of Adult Social Services
- Director of Children's Services

8.0 Post inquiry report monitoring arrangements

8.1 Following the completion of the Scrutiny inquiry and the publication of the final inquiry report and recommendations, the implementation of the agreed recommendations will be monitored. The Scrutiny Board will determine those arrangements at the end of the Inquiry.

8.2 The final inquiry report will include information on the detailed arrangements for how the implementation of recommendations will be monitored.

9.0 Measures of success

9.1 It is important to consider how the Scrutiny Board will deem if their inquiry has been successful in making a difference to local people. Some measures of success may be obvious at the initial stages of an inquiry and can be included in these terms of reference. Other measures of success may become apparent as the inquiry progresses and discussions take place.

9.2 The Board will look to publish practical recommendations.

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 22 July 2008

Subject: Scrutiny Inquiry: Teenage Pregnancy – draft terms of reference

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

1.0 Introduction

1.1 Attached at Appendix 1 is a statement on Teenage Pregnancy, produced by the former Scrutiny Board (Health and Adult Social Care) during 2007/08. As recommended by the previous Board, at its meeting on 17 July 2008, the Scrutiny Board (Health) agreed to undertake a more detailed inquiry into Teenage Pregnancy.

1.2 A copy of the proposed terms of reference is attached for the Board's consideration.

2.0 Views of the Director and Executive Member

2.1 The Scrutiny Board Procedure Rules Guidance Notes require that, before embarking on an inquiry, the Board seeks and considers the views of the relevant Director and Executive Member. These views will need to be taken into account in finalising the terms of reference.

2.2 Views of the Director of Children's Services, the Chief Executive of Education Leeds and the Director of Adult Social Services and Leeds Primary Care Trust (PCT), along with the Executive Board Members with portfolio responsibilities for Children's Services and Learning, respectively, have been sought and will be reported to the meeting.

3.0 Recommendations

3.1 The Board is requested to agree:

3.1.1 The terms of reference for this inquiry, incorporating any amendments identified at the meeting.

3.1.2 The method for undertaking this inquiry, including the membership of any appointed Working Group.

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Leeds CITY COUNCIL

Statement of

Scrutiny Board (Health and Adult Social Care)

Teenage Pregnancy Working Group

Introduction

1. In accordance with its remit to consider health issues relating to children and young people, Scrutiny Board (Health and Adult Social Care) monitors annual performance management information relating to the number of conceptions to females aged 15-17 in Leeds.

2. At our Board meeting in June 2007, we were concerned to note that performance in Leeds had declined in 2006/7. The government target for Leeds is a 55% reduction in the conception rate by 2010 compared with the baseline year of 1998. In 2005/6 there was a 7.9% reduction but this had moved further away from the target during 2006/7 to 2.9%.

3. At its meeting on 8th November 2007, Scrutiny Board (Children's Services) received a report from the Director of Children's Services informing members that conception rates amongst 15-17 year olds in Leeds since 2003 showed an upward trend. Scrutiny Board (Children's Services) suggested that our Board might wish to carry out some scrutiny on this issue. The Executive Member for Children's Services suggested that we might like young people to join us for any scrutiny activity. We agreed to both suggestions.

4. Since then, the Audit Commission has identified lowering the rates of Teenage Pregnancy as an area for continued work in its Comprehensive Performance Assessment of the Council.

5. We acknowledge that teenage pregnancy is a complex and cross cutting issue. We also understand that births in the UK have increased generally since 2001[1]. We felt that a working group 'scoping' exercise might be the best method to ascertain whether a full inquiry might be necessary and, if so, to determine which areas to focus on.

6. In addition, the Board learned that the Department of Health's Teenage Pregnancy National Support Team (TPNST) had been working in Leeds to prepare a report, and we were keen to see their findings and recommendations before commencing any detailed scrutiny involvement.

7. We therefore decided to hold a one-off task and finish working group meeting to consider Teenage Pregnancy before the

[1] Components of population change UK. Office of National Statistics.

Introduction

end of this municipal year, to gain an overview of the issues.

8. The Working Group comprised:-

From Scrutiny Board (Health and Adult Social Care):-
Cllr J Chapman (Chair)
Cllr J Dowson
Cllr P Ewens
Cllr G Kirkland
Cllr L Russell
Laurence Wood
Sally Morgan
Somoud Saqfelhait
From Scrutiny Board (Children's Services):-
Cllr B Lancaster
Lead Member for Children's Services:-
Cllr S Bentley

Attending the Working Group as witnesses were:-

Attending from YSHAG:-
Danny Lipzith
Matthew Jackson
Eleni Athinodorou, YSHAG
Danny Bradshaw, YSHAG

Kiera Swift, Teenage Pregnancy Co-ordinator, Teenage Pregnancy and Parenthood Partnership
Sarah Sinclair, Director of Commissioning & Planning, Children's & Maternity Services, Leeds PCT
Jo Holmes, Senior Sexual Health Worker, Leeds Youth Services
Jenny Midwinter, Teenage Pregnancy Co-ordinator, Education Leeds
Natalie Walker, Teenage Pregnancy Midwife.

9. The Working Group meeting took place on 19th February to consider
   - The facts and figures around teenage pregnancy in Leeds
   - Findings from the recent report produced by the TPNST
   - What is being done to reduce teenage conceptions
   - What options are open to young women to complete their studies or access training after childbirth
   - Whether the Board might make recommendations to assist the work around reducing teenage pregnancies in Leeds
   - Whether any further scrutiny should be undertaken in the next municipal year in the form of a full inquiry.

Comments and Recommendation

Leeds CITY COUNCIL

Facts and Figures

1. The figures supplied to us related to 15-17 year old girls in Leeds and was shown at Ward level from 1998-2004. The data included terminations, live births and stillbirths, but not miscarriages.

2. The TPNST report sets out the scale of the challenge in Leeds. In 2005, Leeds had an under 18 conception rate of 49 per 1000 females aged 15-17. This was 19% higher than the England average of 41.1 per 1000. Between 1998 and 2005, Leeds' under-18 conception rate has remained relatively static, with an overall reduction of just 2.9% compared to an overall decline of 10.2% for Yorkshire and the Humber and an 11% reduction for England. The Government-set target is for a 55% reduction in Leeds by 2010. The Ward rates are very strongly linked to deprivation. A third of Wards in Leeds are 'hotspots', with rates among the highest 20% in England.

3. At the Working Group meeting, we expressed concern that the data we had been given was so old (2002/2004) that it didn't even correspond to the current council Wards, but to the Ward Boundaries existing at the time of the 2001 census. Kiera Swift, Teenage Pregnancy Co-ordinator, Teenage Pregnancy and Parenthood Partnership explained, however, that data for Leeds comes from the National Office of Statistics and takes a long time to turn around because girls who live in Leeds but have given birth outside Leeds have to be tracked and added to the Leeds figures. The data up to 2006 was due to be available later in February 2008 and we have asked for that data to be supplied to the Board as soon as possible.

4. Sarah Sinclair, Director of Commissioning & Planning, Children's & Maternity Services, Leeds PCT and Kiera Swift said the Teenage Pregnancy and Parenthood Partnership acknowledged the need for more robust, up to date data for Leeds. It might be possible to collect data locally which would provide a good indication, although this wouldn't include private terminations or girls giving birth or accessing terminations outside Leeds. However, there would always be a problem providing data for very small areas, since girls might be easily identifiable if an area had only one or two conceptions.

5. We heard that there was data which showed that a higher proportion of teenage pregnancies ended in

termination in the more affluent or 'higher aspiration' areas of Leeds than the deprived areas. Anecdotal evidence supported a theory that, for some girls who did not have a career path to aspire to, becoming a mother was a way of 'proving' adulthood.

6. We asked about the figures for teenage pregnancies under 15 and were reassured that this figure was quite low in Leeds, lower than the national average. However, we heard that numbers were on the increase and we hope this will be addressed before numbers rise further.

Findings from the Teenage Pregnancy National Support Team's Report

7. The TPNST supplied us with a copy of their recent report, which found that
    - there is good support for teenage parents in Leeds, with specialist, dedicated staff
    - the large number of schools presents a particular challenge in terms of co-ordination of delivery of Sex and Relationships Education (SRE) in schools
    - there is an urgent need to improve access to sexual health services for young people. Services need to be delivered in a range of settings, too
    - there is a need to review the Teenage Pregnancy Co-ordinator post to ensure it is placed at a sufficiently senior and strategic level to engage the commitment of senior colleagues and partners and integrate teenage pregnancy into the wider agenda.

8. The TPNST welcomed scrutiny of Teenage Pregnancy in Leeds, suggesting that it be owned by Scrutiny Board (Children's Services) and the recommendations jointly owned by the Boards with responsibility for Health and Children's Services. In practice at Leeds City Council, however, cross cutting issues such as Teenage Pregnancy would be scrutinised by a Scrutiny Commission in line with the scrutiny procedure rules.

Reducing Teenage Conceptions

9. The two areas we focussed on during our Working Group meeting were SRE in schools and provision of advice about, and access to, contraception. However, we do recognise that not all teenage pregnancies are unplanned or unwanted - and

that schools should not be solely responsible for educating young people about sex and relationships. Responsibility for this rests with parents, too.

10. The young people on the Working Group put forward anecdotal evidence to support the theory that where a school has good SRE, this results in a low teenage pregnancy rate and where SRE is poor, there are more teenage pregnancies.

11. Links with the group of young people Not in Education, Employment or Training (NEET) were discussed. Kiera confirmed that teenage parents are over-represented in the NEET group. There are other groups with a high rate of teenage pregnancy, too. Looked-after children are more likely to become teenage parents and there is evidence that children of teenage parents are more likely to become teenage parents themselves.

Options open to young women to complete their studies or training after childbirth

12. The TPNST report found the support available in Leeds to help young women complete education and training after childbirth was particularly strong.

13. The witnesses attending our meeting agreed that there is a focus in Leeds around services for teenage parents. There is a support worker exclusively working with teenage fathers, for example, believed to be the only post in the country dedicated to this task full time. We are encouraged to hear that this is the case and that, in many cases, girls' achievement in school actually improves after giving birth, but we feel that attention should now be given to preventing teenage conceptions in Leeds.

Participants 'wish lists' and further scrutiny of Teenage Pregnancy

14. We asked our witnesses what, in an ideal world, they would like to see happen to help reduce teenage pregnancies. The list appears in full at Appendix 1.

15. It is clear to us that a full scrutiny inquiry into reducing teenage conception in Leeds would be useful. The Leeds Teenage Pregnancy Strategy, currently under review, would be a key document for scrutiny, and an examination of whether the staffing and resources are adequate would be important, too. Both are things we have been unable to look at in-depth

Comments and Recommendation

Leeds CITY COUNCIL

during this brief scoping exercise.

16. Since Leeds already provides good services for young women who are pregnant or have given birth, we feel that these issues should be left out of the inquiry, which should focus on prevention.

17. We have agreed upon four recommendations as a result of our Working Group scoping exercise. These are set out below.

Recommendations

1. **That further scrutiny, in the form of a full inquiry, be carried out into reducing teenage conceptions during the municipal year 2008/9**

2. **That, because this is a cross-cutting issue, Overview and Scrutiny Committee be asked to consider setting up a Commission to carry out this piece of work with membership drawn from the Boards with responsibility for Health and for Children's Services**

Recommendations (cont'd)

3. **That the young people from the Young Sexual Health Action Group (YSHAG) who attended the meeting on 19th February, be invited to take part in any further scrutiny as co-opted members**

4. **That the terms of reference for any inquiry include scrutiny of**

   a) **an investigation of the links between teenage pregnancy and low aspiration**
   b) **consistency of SRE education for both males and females in primary and secondary schools**
   c) **the availability of access to family planning for young males and females in the city, outside standard school/working days**
   d) **the rise in conception rates in under 15s**

Overall

- Someone to keep up the interest and pressure with all partners on progress
- Focused energy to hold people to account to make changes and keep monitoring
- Keep teenage fathers on the agenda
- Don't wait for young people to become parents before focusing services on them

SRE

- SRE champion for the city and strong leadership for SRE
- Consistent SRE in schools, non mainstream educational settings and non school settings, we would have to create the demand in schools and have toolkits, schemes of work, models of good practice and good support
- Educating earlier, in primary school
- Put SRE on the agenda for a full days training
- Schools should have good SRE to become a 'healthy school'

Health services

- CASH services accessible by young people, especially at times that are appropriate, early evenings and weekends and are young people friendly
- If we can't have more CASH services then for the existing services to be widely advertised and known by young people and adults, linking with extended services and community settings
- Specialist midwifery service for 16 - 19 years
- Extend the Healthy Young People Service, currently in a few schools, in more schools and other settings

Raising Aspirations

- Work with schools at primary and secondary level to raise the aspirations especially of those young people who are disengaging or at risk of disengaging
- Look at other avenues of achievement rather than *A-C GCSEs

Working with parents and carers

- Work with parents to increase their confidence and skills to talk to their children

Targeted work

- Target work with the more vulnerable/at risk young people - looked after children, care leavers, underachievers at schools, young offenders, those disengaged or at risk of disengaging, young people from the wards with high levels of teenage pregnancy

Peer education

- Extend the peer education work especially in the areas most at risk

Workforce development and training

- Extend training to cover all professionals who work with young people especially those who support young people in different settings
- Training for professionals to work with parents

Youth service

- A specialist health youth service, well trained and resourced

APPENDIX 2

SCRUTINY BOARD (HEALTH)

INQUIRY INTO REDUCING TEENAGE CONCEPTIONS IN LEEDS

TERMS OF REFERENCE

1.0 Introduction

1.1 In April 2008, the Health and Adult Social Care Scrutiny Board (as it was then known), published a statement on Teenage Pregnancy. This was the product of a one-off 'task and finish' working group which had been established to consider the issue.

1.2 The working group was established following the publication of performance data during 2007 which showed that Leeds was repeatedly failing to make progress in reaching government targets on reducing teenage conception. The issue was also identified by the Audit Commission as part of their Comprehensive Performance Assessment of the Council.

1.3 The working group considered the following areas:

- The facts and figures around teenage pregnancy in Leeds
- The findings from a recent report on the situation in Leeds produced by the Teenage Pregnancy National Support Team (TPNST)
- The action being taken to reduce teenage conceptions in the city
- The options open to young women to complete their studies or access training after childbirth
- Whether the Board might make recommendations to assist the work around reducing teenage pregnancies in Leeds
- Whether any further scrutiny should be undertaken in the next municipal year in the form of a full inquiry.

1.4 The statement produced by the group concluded that, while there were excellent services in Leeds to support teenage parents, there was still much work to be done around reducing teenage conceptions.

1.5 The main recommendation of the working group was that a further inquiry be carried out during the coming municipal year, into the issue of reducing teenage conceptions. The working group also recommended that the inquiry involve members of both the Children's Services and Health Scrutiny Boards, and that young people be co-opted as members for the inquiry, as they had made a very valuable contribution to the working group.

2.0 Scope of the inquiry

2.1 The Teenage Pregnancy working group recommended that the terms of reference for any future inquiry include the following:

- an investigation of the links between teenage pregnancy and low aspiration
- consistency of Sex and Relationship Education (SRE) for both males and females in primary and secondary schools
- the availability of access to family planning for young males and females in the city, outside standard school/working days
- the rise in conception rates in under 15s

2.2 It is planned that young people from the Youth Sexual Health Action Group (YSHAG) will be involved in the inquiry, either as coopted members, or as witnesses.

3.0 Comments of the relevant Director and Executive Member

3.1 In line with Scrutiny Board Procedure Rule 12.4 the views of the relevant Directors and Executive Members have been sought and have been incorporated where appropriate into these Terms of Reference. Full details are available on request from the Scrutiny Support Unit.

4.0 Structure of the Inquiry

4.1 It is proposed that a range of approaches to evidence gathering are used in this Inquiry, including the one or more of the following:

- A working group of the Scrutiny Board to consider some evidence and question key witnesses
- Full meetings of the Scrutiny Board to consider some evidence and question key witnesses
- Discussion with key stakeholders
- Visits to selected establishments, as appropriate, to engage with service users and staff
- Visits to other authority areas and/or areas of best practice, as appropriate

4.2 The Inquiry will conclude with the publication of a report, or statement, and recommendations by the Scrutiny Board that will be submitted to the appropriate forum.

5.0 Timetable for the inquiry

5.1 It is initially planned that the Inquiry will take place over three sessions with a view to issuing a final report or statement during the 2008/09 municipal year.

5.2 The length of the Inquiry is subject to change.

6.0 Submission of evidence

6.1 The following formal evidence gathering sessions are scheduled:

6.2 **Site visits – dates to be confirmed**

6.3 **Session one – (date to be confirmed)**

The purpose of this session will be to consider background information on Teenage Conceptions in Leeds, in particular:

- The final report of the Teenage Pregnancy National Support Team on the situation in Leeds
- The most recent statistical information
- SRE policy in Leeds
- The availability of family planning for young people

Towards the end of the session, consideration will be given to any further and/or specific information required as part of the inquiry.

6.2 **Session two - (date to be confirmed)**

During the second session of the inquiry the board will look at the wider situation and examples of best practice from other authorities. In particular the board will consider:

- The evidence for a link between low aspiration and teenage pregnancy
- The prevalence of teenage pregnancy amongst certain social groups – for example, Looked After Children
- Possible methods for reducing the number of teenage conceptions

Towards the end of the session, consideration will be given to any further and/or specific information required as part of the inquiry.

6.3 **Session three - (date to be confirmed)**

Subject to any additional information being identified, consideration will be given to the content and recommendations of a draft final report or statement.

7.0 Witnesses

7.1 The following witnesses have been identified as possible contributors to the Inquiry:

- Leeds PCT
- Director of Children's Services
- Members of YSHAG
- Leeds Youth Service
- Education Leeds
- Leeds Teenage Pregnancy and Parenthood Partnership
- Representative from the Teenage Pregnancy National Support Team
- Representatives from other authority areas

8.0 Post inquiry report monitoring arrangements

8.1 Following the completion of the Scrutiny inquiry and the publication of the final inquiry report and recommendations, the implementation of the agreed recommendations will be monitored. The Scrutiny Board will determine those arrangements at the end of the Inquiry.

8.2 The final inquiry report will include information on the detailed arrangements for how the implementation of recommendations will be monitored.

9.0 Measures of success

9.1 It is important to consider how the Scrutiny Board will deem if their inquiry has been successful in making a difference to local people. Some measures of success may be obvious at the initial stages of an inquiry and can be included in these terms of reference. Other measures of success may become apparent as the inquiry progresses and discussions take place.

9.2 The Board will look to publish practical recommendations.

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 22 July 2008

Subject: Scrutiny Board (Health) – Work Programme and Draft Terms of Reference

Electoral Wards Affected:	**Specific Implications For:**
	Equality and Diversity ☐
	Community Cohesion ☐
	Narrowing the Gap ☐

1.0 INTRODUCTION

1.1 At its meeting in June 2008, the Board identified a number of issues for its work programme and requested these to be formally presented at a future meeting. As such, the Board's draft work programme is attached as Appendix 1.

1.2 During the previous municipal year (2007/08), the former Scrutiny Board (Health and Adult Social Care) undertook a scrutiny inquiry that considered 'The Localisation of Health and Social Care Services'.

1.3 The Board's final report is attached at Appendix 2 and includes a series of recommendations. Many of these recommendations are cross-cutting, aimed at both health service and social care providers, and as such require a joint/ composite response. Given the context of the inquiry and subsequent recommendations, it would perhaps be inappropriate and somewhat artificial to split the recommendations to report to the newly formed Scrutiny Boards for 'Health' and 'Adult Social Care' respectively.

1.4 As the legislative powers for NHS Scrutiny rest with the Scrutiny Board (Health), it is proposed to incorporate tracking of all the recommendations of the attached report into the Board's work programme, commencing with the initial response in September 2008.

1.5 Notwithstanding the proposal set out in paragraph 1.4, it may be appropriate for any specific Adult Social Care issues that may arise as a result of this monitoring process, to be referred to the Scrutiny Board (Adult Social Care) for specific action/ consideration.

2.0 HEALTH PROPOSALS WORKING GROUP

2.1 At its meeting in June 2008, the Board also agreed to establish a Health Proposals Working Group. Draft terms of reference are presented at Appendix 3. In line with Scrutiny Board Procedure Rules comments on the terms of reference have been sought from the relevant officers and the responsible Executive Board Member. These will be available at the Board meeting.

3.0 RECOMMENDATIONS

3.1 Members are asked to;

(i) Consider the draft work programme attached at Appendix 1
(ii) Note the 'Localisation of Health and Social Care Services' scrutiny inquiry report and agree the proposed approach for monitoring implementation of the recommendations.
(iii) Amend and/or agree the draft terms of reference for the 'Health Proposals Working Group'.
(iv) Amend and/ or agree the Board's work programme.

APPENDIX 1

Scrutiny Board (Health)
Work Programme 2008/09

Item	Description	Notes	Type of item
Meeting date – 22 July 2008			
Review of National Blood Service Strategy	To consider the proposed changes arising from the National Blood Strategy and the implications of healthcare provision in Leeds.	Representatives from the following organisations to attend: ➢ NHS Blood and Transport ➢ AMICAS ➢ Leeds PCT	Inquiry
Children's Hospital Services and Clinical Services Reconfiguration: engagement process and clinical models	To consider an update on the engagement process and clinical models.	Considered by the former Health Proposals Working Group in March 2008.	B
Scrutiny Inquiry into GP led Health Centres (Polyclinics): Draft Terms of Reference	To consider draft terms of reference for the proposed scrutiny inquiry	Need to consider inquiry approach	RP/DP
Scrutiny Inquiry into Teenage Pregnancy: Draft Terms of Reference	To consider draft terms of reference for the proposed scrutiny inquiry	Need to consider inquiry approach	RP

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

APPENDIX 1

Scrutiny Board (Health)
Work Programme 2008/09

Item	Description	Notes	Type of item
Performance Report	To consider the latest performance report considered by the Primary Care Trust Board alongside the outcome of that consideration.	Performance Report presented to the Primary Care Trust Board on 17 July 2008.	PM
Meeting date – 16 September 2008			
Renal Services	To consider the current position regarding transportation of renal patients, in light of the issues highlighted by the previous Board.	Submissions from: ➢ Leeds Teaching Hospital NHS Trust ➢ Leeds PCT ➢ Yorkshire Ambulance Service ➢ Leeds Kidney Patients Association	Inquiry
Wharfedale Hospital – Strategy Report	To consider the long-term strategy for Wharfedale Hospital.	Report from Leeds Teaching Hospital NHS Trust. Consider in the context of the overall 'peripheral hospitals' strategy	B/ MSR
Update on Leeds Local Involvement Network (LINk)	To provide the Board with an update and consider the Board's relationship with the host organisation.	May need some input from Legal regarding relationship issues. Possible input from Tim Gilling – Centre for Public Scrutiny Likely to be reported to the Adult Social Care Scrutiny Board.	B

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

APPENDIX 1

Scrutiny Board (Health)
Work Programme 2008/09

Item	Description	Notes	Type of item
The Localisation of Health and Social Care Services – response to recommendations	To consider a composite response against report and each of the recommendations		MSR
Meeting date – 21 October 2008			
Performance Report	To consider the latest performance report considered by the Primary Care Trust Board alongside the outcome of that consideration.	Performance Report presented to the Primary Care Trust Board on 18 September 2008.	PM
Performance Management	Quarter 1 information for 2007/08 (April - June)	All Scrutiny Boards receive performance information on a quarterly basis	PM
Joint Strategic Needs Assessment (JSNA) - update	To consider an update in the development of a joint assessment that identifies the future needs of the populous of Leeds and any identified service changes/ reconfigurations	Also likely to be reported to the Adult Social Care Scrutiny Board. Need to consider the timing, potential role and activity of the Board and that of the Health Scrutiny Board.	B
Meeting date – 18 November 2008			

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

APPENDIX 1

Scrutiny Board (Health)
Work Programme 2008/09

Item	Description	Notes	Type of item
Children's Hospital Services and Clinical Services Reconfiguration: full business case	To consider an update on the full business case for the proposed service reconfiguration.		
Meeting date – 12 December 2008			
Performance Report	To consider the latest performance report considered by the Primary Care Trust Board alongside the outcome of that consideration.	Performance Report presented to the Primary Care Trust Board on 20 November 2008.	PM
Performance Management	Quarter 2 information for 2008/09 (July-Sept)	All Scrutiny Boards receive performance information on a quarterly basis	PM
Recommendation Tracking	This item track progress with previous Scrutiny recommendations on a quarterly basis	Unlikely to feature on the agenda given the nature of the Board's work to date.	MSR
Meeting date – 20 January 2009			

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

APPENDIX 1

Scrutiny Board (Health)
Work Programme 2008/09

Item	Description	Notes	Type of item
Meeting date – 17 February 2009			
Performance Report	To consider the latest performance report considered by the Primary Care Trust Board alongside the outcome of that consideration.	Performance Report presented to the Primary Care Trust Board (to be confirmed).	PM
Recommendation Tracking	This item track progress with previous Scrutiny recommendations on a quarterly basis		MSR
Meeting date – 24 March 2009			

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

APPENDIX 1

Scrutiny Board (Health)
Work Programme 2008/09

Item	Description	Notes	Type of item
Annual Health Check	To receive and consider the local NHS Trusts self assessment against the 24 "core standards" set by Government under the domains: • Safety; • Clinical and Cost Effectiveness; • Governance; • Patient Focus; • Accessible and Responsive Care; • Care Environment and Amenities; and, • Public Health	Precise timing to be confirmed	PM
Meeting date – 28 April 2009			
Performance Report	To consider the latest performance report considered by the Primary Care Trust Board alongside the outcome of that consideration.	Performance Report presented to the Primary Care Trust Board (to be confirmed).	PM
Performance Management	Quarter 3 information for 2008/09 (Oct-Dec)	All Scrutiny Boards receive performance information on a quarterly basis	PM

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

APPENDIX 1

Scrutiny Board (Health)
Work Programme 2008/09

Item	Description	Notes	Type of item
Annual Report	To agree the Board's contribution to the annual scrutiny report		

Working Groups			
Working group	**Membership**	**Progress update**	**Dates**
To be confirmed	*To be confirmed*	*N/A*	*To be confirmed*

Unscheduled / Potential Items		
Item	**Description**	**Notes**

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

APPENDIX 1

Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Mental Health Legislation	To consider the impact, implications and proposed response to legislative changes regarding: • The Mental Health Act • Mental Capacity	Lead Officer – Dennis Holmes. Need to consider format and timing of any report and implications on Leeds Partnership Foundation Trust (LPFT). Possibly seek a report to the Board from LPFT in November.
Continuing Care Implementation	To consider the local impact and future activity associated with implementing the national framework for continuing NHS care, further to the report presented to the Executive Board in October 2007.	Lead Officer – Dennis Holmes. Need to consider format and timing of any report, the potential role and activity of the Board and that of the Adult Social Care Scrutiny Board.
Leeds Teaching Hospitals NHS Trust – foundation status	To consider the process and implications of the Leeds Teaching Hospitals NHS Trust bid to achieve foundation hospital status.	

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
RP	Review of existing policy	SC	Statutory consultation
DP	Development of new policy	CI	Call in

The Localisation of Health and Social Care Services

Scrutiny Inquiry Report

Introduction and Scope

Introduction
We undertook this inquiry because we wanted to learn more about the impact on the people of Leeds of national reforms in how health and social care services are delivered (*Our Health, Our Care, Our Say*) and the local initiative to reform health and social care services in Leeds (Making Leeds Better).

The national and local reforms are both driving forward localisation of health and social care services, to provide people with care closer to home.

National reform: *Our Health, Our Care, Our Say*
In 2005, as part of the ten-year programme of reform which began with the NHS plan, in 2000, the Department of Health conducted a listening exercise, *Your Health, Your Care, Your Say*. Nearly 143,000 people contributed views of what they expect from their local social care and NHS services. People want their local services to:

- understand how they live and support them to lead healthier lives
- help them to live independently if they have ongoing health or social care needs
- be easy to get to and convenient to use
- be nearer to where they live, or easily available in the areas they work.

In January 2006, the Government published a White Paper *Our Health, Our Care, Our Say: A New Direction for Community Services*. The paper recognised how NHS and social care services work together. It identified how the delivery of those services could adapt to provide people with the health and social care services they need closer to their homes.

Local reform*:* Making Leeds Better
Making Leeds Better was launched in 2005, as the biggest health and social care reform programme in the country. The Making Leeds Better vision is for:-

> "A future where people who need health and social care get the best possible treatment and support in modern settings closer to their own homes. And when people do need hospital care it will be in up to date facilities fit for the 21st century."[1]

One of the aims of Making Leeds Better is to deliver health services locally; more care and treatment closer to home; modern facilities in the community and better and faster care out of hospital.

In June 2007, we discussed the increasing drive towards the localisation and personalisation of

[1] Sourced from the Making Leeds Better website www.makingleedsbetter.org.uk

Introduction and Scope

healthcare services in Leeds and the need to ensure that the use of local health care facilities is maximised in a way that best meets the needs of the local communities.

We agreed that, with the localisation of health and adult care services featuring as a high priority both nationally and locally, it would be timely to adopt this theme for our inquiry work for the year ahead.

We wanted to examine how decisions are reached about which method of service delivery is appropriate for a particular area of Leeds and how local people are able to contribute to the planning and decision-making process. We wanted to be sure that new local health centre facilities are being used as fully as possible. The terms of reference for this inquiry were drafted and subsequently agreed at the meeting in September 2007.

We set out to explore the localisation of health and social care services in Leeds, to see how the new direction for community services outlined in Our Health, Our Care, Our Say, is being followed in Leeds. We wanted to look, in particular, at some of the new modern facilities in the community which are key to the reforms in the White Paper and the delivery of Making Leeds Better.

During our Inquiry we carried out a number of site visits to locations where health and social care is delivered in a community setting. We also sought the views of some key stakeholders on the implications of localisation. These stakeholders included the Leeds Primary Care Trust, Leeds Teaching Hospitals NHS Trust, Adult Social Services, Leeds Voice and the staff planning, managing and delivering health and social care services at the sites we visited.

We would like to sincerely thank everyone for their commitment and contribution to our Inquiry.

Scope

The aim of this particular inquiry was to make an assessment of and, where appropriate, make recommendations on:

- The range of methods available for delivering health and social care services in Leeds, in particular, hospitals, Health Centres and GPs.
- How commissioners plan provision, how decisions are reached about where services should be located and the method of delivery.
- How commissioners involve local people in the planning and decision-making process

Conclusions and Recommendations

The principles behind the localisation of Health and Social Care Services

At the first session of our inquiry, we heard from local NHS Trusts and Adult Social Care about the factors driving the localisation of services they commission and provide.

The public want to have services delivered closer to home and expect a wider range of services locally in GP surgeries and health centres. This was borne out in the national consultation *Your Health, Your Care, Your Say.*

We heard from Leeds PCT that a recent poll of Leeds residents supported these findings, with over 70% of people saying they would like more services delivered in local settings rather than hospitals[2].

Technological advances in recent years mean that diagnosis, care and treatment has changed over time. It is now possible to safely treat some patients in their own homes, at their GP's surgery or in a mobile health unit or local health centre.

There are long term health conditions, such as diabetes and chronic obstructive pulmonary disease, which can now be managed at home or in primary care, rather than in hospital, because services have been commissioned and developed to support this change. Telemedicine, where medical information is transferred via telephone, the Internet or other networks for the purpose of consulting, can now support people to check their own health status at home. Patients are able to access a health professionals if they need to.

Sometimes particular communities have specific needs. Services might be targeted, for example, at the Super Output Areas (SOAs) with the worst health outcomes. SOAs are a new geography for the collection and publication of small area statistics, rather than wards. This is one of the ways in which health inequalities can be tackled.

Intermediate care teams, which are groups of health and social care professionals working together, can help avoid hospital admission in some cases. They can also support early discharge from hospital. Intermediate care beds, as we saw on our site visits to Middlecross and Richmond House, prevent hospital stays or provide rehabilitation after a stay in hospital, prior to returning home.

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[2] Joint briefing from Leeds Primary Care Trust, Leeds Teaching Hospitals NHS Trust (LTHT) and Leeds Partnership Foundation Trust on the localisation of Health Services supplied for the Scrutiny Board meeting in November 2007

Conclusions and Recommendations

National policy and directives, such as the Darzi review, which aims to support local change, extend patient choice and make care more personal, are factors influencing localisation.
Our local NHS trusts also cited the Leeds district partnerships as a factor influencing the location of health services because they work across all agencies to reflect what is wanted locally.

Area Committee Involvement
During this inquiry, we consulted with four of the ten area committees in Leeds to assess the extent of their involvement with the planning process for health services locally. We wanted to know whether they had been included in any consultation and engagement undertaken by any of the Trusts.

The Area Committees we spoke to (the Inner and Outer Committees in South and North West Leeds) reported that there was little or no dialogue with local health bodies. The Chair of Inner South Area Committee felt that there was no relationship with the PCT, although as a ward member she did receive occasional emails about changes of opening hours for local GP surgeries. Inner South Area Committee also reported that there was face-to face contact with their area PCT when there were five PCTs in Leeds but this has not happened since the restructure to one city-wide PCT for Leeds. We heard that there is an extensive network of local community groups in inner South Leeds, which the PCT could consult with directly. The Chair of Inner South reported that she personally attends the local community group meetings in the area and reported no health input there.

The Outer North West Committee reported receiving a progress report on Making Leeds Better in September 2006 but this was a standard progress report about the initiative. It was not a report presenting information particular to North West Leeds.

Councillors on the Inner and Outer North West Area Committees felt that it would be more useful to be kept informed about local developments in the NHS, such as the closure of a hospital ward and sale of NHS Trust land. These are both examples of actual events which Councillors were not informed about by the NHS and discovered from other sources.

In 2004, five district partnerships were set up to improve coordination and effectiveness of partnership work at the district/area level. Each of the five Leeds PCTs was represented on each relevant partnership. Since the five PCTs were restructured to form one Leeds PCT in October 2006, the Leeds PCT has been represented on each partnership.

The partnership structure was reviewed over 2007 with a view to ensuring the structures were still the most effective way of achieving improvements in the most deprived

areas. As a result of the review the partnerships were reduced from five District Partnerships to three area Officer Co-ordination Groups in April 2008. There are still ten Area Committees, one inner and one outer committee for each of the five 'wedges'; Leeds North East, North West, South, East and West.

The three Officer Co-ordination Groups, based on the same boundaries as the revised area management structure, will each include representation from the Leeds PCT and will support the delivery of the Area Committee Plans. We understand that there is scope to develop thematic groups within each area and we would like thematic groups for Health and Social Care to be established.

One thing which Area Committee members urged us to bear in mind was that the localisation of health and social care services is not just a geographical issue – it also calls for community engagement. We would therefore like to see the health and adult social care bodies in Leeds inform and engage the ten Area Committees in the decision-making process for the services in their areas through the health and wellbeing thematic groups.

Recommendation 1:

That

- **a thematic group be developed for health and wellbeing, including adult social care, in each of the three areas**
- **the thematic groups work with the area committees to discuss and agree the nature and regularity of their dialogue in the future**

Health Centres

During the first of our inquiry sessions we raised the issue of Health Centres with the Leeds PCT. We had read with concern a report in the local press in May 2007 about the Parkside Community Health Centre, which alleged that only two out of four GP practices expected to move into the centre had actually done so. As a result, half the consultation rooms were lying empty, or being used to store furniture, almost 18 months after the centre first opened.

The Parkside Centre is one of nine LIFT (Local Improvement Finance Trust) health centres in Leeds. Not all the centres are open yet, some are still being constructed. Leeds LIFT Limited is a public/private partnership in which the local NHS and the Department of Health are shareholders. It is not the same as a Private Finance Initiative (PFI).

Conclusions and Recommendations

The nine centres are:-
Armley Moor Health Centre
Beeston Hill Community Health Centre
Parkside Community Health Centre
East Leeds Health Centre
Wortley Beck Health Centre
Middleton Community Health Centre
Wetherby Health Centre
Woodhouse Enhanced Primary Care Centre
Yeadon Community Health Centre

We also raised the issue of the older health buildings in Leeds, some of which we feel are in a poor state of repair.

We were told that planning had been undertaken to maximise the use of all the health facilities across the city, particularly those in the LIFT programme. There would also be investment to repair and maintain buildings.

We felt we needed to make site visits to some of the Health Centres in Leeds to assess how fully the LIFT centres were being used and compare these new facilities with one of the older health buildings. We chose to visit

- Yeadon Community Health Centre
- Beeston Hill Community Health Centre
- Middleton Community Health Centre
- Otley Clinic

The three LIFT developments (Yeadon, Beeston Hill and Middleton) were chosen because two are relatively new and one is more established. Yeadon opened in October 2007, Beeston Hill in May 2007 and Middleton in October 2005.

We chose to visit Otley Clinic, which was built in the 1960's, as an example of older building stock in need of refurbishment.

Yeadon Community Health Centre was purpose built under the LIFT initiative. Services are provided on three floors including a GP practice, Dr Marshall and Partners, on the ground floor. The sign which says "Yeadon Community Health Centre" is visible from quite a distance but when standing outside the centre, the sign for the GP practice is most prominent and there is no sign which acts as a 'menu' for all of the other community health services which are provided there.

There are two reception desks on the ground floor, one for the health centre and one for the GP practice. We feel this is confusing for service users. If there was just one reception desk, service users who have difficulty signing in for their GP appointment using the touch screen system - and we witnessed several people struggling to log in - would then be able to get assistance from staff at the main reception desk. Currently, the GP practice is very separate from the

health centre and patients asking for assistance with the touch screen at the health centre reception desk are sent across the room to ask for help from the GP reception desk.

We accept that the PCT has an obligation to work in partnership with the GP practices in its new health centres and to honour whatever reception arrangements the practices wish to put in place. In our opinion, however, the logic of the building as a centre for health is undermined by the existence of two reception desks. We feel this adds to the overall impression of the Community Health Centre as a collection of different health related services placed together in one building, rather than one coherent whole.

Disappointingly, we understand from the PCT that almost all the GP practices in these new LIFT buildings have opted for separate reception areas.

The staff room at Yeadon is very pleasant, light and airy and the public areas of the building are neat and free from posters and notices, except on designated notice boards.

Patients are sent from the ground floor reception to see clinicians in rooms on the first floor of the building. There is a purpose built reception desk on the first floor. The shutters were down on the day we visited and we were told this desk is never used and that there are no plans to use it in the future.

We were struck by the lack of security on the first floor. With no staff on reception, members of the public are free to wander around the floor unchallenged. We have genuine concerns that service users might forget which room they had been sent to and feel quite lost when faced with a floor containing numerous consulting rooms and waiting areas with no member of staff to ask for help. There is also potential for a patient to become ill and not be noticed for some time, given the low activity levels on this floor. We understand that CCTV is in place, but is monitored by busy reception staff on the ground floor.

We were shown a minor surgery suite on this floor which is not used. Doctors at the GP practice in the centre use their own consulting rooms to carry out minor surgery.
We also looked at a group therapy room which we were told was used for ante natal and post natal groups and smoking cessation. We felt this room was an excellent facility which had the potential to serve a variety of community health uses.

Finally, we visited the second floor where dental services will be provided. The equipment was in place but not the dentists. We are pleased to hear that the Community Dental service has since moved into this area and procurement is underway to fill the remaining dental chair permanently, with arrangements being made for a locum service provision in the interim.

Conclusions and Recommendations

At Beeston Hill Health Centre, another LIFT initiative, the dental provision comprises three dental chairs. Again these were not in use at the time of our visit. There are seven training rooms which we were told the Leeds Dental Institute (LDI) will be using from Easter 2008. However, this conflicts with information received on a later site visit to the LDI, where we were told that the Beeston site is not expected to be fully operational until the autumn because of a number of delays.

We were pleased to hear that the dental chairs would be in use from late February 2008 (our visit was on February 13th). However we remain concerned about the length of time taken since the opening of Beeston Hill (May 2007) to the start of dental services.

Like Yeadon, Beeston Hill houses a minor surgery suite, which is not used. Doctors at the City View Medical Practice, co-located at the Beeston Hill Health Centre, carry out minor surgery in their own consulting rooms.

It is clear to us that the LIFT facilities at Yeadon, Beeston Hill and Middleton are under-utilised. We were pleased to hear that some of the rooms at Beeston Hill are let out to community groups free of charge.

We visited Middleton Health Centre, because we hoped to see a contrast between Middleton, as a more established LIFT building and Yeadon and Beeston Hill, which both opened less than 12 months ago.

At Middleton, we were pleased to see one reception desk and to hear that staff from the GP practice work on reception and also take bookings for other services within the building. However, we found that the centre, despite being open since 2005, is not being used to full capacity. For example, there is an empty space on the ground floor of the building, which we were told was initially intended to be an internet café. We understand that staff are currently discussing other uses for the area, including additional seating, or children's play space.

We understand the minor surgery unit at Middleton has been used by GPs for nail surgery. It appears to us that there is not enough demand from GPs for these minor surgery units to have justified their inclusion at the planning stage.

After our site visits, we were told that the PCT is undertaking a review of minor surgery in Leeds.

Recommendation 2:

That the results of the PCT's review of minor surgery in Leeds be reported to this scrutiny board at the earliest opportunity.

To summarise our visits to the three LIFT Health Centres, we are concerned that not one of these costly

new buildings is being used to its full potential. Rooms which are seldom used are generating running costs for heating and lighting.

It appears that, as part of a forward moving plan to localise health services, there has been a huge capital investment in several new high-quality buildings in Leeds to deliver healthcare. There seems, however, to be a disconnection between capital and revenue planning, resulting in under-utilisation of the new buildings. If this is left unresolved, we feel that the people of Leeds will become increasingly concerned about the future of these new buildings.

Recommendation 3:

That Leeds PCT provides quarterly reports to this Board during 2008/9 regarding the development of services in the new LIFT financed health centres in Leeds. We hope to hear of an explicitly strategic approach which harmonises revenue and capital expenditure to make full use of the high quality buildings housing the new Community Health Centres.

We feel that greater community involvement with the centres might be one way to increase usage and we are particularly keen to see more 'joined-up care' and health promotion work for individuals with health and social problems. We feel that if local people are consulted about possible uses for the buildings, they will be more likely to feel 'ownership' of the facilities and the centres could become community resources, rather than simply outposts of the health services. We are very concerned that this issue does not seem to have been addressed by the five Leeds PCTs when the buildings were planned.

Recommendation 4:

That, during the summer of 2008, Leeds PCT carries out consultation to determine what services and opening times local people would like to see for their new Community Health Centres and reports the findings back to this Scrutiny Board at the October meeting.

We visited Otley Clinic because we wanted to look at one of the city's older health centres.

We noted a number of concerns. Firstly, the clinic is hard to find, there is no signpost on the main road.

The interior of the building is covered with unnecessary posters, signs and notices on all the walls and windows, making the small space feel very cluttered.

Some services have ceased without informing local people and the PCT doesn't seem to be aware of some of the changes. For example, we were provided with a list of the services provided by Otley Clinic for the first session of our inquiry. This included

CASH (Contraception and Sexual Health services). However, we were told at the clinic that family planning services ceased there in mid-2007. Staff provided us with a list of CASH services elsewhere in Leeds, but none are located in the North West area of Leeds.

We are disappointed to hear that family planning services are being withdrawn from any location in Leeds, particularly at a time when the rate of teenage pregnancies in Leeds is rising. We especially feel that young people might be more comfortable visiting a clinic for contraception, than making an appointment to see their family doctor.

The age of the building inevitably means that it fares badly in comparison to the new LIFT health centres. We are pleased to note that the PCT has funds set aside for a capital programme of maintenance and refurbishment of some of its premises which are no longer fit for purpose.

We look forward to visiting some of the refurbished premises next year.

Recommendation 5:
That

- **Leeds PCT keeps this Board informed of progress with the programme of refurbishment over the next municipal year.**

Our impression of the new health centres - as a collection of different health-related services operating very independently in separate rooms within one building - was echoed at Otley Clinic. Again we felt that there was no coherent "whole" for the clinic itself and even less coherence with the neighbouring health buildings. Otley Clinic is very close to Wharfedale Hospital and Yeadon Community Health Centre, and, given the ward closure and low level of usage at Wharfedale we question whether building such an extensive new facility at Yeadon was a wise decision.

Wharfedale Hospital

We have been concerned for some time about what we feel is a lack of a strategic direction for Wharfedale hospital.

The hospital opened in October 2004 with three wards. Two of the three wards are now closed. The remaining ward houses a 26 bed older adult unit. The hospital has two operating theatres and operations are carried out through the day surgery service. The hospital is under-utilised, with an activity rate below 50% of capacity. Outpatients and the operating theatres are particularly under-used.

When visiting the hospital, we were immediately impressed by the commitment and dedication of the Matron and nursing staff we spoke to. We also noted the very high standard of cleanliness throughout the building.

Conclusions and Recommendations

What concerned us on our visit, was seeing for ourselves the empty wards and the low activity levels throughout the hospital areas. We were pleased to hear that the lymphoedema service has recently transferred to Wharfedale from Cookridge Hospital, taking patients from all over Leeds. This is utilising some of the empty space with a very necessary service.

At our first inquiry session, we received a document produced in April 2007 entitled A Framework for the Development of the Strategic Direction of Wharfedale Hospital, developed by the Leeds Teaching Hospitals NHS Trust; Leeds PCT and the Wharfedale Hospital Forum. This sets out some good intentions to use Wharfedale Hospital to its full potential and serve both the local and wider community in a safe, efficient and effective way. It is merely a framework, however and, as such, it does not provide any detail.

Overall, we feel there isn't sufficient sense of urgency, on the part of the Leeds Teaching Hospital's Trust and PCT, to address this issue of under-utilisation at Wharfedale. The hospital has excellent potential which needs to be fully maximised. We feel this should be a high priority for the local NHS.

We look forward to receiving the detailed strategy:-

Recommendation 6:

That the strategy for Wharfedale Hospital, due to be developed during early 2008, be presented to the first meeting of Scrutiny Board (Health and Adult Social Care) in the municipal year 2008/9.

Capacity to deliver services locally

We gratefully acknowledge the work that the many local voluntary and community organisations carry out to provide much needed services to the people of Leeds. Localisation of health and social care services, where there is an emphasis on keeping people at or close to home during periods of illness or incapacity, will lead to an increased demand for help in the future, which is likely to be commissioned from these third sector agencies.

We want to encourage the third sector and it concerns us that smaller organisations may find the commissioning and procurement processes difficult to navigate, discouraging them from bidding for contacts which they could actually deliver very well. Small voluntary and community groups are not always run by professional staff and commissioning language can be very hard to understand. We would like to see commissioners make more effort to use plain English in their commissioning and procurement processes and make personal contact

with small organisations to offer assistance.

Recommendation 7:

That Leeds Adult Social Services and Leeds PCT make arrangements to

- **Produce commissioning and procurement documentation in plain English**
- **Offer personal contact for voluntary and community groups to explain tender documentation and procurement processes**

and report these arrangements back to this Scrutiny Board by December 2008.

Preventative Health

Knowing what to do to maintain good health, prevent illness and take responsibility for our own health, is directly relevant to the localisation agenda, which aims to reduce the number of hospital admissions for severe illnesses. It follows on from the Government's White Paper in 2004, *Choosing Health*, which sets out the principles for supporting the public to make healthier and more informed choices about their health.

We were concerned to read in the national press in October about a British Medical Journal report stating that NHS Trusts across England had used funds intended for public health to avoid financial crisis. These were funds earmarked to tackle key *Choosing Health* issues such as obesity, alcohol misuse and sexual health.

We requested information from Leeds PCT about the 2006/7 public health allocation for Leeds, specifically if the funding was spent on public health or used for other purposes.

We were disappointed to hear that none of the five former Leeds PCTs chose to spend all of its Choosing Health public health allocation of funds for 2006/7 on public health programmes. Leeds South PCT spent just over a quarter of its allocation on public health programmes (26.19%). Of the total allocation of £1.687m for the whole of Leeds, just £1.143m (68%) was spent on public health programmes.

We were, however, pleased to receive confirmation from the Chief Executive of Leeds PCT that the total allocation of Choosing Health funding for 2006/7 is fully available from 2007/8 to meet Choosing Health priorities. We look forward to hearing about how the money was spent:-

Recommendation 8:

That Leeds PCT provides a report to the Scrutiny Board in July 2008, providing information about the funding spent on Choosing Health priorities in 2007/8.

Conclusions and Recommendations

Leeds Dental Institute and the out of hours dental provision

We wanted to include dental services in our inquiry, as the provision of NHS dentistry in Leeds is an issue the Board scrutinised last year and we have revisited this year.

We went to the Leeds Dental Institute. Students at the Institute provide free treatment to around 40-60 walk-in patients per day. There is always a consultant on hand in case of difficulties. This is a very valuable service for the people of Leeds, which only exists because we are fortunate enough to have a dental school in Leeds. At present, the dental school is in a very secure position, with a high research rating and no danger of closure. However, we are concerned that this free service, which so many people rely on, is vulnerable because it is dependent upon the University of Leeds Dental School, rather than the PCT.

Another site we visited during our Inquiry was Leeds PCT's out of hours dental treatment centre at Lexicon House. The centre is operated by Local Care Direct, on behalf of Leeds PCT.

We heard that call rates to the centre vary but would typically be between 30-40 per night. There is a telephone triage process to decide whether attendance at the centre is the appropriate option for the patient and, if so, the patient is given a time slot within which to attend, rather than a timed appointment.

We feel the out of hours dental provision is a valuable service. The public has clearly identified the advantage of being able to attend a dentist at a more convenient time. Unfortunately this has led to some patients using the out of hours emergency service as they might use a general dental practitioner.

We would like consideration to be given to replicating the out of hours clinic in one or two other areas of the city to provide better coverage for dental emergencies, in view of the shortage of NHS dental provision.

Recommendation 9:

That Leeds PCT gives consideration to replicating the out of hours dental provision at Lexicon House elsewhere in Leeds to provide better coverage for areas outside the city centre.

Intermediate Care

We visited Middlecross Resource Centre and Richmond House to look at intermediate care services. Middlecross specialises in providing care for older people with dementia. There is a day centre and a Home for Older People (HOP) on the Middlecross site. The home has 32 beds. 24 beds are for permanent residents, three are for respite care and five are for intermediate care use. Richmond House has eight

intermediate care beds out of a total of twenty. There are also 11 respite beds and one permanent resident.

At Middlecross, funding for the intermediate care beds is secured for 2008/9, partly through the Partnerships for Older People Programme (POPP). After 2009, we understand the funding is less certain. Intermediate care is multi-disciplinary, with occupational therapy, physiotherapy, community psychiatric nursing and mental health teams working in partnership with Middlecross care staff.

We were interested to hear how working together has helped staff to share skills and good practice with each other. Middlecross staff have picked up lots of knowledge from the therapists working there and the PCT staff have learned useful techniques for working with people with dementia from the staff at Middlecross. Task-based rehabilitation works best, such as how to make toast or a cup of tea, or to learn to walk from the bed to the bathroom, etc.

The staff we spoke to at Middlecross demonstrated a high level of caring and commitment, which is much appreciated by the users and carers they provide the service for. We spoke to one husband/carer who said the day centre helped him and his wife. It allowed him to take a break from caring and it provided stimulating activities and company for his wife.

The facilities and activities on site provide opportunities for residents to mix with others or be quiet on their own, however they choose. Family members are welcome and free to come and go, without set 'visiting times'.

There is a large and growing demand for services for older people and Middlecross and Richmond House are working to full capacity. There are no unfilled places at the Middlecross day centre and rarely any empty beds at Middlecross HOP or Richmond House. We are anxious to make sure that intermediate care continues, grows and develops and there is adequate funding, post-POPP:-

Recommendation 10:

That Leeds Adult Social Care and Leeds PCT keep this Board informed, during 2008/9, of the future funding situation for the intermediate care provision at Middlecross Resource Centre.

The majority of people treated by the intermediate care team at Richmond House have suffered fractures, although the service is open to anyone who is having difficulties with standing, walking, washing or managing medication. The priority is to help people regain their mobility and independence. Staff work alongside the neighbourhood care teams to ensure that the correct care packages are being provided and that relatives are happy with the situation.

Conclusions and Recommendations

Leeds CITY COUNCIL

Patients are not currently able to have a 'trial run' before they are discharged, although they are assessed at home by the Occupational Therapist on their return. We feel that this area is worth exploring, as it might give people the opportunity to access more support in their own home.

Recommendation 11:

That the Director of Adult Social Services explores the possibility of instigating 'trial runs' at home for patients prior to discharge from Richmond House, to assess how well they will cope.

Practice Based Commissioning (PBC)

PBC is a government policy which devolves responsibility for commissioning services from PCTs to local GP practices. Under the scheme, practices will be given a commissioning budget which they will have the responsibility for using to provide services. The aim is to give local clinicians greater control over resources, freeing them to respond better to local and individual need.

In Leeds, practices have grouped together into consortia to implement PBC. We were disappointed to learn that the consortia in Leeds are not configured around localities, but are groups of 'like minded' practices. We feel this works against the aim to be responsive to local need.

A Patient Advisory Group (PAG) has been established for PBC in Leeds, advising the PBC Governance Committee, which is a sub-committee of the Leeds PCT Board. Membership of the PAG is drawn from a range of patient groups and community and voluntary organisations in Leeds.

Monitoring of the development of PBC in Leeds, particularly the PAG, and other mechanisms for local engagement in PBC, is something which we feel the Scrutiny Board should undertake in the new municipal year. The Patient and Public Involvement Forums (PPIFs) are represented on the PAG at present. We hope that there will be interim arrangements in place for patient representation on the PAG after the abolition of the PPIFs and before the new Local Involvement Network (LINk) is up and running.

The PBC Forum has been set up in Leeds to bring together clinical leaders from the PBC consortia with strategic commissioners from the PCT to allow PBC to take place in the context of the overall vision and strategic priorities for the PCT. It also enables sharing of commissioning plans between consortia and looks at opportunities to work collaboratively.

Some of the frustrations which local doctors have reported to us, through our consultation with the Leeds Local Medical Committee (LLMC), are that the PBC Forum hasn't yet carried out much commissioning, nor has it had

any significant influence so far on the main provider of services in Leeds, LTHT.

LLMC report that the health data from the LTHT and the PCT in Leeds is quite poor. The committee has concerns about the accuracy of the statistics to support PBC. Key data about what procedures are being done and how much it is costing for example, or knowing what budget is available.

The LLMC advise that one of the successes so far would appear to be a drop in the number of referrals to secondary care, as GPs are making use of the new outreach clinics that are being set up through PBC, although it is hard to be certain about this without seeing full city-wide figures.. Progress with PBC in Leeds also compares reasonably well with progress elsewhere in the country. On the downside, there is little room for expansion in the buildings housing most GP practices, which will limit the new services which might be provided. LLMC also feels that PBC in Leeds would benefit from an increase in management support.

PBC has the potential to shape local services in Leeds and we will watch its progress with interest. We are pleased to hear that Health and Adult Social Care colleagues in Leeds have begun discussions to identify how PBC could help co-location opportunities and the adjustment of services to reduce duplication and maximise efficiency and effectiveness of staff.

Recommendation 12:

That progress with the development of Practice Based Commissioning in Leeds, particularly the arrangements for

- **management support for the PBC Forum**
- **patient and public involvement, and**
- **the continuing discussions between Health and Adult Social Care colleagues of joint opportunities presented by PBC**

are monitored by this Scrutiny Board in 2008/9.

Joint Strategic Needs Assessment

The new statutory duty to develop a Joint Strategic Needs Assessment (JSNA) comes into force on 1st April 2008. This assessment of current and future health and well-being needs in Leeds will be jointly led by the Director of Adult Social Services, the Director of Children's Services and the Director of Public Health. It will highlight the health inequalities that exist locally and inform future service planning so that commissioning priorities are set to improve health and well-being outcomes and reduce inequalities.

The JSNA is an important piece of work of great interest to this Board. We look forward to receiving regular reports on the findings as they emerge over the next few months.

Evidence

Leeds CITY COUNCIL

Membership of the Board 2007/08

Councillors:-
J Bale
J Chapman (Chair – part year)
J Dowson
G Driver
P Ewens
C Fox (part year)
S Golton (Chair – part year)
J Illingworth
M Iqbal
G Kirkland
M Rafique
L Russell
P Wadsworth (part year)

Co-opted Members:-
J Fisher (Alliance of Service Users and Carers
E Mack (Leeds Voice Health Forum)
S Morgan (Equalities)
S Saqfelhait (Touchstone)
L Wood (PPI forums)

Background Papers, Reports and Publications Submitted

The NHS Improvement Plan: Putting People at the Heart of Public Services, Executive Summary (DoH, June 2004)

Health Reform in England: update and next steps (DoH, December 2005)

Our Health, Our Care, Our Say: A new direction for community services (Govt White Paper, January 2006)

The Future of Health and Adult Social Care: A partnership approach for well-being (Local Government Association)

Our Health, Our Care, Our Say: making it happen (October 2006)

The Vision and Key Goals of Making Leeds Better on the MLB website (www.makingleedsbetter.org.uk)

Joint briefing from Leeds Primary Care Trust, Leeds Teaching Hospitals NHS Trust (LTHT) and Leeds Partnership Foundation Trust on the localisation of Health Services supplied for the Scrutiny Board meeting in November 2007

Framework for the Development of the Strategic Direction of Wharfedale Hospital, April 2007, LTHT

Evidence

Background Papers, Reports and Publications Submitted (continued)

Briefing from the Deputy Director of Leeds Adult Social Care on Localisation: The Adult Social Care Perspective.

Briefing from Leeds Primary Care Trust on the planning and decision-making process for commissioning health services in Leeds, supplied for the Scrutiny Board meeting in January 2008.

Report of the Director of Adult Social Services on the development of the Leeds Joint Strategic Needs Assessment and potential options for the future co-location of Health and Social Care Staff.

Guidance on Joint Strategic Needs Assessment (DoH 2008)

Report from Leeds PCT on care closer to home, supplied for the Scrutiny Board meeting in February 2008.

Information supplied by Middlecross House including:

POPPs Resource Centres Operational Policy.

Eligibility Criteria, Dementia Day Services.

Outcry over health centre used to store furniture, Yorkshire Post 19th May, 2007

Vital sections of new health centres unused, Yorkshire Post 20th September 2007

Monitoring arrangements

Standard arrangements for monitoring the outcome of the Board's recommendations will apply.

The decision-makers to whom the recommendations are addressed will be asked to submit a formal response to the recommendations, including an action plan and timetable, normally within two months.

Following this the Scrutiny Board will determine any further detailed monitoring, over and above the standard quarterly monitoring of all scrutiny recommendations.

Evidence

Leeds CITY COUNCIL

Witnesses Heard

Cllr B Anderson	Area Committee Member (Outer North West)
Maggie Boyle	Chief Executive, Leeds Teaching Hospitals NHS Trust
Lisa Butland	Director of Planning and Commissioning (Capital and Transport)
Cllr C Campbell	Area Committee Member (Outer North West)
Jill Copeland	Director of Strategic Development, Leeds PCT
Clare Dean	Practice Manager, City View GP Practice, Beeston Hill
John England	Deputy Director, Strategy and Performance, Adult Social Services
Joanne Evans	Practice Manager, Dr Marshall and Partners, Yeadon
Cllr C Fox	Area Committee Member (Outer North West)
Cllr Angela Gabriel	Chair, Area Committee (Inner South)
Cllr Terry Grayshon	Chair, Area Committee (Outer South)
Mark Harrington	Leeds Dental Institute
Dennis Holmes	Chief Officer, Commissioning, Adult Social Care
Martin Hudson	Manager, Middlecross HOP
Samatha Hunter	Dental Services Manager, Leeds Out of Hours Dental
Sandie Keene	Director of Adult Social Services
Alison Keighley	Health Centre Administrator, Yeadon
Zoe Kirk	Matron, Wharfedale Hospital
Sandy Lay	Senior Charge Nurse, Wharfedale Hospital
Judith Lund	Assistant Director, LTHT
Susan Meehan	Manager, Middlecross Daycentre
Cllr Elizabeth Minkin	Area Committee Member (Inner North West)
Cllr James Monaghan	Chair, Area Committee (Inner North West)
Christine Outram	Chief Executive, Leeds Primary Care Trust
Sam Prince	Director of Operations for West Leeds
Angela Richardson	Dental Services Co-ordinator
Dave Richmond	Area Manager, South Leeds
Catherine Scott	Health Centre Administrator, Beeston Hill
Maggie Shires	Senior Sister, Surgical Ward, Wharfedale Hospital
Mike Simpson	Principal Unit Manager, Adult Social Services
Jason Singh	Acting North West Area Manager
Sue Stead	Health Centre Administrator, Otley Clinic
Martyn Stenton	Partnerships Manager, Neighbourhoods and Housing
Jackie Todd	Consultant Physiotherapist
Cllr Chris Townsley	Chair, Area Committee (Outer North West)
Julie Turner	Executive Support Manager, Leeds PCT
Dr Richard Vautrey	Leeds Local Medical Committee
Linda Wolstenholme	Customer Services Manager, Leeds Out of Hours Dental Service

District Nursing, Health Visitor and Podiatry staff at Otley Clinic
Staff at Richmond House

Evidence

Leeds CITY COUNCIL

Dates of Scrutiny

19th November 2007	Scrutiny Board Meeting
17th December 2007	Scrutiny Board Meeting
21st January 2008	Scrutiny Board Meeting and site visit to the Leeds Out of Hours Dental Surgery
28th January 2008	Site Visits to Otley Clinic and Wharfedale Hospital
31st January 2008	Site Visit to Yeadon Community Health Centre
4th February 2008	Site Visit to Richmond House
12th February 2008	Site Visit to Middlecross Day Centre and HOP
13th February 2008	Beeston Hill and Middleton Park Avenue Health Centres
18th February 2008	Scrutiny Board Meeting
21st February 2008	Meeting with Leeds PCT regarding Yeadon Community Health Centre
3rd March 2008	Site Visit to the Leeds Dental Institute
17th March 2008	Scrutiny Board Meeting
21st April 2008	Scrutiny Board Meeting

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APPENDIX 3

SCRUTINY BOARD (HEALTH)

HEALTH PROPOSALS WORKING GROUP

DRAFT TERMS OF REFERENCE

1.0 Background

1.1 The legislative background regarding scrutiny's consideration of NHS proposals for changes to local health services is as follows:-

- The Health and Social Care Act, 2001, (the Act) sets out a series of statutory requirements for the NHS in relation to patient and public involvement.

- Section 11 of the Act places a duty on the NHS to involve and consult patients and the public in planning services, developing and considering proposals for changes in the way those services are provided, and in decisions that affect how those services operate.

- Section 7 of the Act requires NHS organisations to consult the Scrutiny Board (Health and Adult Social Care) on any proposal for a **substantial** development or variation to health services.

- The Act further provides powers for Scrutiny Board (Health and Adult Social Care) to refer issues, on which they have been consulted under the "substantial variation" clause, to the Secretary of State for Health either where they believe that consultation with patients, the public and other stakeholders has not been satisfactory or where they consider that a proposal of an NHS body is not in the interests of the health service in the area.

2.0 Scope

2.1 It is widely acknowledged that the definition of 'substantial' development or variation of health services is subjective, with proposals often open to interpretation.

2.2 The purpose of the Working Group is to allow local NHS bodies to inform Scrutiny of future proposals for service changes at an early stage to allow the Working Group to discuss and agree the status of such proposals according to the following table:-

Degree of variation	Colour code	Contact with Scrutiny
Substantial variation (e.g. change of site of highly specialist service)	Red	Consult
Significant change (e.g. change in opening times)	Orange	Inform
Minor change (e.g. change of location within same hospital site)	Yellow	Inform
Ongoing improvement (e.g. redesign of patient information leaflet)	Green	No

2.3 However, as the statutory duty to consider substantial changes will remain with the full Scrutiny Board, the remit of the Working Group will be to:

- Agree whether a proposal amounts to a substantial variation and needs to be considered by the full Board.
- Consider whether the Trust's plans for consultation with patients, the public and other stakeholders seems satisfactory.
- Consider whether the proposal is in the interests of the health service in the area.

2.4 In the case of substantial changes, the view of the Working Group on bullet points two and three will assist the full Board in coming to a decision about whether further scrutiny is necessary.

3.0 Frequency of meetings

3.1 It is initially proposed that the Working Group will meet on a bi-monthly basis, commencing in September 2008.

3.2 However, it is planned that the Working Group will adopt a flexible approach to meeting dates and, as such, may choose to meet outside of the bi-monthly timetable.

4.0 Membership

4.1 The membership of the Health Proposals Working Group for the duration of the current municipal year (2008/09) is as follows:

- Councillor Pauleen Grahame
- Councillor Andrea McKenna
- Councillor Judith Chapman

5.0 Key stakeholders

5.1 The following key stakeholders have been identified as likely contributors to the Working Group:

- Leeds Primary Care Trust (PCT)
- Leeds Teaching Hospitals NHS Trust (LTHP)
- Leeds Partnership Foundation Trust (LPFT)
- Director of Adult Social Services

6.0 Monitoring arrangements

6.1 The full Scrutiny Board (Health) will be kept appraised of the activity of the Working Group and regular updates will be provided.

July 2008