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Leeds CITY COUNCIL

SCRUTINY BOARD (HEALTH)

Meeting to be held in Civic Hall on
Tuesday, 24th March, 2009 at 10.00 am

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

MEMBERSHIP

Councillors

A Blackburn	-	Farnley and Wortley
J Chapman	-	Weetwood
D Congreve	-	Beeston and Holbeck
P Grahame (Chair)	-	Cross Gates and Whinmoor
J Illingworth	-	Kirkstall
M Iqbal	-	City and Hunslet
G Kirkland	-	Otley and Yeadon
A Lamb	-	Wetherby
G Latty	-	Guiseley and Rawdon
A McKenna	-	Garforth and Swillington
J Monaghan	-	Headingley
L Rhodes-Clayton	-	Hyde Park and Woodhouse
	-	

Co-opted Members

E Mack	-	Leeds Voice
S Saqfelhait	-	Touchstone

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 MEETINGS HELD ON 17 AND 19 FEBRUARY 2009** To receive and approve the minutes of the meetings held on 13 February 2009 and 17 February 2009	1 - 10
7			**PERFORMANCE MANAGEMENT** To receive and consider the attached report of the Head of Scrutiny and Member Development	11 - 44
8			**ANNUAL HEALTH CHECK** To receive and consider the attached report of the Head of Scrutiny and Member Development	45 - 82
9			**INQUIRY INTO HOSPITAL DISCHARGES** To receive and consider the attached report of the Director of Adult Social Services	83 - 132

Item No	Ward/Equal Opportunities	Item Not Open		Page No
10			**RECOMMENDATION TRACKING** To receive and consider the attached report of the Head of Scrutiny and Member Development	133 - 156
11			**WORK PROGRAMME** To receive and consider the attached report of the Head of Scrutiny and Member Development	157 - 176
12			**DATE AND TIME OF NEXT MEETING** Tuesday, 28 April 2009	

SCRUTINY BOARD (HEALTH)

FRIDAY, 13TH FEBRUARY, 2009

PRESENT: Councillor P Grahame in the Chair

Councillors A Blackburn, J Illingworth, J Monaghan and L Rhodes-Clayton

65 Apologies for Absence

Apologies for absence were submitted on behalf of Councillors J Chapman, D Congreve, M Iqbal, G Kirkland, A Lamb, G Latty and A Mckenna, and Mr E Mack.

66 Minutes of the Previous Meeting

RESOLVED – That the minutes of the meeting held on 20 January 2009, be confirmed as a correct record.

67 GP-Led Health Centre - Scrutiny Inquiry

The Head of Scrutiny and Member Development submitted a report which gave the Board an overview of the Inquiry into the provision of a GP-led Health Centre for Leeds. The report detailed a summary of the Board's Working Group meetings into the Inquiry and discussion held at full meetings of the Board.

The Chair welcomed the following to the meeting:

Dr Damian Riley – Director of Primary Care, NHS Leeds
Kathryn Hilliam - GP Contract Lead, NHS Leeds
Emma Wilson – Head of Strategic Support and Development, Primary Care, NHS Leeds
Sharon Dunsmore – Care UK Clinical Services
Councillor Ralph Pryke – Ward Member for Burmantofts and Richmond Hill

It was reported by the chair that the Board was still in some confusion as to what was to be provided at the GP-led Health Centre and concern was expressed by the chair that it was felt that differing information had been received from different representatives of NHS Leeds who had addressed the Board throughout the Inquiry. This was categorically denied by Dr Riley, who stated that consistent information had been provided.

Representatives of NHS Leeds addressed the meeting. It was reported that the GP-Led Health Centre would have both a Walk-In Centre and a practice where patients could register for GP services. The centre would be based at

the Burmantofts Health Centre and would be known as the Shakespeare Medical Practice. Other new features of the GP-led Health Centre would be opening hours of 8.00 a.m. to 8.00 p.m., 7 days a week, 365 days a year. It was acknowledged that some confusion may have arisen following the description in the media of the new centre as a 'Polyclinic', but it was felt that during the course of the Inquiry it had always been made clear that the new centre would be a 'GP-led Health Centre'. It was reported that there would be more GP provision than previously available at the site and the public would have better access to primary care. There would not be any patients registered at the practice when it first opened and GP provision at the centre would increase in line with contractual obligations should there be demand.

In response to Members comments and questions, the following issues were discussed:

- Registered patients who could not get a GP appointment would be able to use the walk in facility.
- Introduction of other walk in facilities had not caused mass migration of patients from one practice to another and it was felt that demand could be coped with.
- IT systems would be linked to other practices and eventually to all. This would help prevent false registering of patients although it was recognised that this was an ongoing concern nationwide.
- In response to concerns that services previously provided at the centre would not be available, such as sexual health services, it was reported that different GP services did not always provide the same services. Family planning services would be available along with other services and a wider range of services would be provided from the Shakespeare Medical Practice than from the previous Dr Potts surgery.
- It was planned that there would only be one locum GP used at the centre, and that this would only be during the first 12 weeks of its operation. All other GPs at the centre would be salaried. Locum GPs would only be used in case of unforeseen absences and this would be monitored by performance information.
- There would always be a GP on site. In case of GPs carrying out home visits or other off site work, a replacement would be present.
- Patients were not guaranteed to see a GP if they could be treated by another medical practitioner.
- It was expected that the opening of the centre would alleviate demand for Accident and Emergency services, but it was acknowledged that it was difficult to predict to what extent.
- There would not be treatment for minor injuries at the walk-in centre, but minor surgery would be available through the GP-practice.
- Continual assessment would be needed to review the level of services at the centre in relation to demand.
- All staffing requirements would be arranged by Care UK Clinical Services as part of the contract. It was felt that funding within the contract would be sufficient to meet needs.

- Concern was expressed by a member of the public present at the meeting regarding the closure of the previous GP practice based at the centre. The member of the public questioned why this practice had not yet been replaced and informed those present of his subsequent difficulties in getting appointments elsewhere. It was reported that the providers of the previous practice had decided to leave the centre, and this was out of the control of NHS Leeds. GP Services were independent businesses and the previous practice had served full notice to leave the centre. Review of local provision had shown there was enough capacity elsewhere to cope with demand. The procurement process to replace GP provision at the centre was bound by European legislation and this caused delay in the provision of new services. Other personal issues in relation to the member of the public would be dealt with outside of the public meeting.
- Considerable investment had been made to bring the centre premises up to standard.
- Concern regarding the adequacy of the building and disabled access.
- Councillor Pryke, as ward member for Burmantofts and Richmond Hill, was invited to address the meeting. The following points were raised:
    - Concern had been raised when the providers of the previous GP service based at the Burmantofts Health Centre had given notice of their intention to leave. NHS Leeds had attended local forum meetings and had given satisfactory assurances on patient placement and availability of GP practices.
    - Concern over public transport links.
    - Visit to Manchester to see a similar centre provided by Care UK Clinical Services – it was reported by local councillors in Manchester that this was running well and meeting the needs of local people.

RESOLVED –

(1) That the report and discussion be noted.
(2) That the Board receive an update at its April meeting following the opening of the Shakespeare Medical Practice.

68 Date and Time of Next Meeting

Tuesday, 17 February 2009 at 10.00 a.m. (Pre-meeting for Board Members at 09.30 a.m.)

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SCRUTINY BOARD (HEALTH)

TUESDAY, 17TH FEBRUARY, 2009

PRESENT: Councillor P Grahame in the Chair

Councillors A Blackburn, D Congreve, J Illingworth, M Iqbal, G Latty, A McKenna and L Rhodes-Clayton

CO-OPTEES Mr E Mack

71 Declarations of Interest

Councillor Illingworth declared a personal interest in Agenda Item 6, Draft Health and Wellbeing Partnership Plan 2009 to 2012 due to his employment with the University of Leeds (Minute No. 73 Refers).

72 Apologies for Absence

Apologies for absence were submitted on behalf of Councillors Chapman and Lamb.

73 Draft Health and Wellbeing Partnership Plan 2009 to 2012

The report of the Director of Adult Social Services presented the latest working draft of the Health and Wellbeing Partnership Plan for 2009 to 2012. This plan would replace the Leeds Health and Wellbeing Plan 2005 to 2008 and build on partnership priorities that had already been consulted on and agreed in the Leeds Strategic Plan. It was reported that the Plan had been brought to Scrutiny Boards prior to submission to the Executive Board and full Council.

The Chair welcomed John England, Deputy Director, Adult Social Services and Mike Simpkin, Public Health Strategy Manager to the meeting.

It was reported that the plan was still a working. The plan would go to Executive Board in March 2009 and full Council for approval in April 2009. Members attention was also brought to the action plan that had been developed.

The Board was given a presentation on the Health and Wellbeing Partnership plan. The presentation focused on the following issues:

- Visions and Strategic Outcomes – Emphasis on reducing inequalities in health
- Areas of Action – Developed in 3 main themes:
    - Influences on Health

    - The Lives People Lead
    - The Services People Use
- Ward Mortality – differences in life expectancy across Leeds
- Four Main Strategic Objectives:
    - Reducing Health Inequalities
    - Improving Quality of Life
    - Enhanced Safety and Support for Vulnerable People
    - Inclusive Communities
- Improvement Priorities – linked to Leeds Strategic Plan priorities.
- Key Connections – delivery of health and wellbeing outcomes working across a number of plans, services and strategies.
- How to Deliver Priorities – Strategic Lead Teams, joint commissioning and working between NHS Leeds and the Council, integrated services, locality working, links to the Joint Strategic Needs Assessment (JSNA).
- Current and Emerging Challenges – changing demographics and ageing population leading to different health issues.
- Action Planning and Examples of Action – including the provision of services, influences on health, preventative measures, physical activity and strengthening partnerships at local level.

Further to the presentation and in response to Members' comments and questions, the following issues were discussed:

- Infant mortality rates – it was reported that these were higher in areas of deprivation.
- Progress on health issues in recent years – while it was recognised there had been significant improvements, there was a need to intensify this improvement.
- Alcohol and licensing issues – when the Licensing Act 2005 was introduced, there was no provision for considering health issues in relation to licensing applications. There had since been amendments to allow this and it was noted that there had been a recent decrease in the number of licensed premises across Leeds. There was however, concern regarding the sale of alcohol from off licensed premises and the possible affects on health.
- The role of locality enablers – there would be 3 locality enablers based across the 3 Area Management teams and these would work closely with appointed Health and Wellbeing champions to help deliver improvement priorities at local level to meet local needs. It was suggested that the locality enablers should report to Area Committee to keep Elected Members involved and informed of health issues. Concern was expressed at the need and cost of additional staffing and that the Council should be taking a holistic approach at this stage. It was reported that other Council Directorates outside those relating to Health and Social Care had been involved including those with responsibility for highways and sports facilities and it was confirmed that locality enablers would report to Area Committees.

- Work with employers – work had been undertaken with NHS Leeds and a Workplace Health Award Scheme had been introduced. It was hoped to extend this before the end of 2009.
- Physical activity and links to childhood obesity, lack of facilities for physical activity and loss of areas for physical activity due to new developments, particularly in areas of deprivation. It was reported that the Physical Activity Strategy had been launched in December 2008 and steps to measure physical activity had been implemented.
- The role of the Voluntary, Community and Faith Sector and how it could contribute to joint working, particularly on a local level and how to attract the involvement of smaller VCFS organisations.
- Conditions such as diabetes and coronary heart disease and how these could affect specific communities.
- Alcohol and drug misuse, particularly among young people and treatment for related health problems.

RESOLVED – That the Head of Scrutiny and Member Development drafts a response from the Board, regarding the key concerns and issues discussed in relation to the draft Health and Wellbeing Plan 2009-12 and prior to its submission to Executive Board.

74 Provision of Hospital Food in Leeds

The report of the Head of Scrutiny and Member Development reminded the Board of a request for Scrutiny from Councillor Denise Atkinson regarding the Provision of Hospital Food. Appended to the report was a submission from Leeds Teaching Hospitals Trust (LTHT) regarding Patient Food Services within the Trust and the Board was asked to consider whether further action was required.

The Chair welcomed Councillor Denise Atkinson and Andrew Matthews, Deputy Head of Facilities, LTHT to the meeting.

Councillor Atkinson recounted on her recent experiences in Hospital and along with some Members of the Board raised the following areas of concern and discussed related issues:

- Very poor quality food, to the extent that patients were going out to eat where possible or having food brought in.
- No food available to newly admitted patients when snack boxes should be provided.
- Having little or no choice of food and items listed on menus not being available.
- Lack of working facilities for preparing food including toasters and microwaves.
- Inappropriate food being offered to people with illnesses such as diabetes.
- Concern that food was being sent from Wales.

- Lack of choice for those with special dietary needs whether it be on religious or health grounds.
- Not all experiences of Members had been negative, with others reporting on standards being acceptable.

Andrew Matthewman addressed the meeting. He reported that LTHT served over 2,000 meals per day and accepted that different views would be expressed due to people having different requirements and tastes. He apologised for what were accepted to be valid concerns. With regard to food being brought in from Wales, it was reported that this was the pre-cooked main meals and other food was sourced locally. The contract for the main meals was due to expire in 2011 and had been awarded for 10 years. LTHT was beginning the process to procure the next contract and supply of local goods and services was of concern.

In response to other concerns and questions of the Board he reported the following:

- Dieticians did work with patients to discuss requirements.
- Snack boxes of food should be made available for patients admitted outside of normal hours and meals may be available where patients had been discharged, and someone else had taken their place.
- There would always be waste due to issues such as patients discharging themselves and those who were too ill to eat what had been pre-ordered.
- LTHT did want to improve services and Members of the Board were invited to attend for lunch in line with inspections previously carried out by members of the Public and Patient Involvement forums.
- Cost of food per patient was £2.92 for 3 meals per day.
- Complaints had been received about provision of food, but the vast majority of patients were satisfied.

RESOLVED – That the report be noted.

(Councillor Iqbal left the meeting at 11.50 during the discussion on this item).

75 GP-led Health Centre - Scrutiny Inquiry

The report of the Head of Scrutiny and Member Development referred to the Inquiry into the proposals for the provision of a GP-led Health Centre in Leeds. Members were asked to discuss the outcomes of the Inquiry and were reminded that the Board would be provided with a review of the Centre following its opening.

RESOLVED – That the Board receive an update on the first few weeks of operation at its April meeting.

76 Work Programme

The Head of Scrutiny and Member Development submitted a report which outlined the Board's Work Programme. Also appended to the report was a copy of the Executive Board minutes from 14 January 2009.

It was reported that the review of the GP-Led Health Centre would be added to the Work Programme for the April meeting. It was also noted that the issue of Co-opted Members for all Scrutiny Boards, including Scrutiny Board (Health), was due to be discussed by the Scrutiny Chairs Advisory Group in the near future.

RESOLVED –

(1) That the minutes of the Executive Board held on 14 January 2009 be noted.
(2) That the Work Programme be approved.

77 Date and Time of Next Meeting

Tuesday, 14 March 2009 at 10.00 a.m. (Pre-meeting for all Members at 09.30 a.m.)

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Leeds CITY COUNCIL

Originator: Laura Nield

Tel: 395 0492

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 24th March 2009

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 Throughout this municipal year, the Scrutiny Board (Health) have received performance reports relating to issues within the board's remit, from both NHS Leeds and Leeds City Council on a quarterly basis.

1.2 At the board's meeting in January 2009 it was decided that in the future a joint report from both organisations should be presented. This is the first of these joint reports.

2.0 PERFORMANCE MATTERS

2.1 The officers from NHS Leeds and Leeds City Council will attend the meeting to present the key issues highlighted by the attached report and to address any specific questions identified by the Scrutiny Board.

3.0 RECOMMENDATIONS

3.1 The Board is requested to consider the information provided in this report and the attached report and determine any matters that require any further scrutiny.

4.0 BACKGROUND PAPERS

4.1 None

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Health Scrutiny Board
Joint Performance Report

March 2009

Health Scrutiny Board Joint Performance Report – March 2009

Overview

This is the first Leeds City Council/NHS Leeds joint performance report. The principle of a joint report has been established to align performance reporting, with the aims of

- Reducing duplication
- Eliminating potential confusion
- Streamlining documentation
- Bringing closer together the performance teams/functions from both organisations

The work to totally integrate the two separate reports is still in progress, therefore as a first step, on this occasion this document simply pulls the two reports under the same cover. The intention is that the report will over time, move toward a single style and format. It is planned that this will happen during the early part of the 2009/10 year, following joint work between the two performance teams.

The content of the report will be tailored to meet the requirements of the national reporting systems, ensuring that that the Health Scrutiny Board is fully involved in the process. This will deliver a report that is of best use to the Board, providing assurance where required. The working approach is to report by exception, except for top level indicators, which will be reported on each occasion. One of the other key considerations will be to develop a clearer understanding of the timings of the performance report data from the NHS and Leeds City Council (LCC), so that the reports will present the most recent data possible.

The plan now is for the two performance teams to work together to develop the format of future Health Scrutiny reports, detailing the specific content and to prepare a draft report in readiness for the April Health Scrutiny Board.

Executive Summary – Performance Information

The NHS Leeds information that is provided here is the latest published data (as at 12 Feb 2009), at the time this joint report was drawn up. Further verbal updates can be provided at the meeting of the Scrutiny Board, if required.

The LCC information is based on data from the quarter 3 performance report (as at 31st December 2008).

There are several performance indicators that are delivering weaker performance than planned. Some of these indicators are already well known to the Board, whilst others are becoming clearer as definitions are made available. The key performance points are -

- **Health Care Associated Infections (HCAIs)**
  This heading covers the reports on the rate of C.difficile and of MRSA, shown separately within the body of the report.

  MRSA numbers continue to breach the minimum standards, both for each month and for the whole year. Cases continue to occur across a wide range of specialties. In some cases, where policies and procedures have not been followed, disciplinary action has been taken.

C.diff rates are also similarly high and the annual target has not been achieved. A slight downward trend overall is evident, attributed to the application of antibiotic protocols and better isolation facilities.

A visit by the Department of Health (DH) to Leeds Teaching Hospitals Trust (LTHT) identified specific issues and recommended actions, which are now being progressed by the hospital. These include improved staff compliance with policies. A contractual Performance Notice has been issued to LTHT; this action carries a significant financial penalty. The exact details of how this will apply are still being worked out, though are likely to impact on the development of the NHS Leeds contract with LTHT for next year.

- **Childhood immunisation programme**
  Performance continues below required levels. As reported previously, the most significant issue is with levels of coverage for the MMR vaccine. There are two difficulties here, the first is the accurate capture of data and the second is one of poor uptake. There is an update on the actions described in the previous report.

- **Early intervention service**
  The Board have heard previously that performance in this area is lower than planned. The issue is again featured to maintain focus. The year to date performance is still below the target trajectory. It is anticipated that the extra funding agreed to support this work will realise improved levels of performance, although it is now clear that this alone will not meet the target. The use of an estimated element, covering patients transferred who would not be counted otherwise, will be used as in previous years. Coupled with the increase in activity, this should see the target achieved.

- **13 and 26 Weeks**
  There were no 13 week breaches during December 2008, but the 26 week position is still not resolved. Due to the complex nature of some of the clinical considerations surrounding such cases, the challenge remains to secure additional capacity with alternative providers and to ensure it is used to minimise breaches, whilst LTHT deliver planned activity increases.

- **Delayed discharges**
  The data on delayed discharges is one of the areas in which previously different definitions has resulted in different positions being reported. Whilst further clarification of the definition is being sought from the Audit Commission and from the Department of Health, the NHS definition only is being used, as the single illustration of performance. As the NHS is the lead organisation for the indicator, at this time this is felt to be a reasonable course of action.

Report prepared by:

Graham Brown NHS Leeds
Marilyn Summers Leeds City Council

26 Feb 2009

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 NHS Leeds. The performance trajectory draws from the plan agreed with the Strategic Health Authority (SHA) for delivery of the operational targets.

The target position for delivery of 18 weeks was not totally achieved for November, partly due to backlog clearance issues, though subject to validation the target has been achieved for December. This performance in November will not affect the ratings under the Annual Health Check, which is based on achievement from January to March inclusive.

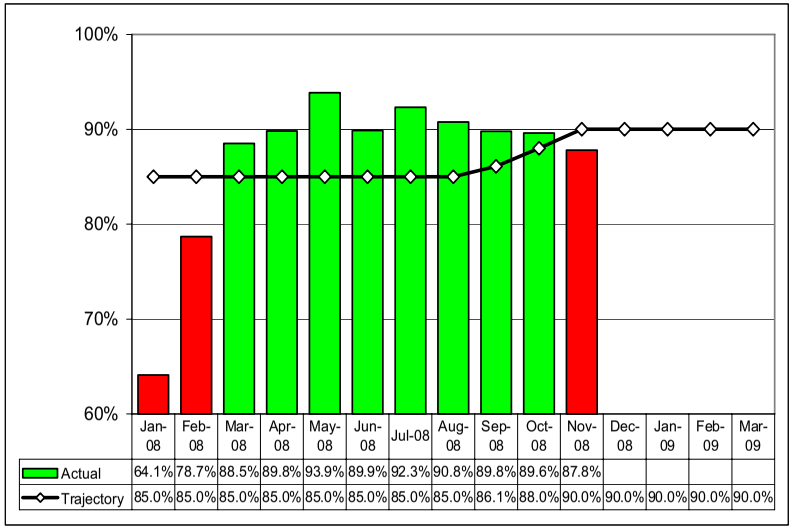
There are risks around achievement into January, due to increases in elective referrals since September, particularly in some specialties, Ear, Nose and Throat (ENT) being one. The issues relate both to specialty and sub-specialty level capacity and to very specific constraints within highly complex sub-specialties. This latter set of issues has been escalated to the SHA for discussion in national commissioning forums.

To address the potential capacity issues, LTHT have increased their capacity through their own consultants providing additional sessions. In addition independent sector providers are working with both LTHT and NHS Leeds to relieve pressure in risk areas such as in ENT, gynaecology and general surgery.

Lead Executive Director:	Matt Walsh
Management Lead:	Nigel Gray
Operational Lead:	Ruth Middleton

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

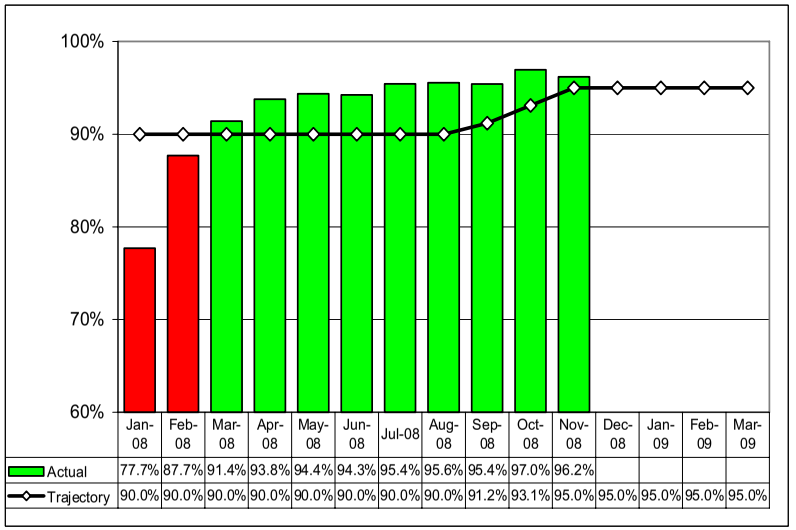
Percentage of patients seen within 18 weeks - admitted



	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%	93.9%	89.9%	92.3%	90.8%	89.8%	89.6%	87.8%				
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%

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%	94.4%	94.3%	95.4%	95.6%	95.4%	97.0%	96.2%				
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%

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.

The number of breaches has fallen dramatically over the period since August. Given the position in the early part of the year this is a significant achievement.

There was one breach reported for November and two in December against a target of zero. The November breach was from Neurophysiology and the December breaches were both imaging.

Examples of the circumstances of the breaches were, in one case the referral was not received until two days before the breach date leaving no capacity at such short notice. Both of the December breaches were administration errors generated by temporary staff. Lessons on all of the breaches have been drawn and will enable the teams at LTHT to ensure that risks are identified at an earlier stage and minimise the risk of breaches in future.

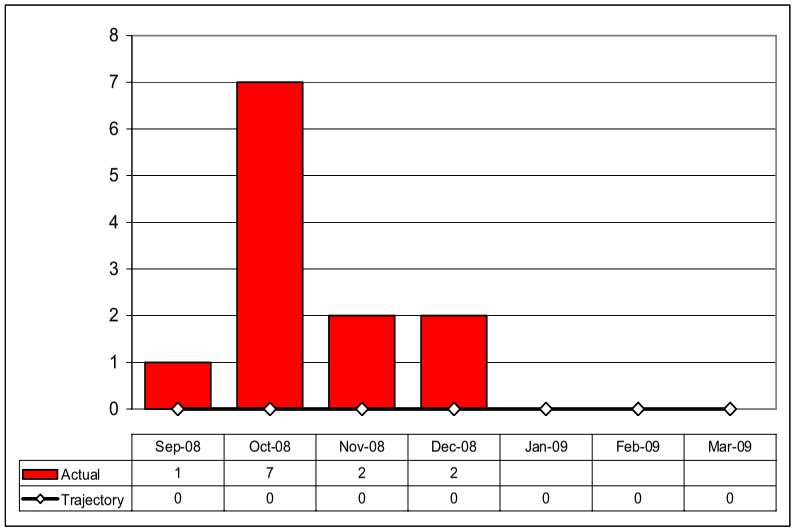
The November and December position represents the final stages in embedding the culture of no breaches. There is no evidence that the breaches are indicative of a wider system failure, but more a matter of ensuring that all the possible eventualities and possibilities for breaches to occur have been addressed.

The chart data shows breaches of the minimum standard from September 08 only, due the very low numbers occurring since that time, compared to the start of the financial year, when for example around 770 patients waited longer than 6 weeks.

Lead Executive Director: Matt Walsh
Management Lead: Nigel Gray
Operational Lead: Ruth Middleton

Waits for diagnostics to be reduced to 6 weeks maximum

Number of patients waiting 6+ weeks for 15 key diagnostics



	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
Actual	1	7	2	2			
Trajectory	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 were no 13week breaches during Dec, shown as a green numeral in the top chart. There were 6x26 wk breaches each in both Neurosurgery and Plastic Surgery. Additionally, a breach in General Surgery occurred, due to both the complexity of care required and the cancellation of a theatre slot. A further breach also occurred in the independent sector. Actions include:

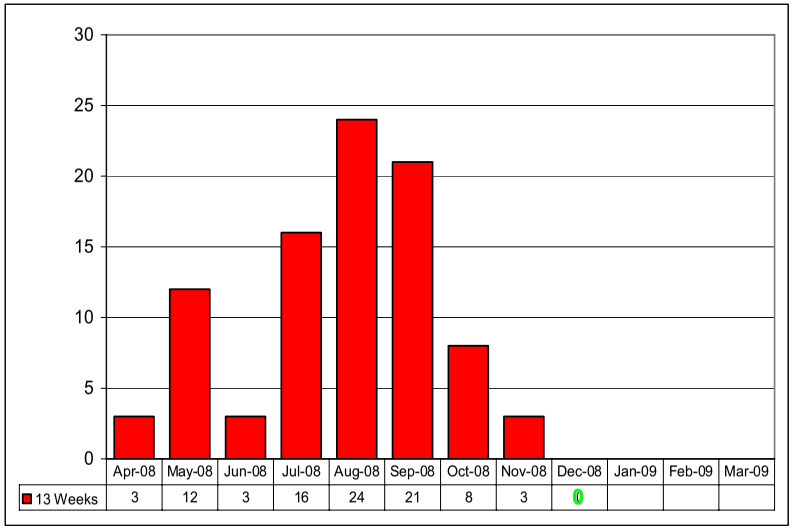
- Discussions with other PCTs to stem the flow of referrals into the Neurosurgery service.
- Expansion of the Spinal Assessment Service, to filter for the LTHT Neurosurgery service.
- Associate PCTs have been encouraged to re-direct patients to alternative providers.
- Transfer work to the local Independent Sector.
- The PCT is initiating an Any Willing Provider procurement process to assess if alternative provision can be found.
- LTHT are progressing with plans to increase the level of capacity provided for neurosurgery locally, though it is not envisaged that the level of LTHT capacity LTHT will improve until June 2009.

Plastic Surgery remains a key risk in respect of 26week breaches, with the main area of capacity constraint being reconstructive limb surgery. A capacity review has been undertaken, which is likely to suggest significant additional consultant investment in plastic surgery at LTHT. The issue of one surgeon being used as a national resource remains, with discussions on how this work can be re-classified as a Nationally Specialist Commissioned Service ongoing

Lead Executive Director:	Matt Walsh
Management Lead:	Kevin Gallacher
Operational Lead:	Neil Hales, Richard Wall & Claire Walker

Ensure a maximum wait of 13 weeks for outpatients

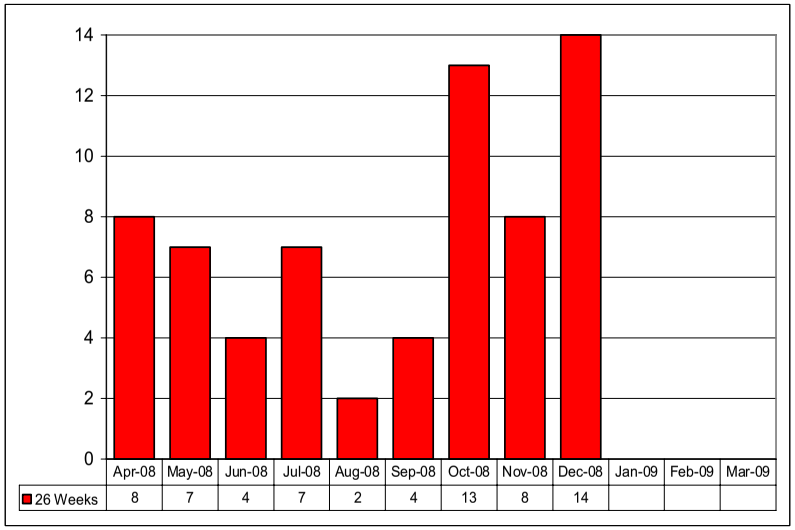
Number of outpatients breaching 13+ weeks at each month-end



	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
13 Weeks	3	12	3	16	24	21	8	3	0			

Ensure a maximum wait of 26 weeks for inpatients

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



	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09
26 Weeks	8	7	4	7	2	4	13	8	14			

18 weeks standards

18 week supporting indicator: GP referrals for outpatient (general & acute)

Target:

No specific target; the intention being to support decision making around the demand and capacity needed to deliver and sustain a maximum 18 week wait time.

Since about March 2008 there has been a step change in the level of GP referrals being recorded as received by Trusts.

Some of this can be attributed to better counting, for instance, NHS Leeds' Care Services did not start reporting referrals received until last spring. The drive to improve the completeness and accuracy of recording has been due to the stringent requirements associated with monitoring 18-week waits. There have also been practice changes, for example where consultant to consultant referrals within secondary care are being reduced. Patients are being referred back to their GP, who could then choose to make another referral to secondary care.

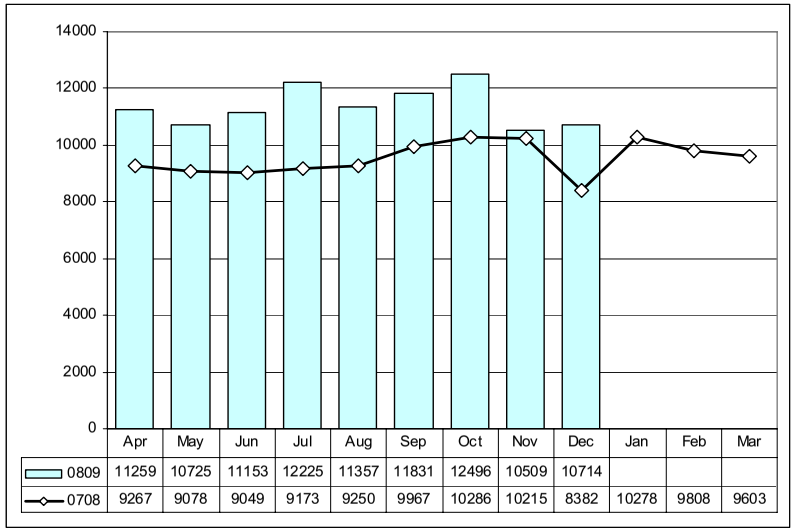
However, there is no doubt that a significant proportion of the step change is due to real demand increases. A wide range of factors are understood to be contributing to this, for example, shorter waits, increased patient awareness, 'free choice' and thus easier access to treatment, clinical guidelines improving treatment pathways and less use of private healthcare. Whilst the step increase is visible at a city level it is much less so at the daily, individual GP and practice level.

It is the intention to engage Practice Based Commissioners in understanding the true nature of the increase in demand, ensure it is appropriate and to identify and increase alternatives to referrals to secondary care. Further reports will be provided as appropriate.

Lead Executive Director: Lynton Tremayne
Management Lead: Alastair Cartwright
Operational Lead: Alastair Cartwright

18 weeks

18 week supporting indicator: GP referrals for outpatient - G&A



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
0809	11259	10725	11153	12225	11357	11831	12496	10509	10714			
0708	9267	9078	9049	9173	9250	9967	10286	10215	8382	10278	9808	9603

18 weeks standards

Maximise the use of the Choose & Book system

Target:

To secure 90% usage of Choose & Book system, in line with the Atos report.

Data for December showed performance at 26%, slightly down on November, mirroring the national data, with only 9 of 152 PCTs improving their performance. However, data for January so far shows that performance is running at 33-35%.

A Joint Programme Manager for NHS Leeds and LTHT has been appointed. One of the first tasks of the Manager is to produce a detailed plan to show how delivery of recommendations in the Atos report will be achieved.

In the meantime, work on GP uptake and inclusion of community services on Choose and Book (C&B) menus continues. Only 2 Leeds practices are not engaging in the use of Choose and Book. LTHT have 95% of eligible services available directly, the remainder as indirectly bookable.

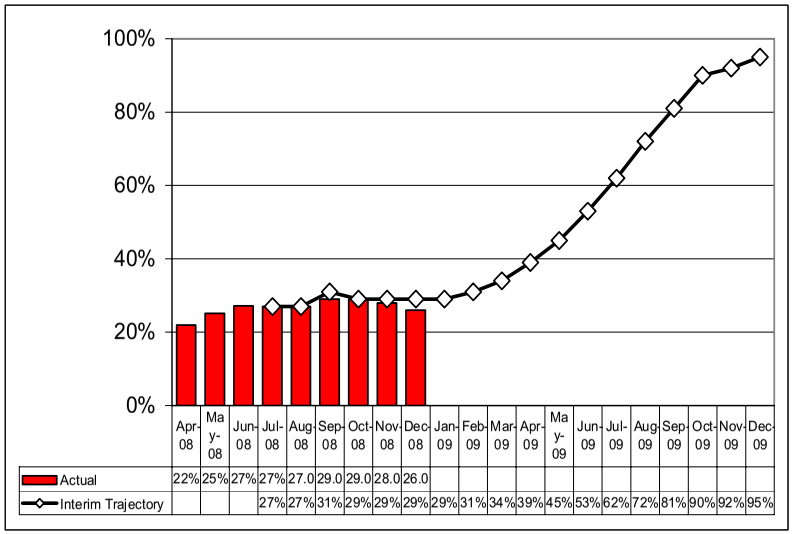
Additional actions being undertaken to improve the use of the C&B include

- NHS Leeds' Spinal Assessment Clinic went live as an indirectly bookable service on 19th January.
- It is expected that the remaining Musculo-skeletal Direct Access services will go live as indirectly bookable services by the end of February.
- Assessment for bariatric surgery will go live as an indirectly bookable service by the end of February.
- General Paediatric services (Chics clinics) expected to go live in Feb.
- LES payments have been calculated and agreed for Q2, payment in Jan.
- LTHT direct access diagnostic services are being scoped.
- LTHT are reviewing the number of patients who did not attend (DNAs).
- The format of referral letters is presenting issues. This is resulting in rejection due to the unworkable operational process.

Lead Executive Director: Matt Walsh
Management Lead: Philip Grant
Operational Lead: Rob Goodyear

Choose and Book

Percentage of outpatient bookings made using the Choose & Book system



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 98% patients seen.

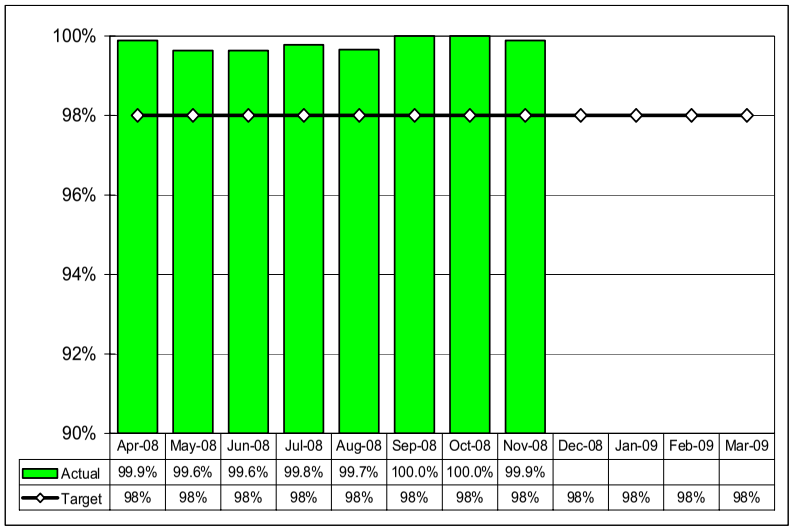
The validated position for November is 100% for both NHS Leeds and all patients to LTHT. The projected December position is also to achieve the target of 100%.

Implementing the 'no adjustments' processes from the 'Going Further on Cancer Waits' standards from 1 January, is impacting on achievement of the target in January. The estimated January position is 93.4% with 33 breaches out of 499 patients so far this month.

The main issues seem to be around patients wanting appointments outside the 14 day target period. Data is being collected to verify the position. There is an agreement to maintain the current method of offering patient choice, but NHS Leeds is to write to all GPs emphasising the importance of patients being aware of the need to attend their 1st appointment within 14 days. In addition, the script that LTHT Referral and Booking Service use with patients has been strengthened to emphasise the urgent referral status and the need to be free to attend within 14 days.

Access to Cancer Services

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



	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	99.9%	99.6%	99.6%	99.8%	99.7%	100.0%	100.0%	99.9%				
Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%

Lead Executive Director: Matt Walsh
Management Lead: Nigel Gray
Operational Lead: Sandra Frier

Cancer wait times

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

Target:

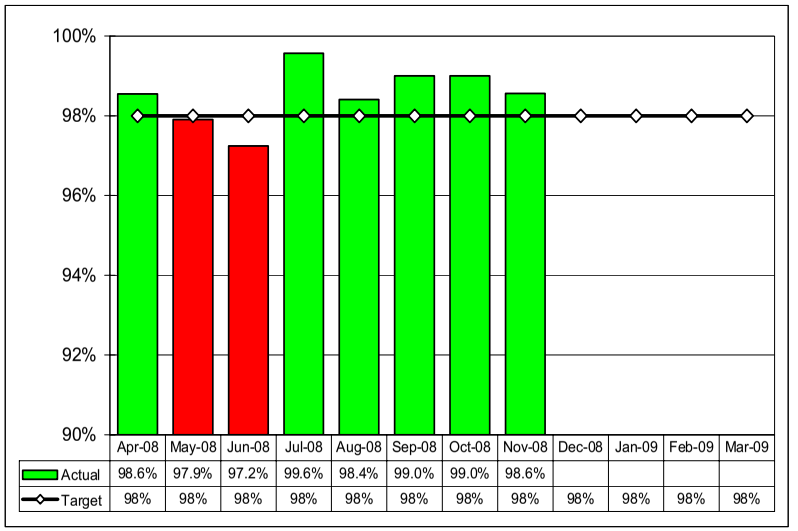
That there be a maximum wait time of 31 days from diagnosis of cancer to the beginning of treatment , with a target of 98% of patients seen.

The validated position for November is 99% for all patients to LTHT. There were a total of 4 breaches across skin, lung and HPB out of 303 cases.

The December, yet to be validated, position is 98% for all patients to LTHT and the projected January 09 position is 98.5% with 3 breaches out of 204 patients as at 26 January.

Access to Cancer Services

Percentage of patients receiving treatment within 31 days of diagnosis



	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	98.6%	97.9%	97.2%	99.6%	98.4%	99.0%	99.0%	98.6%				
Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%

Lead Executive Director: Matt Walsh
Management Lead: Nigel Gray
Operational Lead: Sandra Frier

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% of patients seen.

The November position is that 92% was achieved. There were 10 patients who breached, across a range of tumour groups out of 103 cases. December performance is projected to be around 88% (14.5 breaches out of 150 cases). Of the breaches, 9 relate to Leeds patients. The remaining breaches relate to inter trust referrals. The January estimate (under the new rules, without adjustments) is 73%-74%. This position was made worse due to patient deferrals prior to the recent holidays.

DH confirmation of the required standard of performance within the revised definition is anticipated to be issued in May. It is thought that the revised national performance standard may be set at around 85%.

A key problem remains with lung surgery and inter trust referrals. From 26 January until the end of February, some lung cancer patients will be treated in the independent sector. This will free up resources at LTHT, coupled with specific actions to improve the lung pathway. These include:

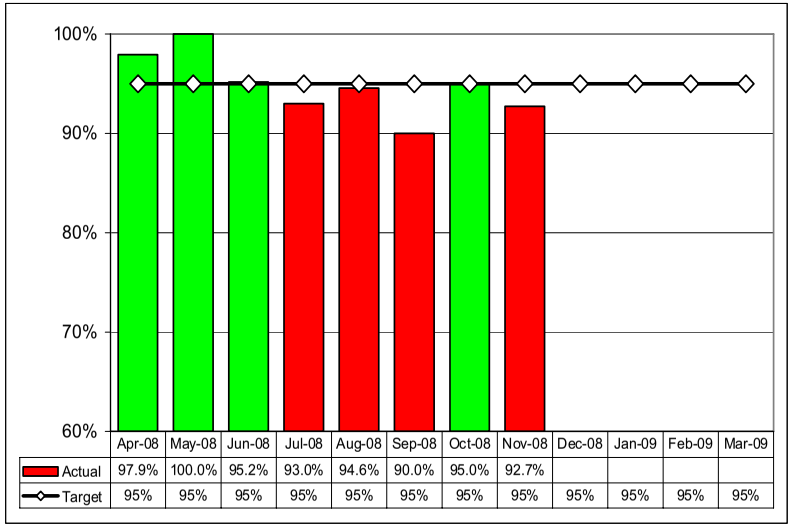
- Agreement of a timed patient pathway for lung cancer patients.
- Joint work with the YCN to achieve early successes during February and March, including addressing the issue of inter trust referrals.

This has already resulted in a reduction in the waits for inpatients from 6 to 2 weeks. This is aimed to reduce to 1 week. There is also a similar reduction for outpatients from 6 to just 1 week. These and other actions being taken to improve patient pathways and escalation processes will result in sustainable improvements in performance from February onwards.

Lead Executive Director: Matt Walsh
Management Lead: Nigel Gray
Operational Lead: Sandra Frier

Access to Cancer Services

Percentage of patients receiving treatment within 62 days of referral



	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	97.9%	100.0%	95.2%	93.0%	94.6%	90.0%	95.0%	92.7%				
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

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.

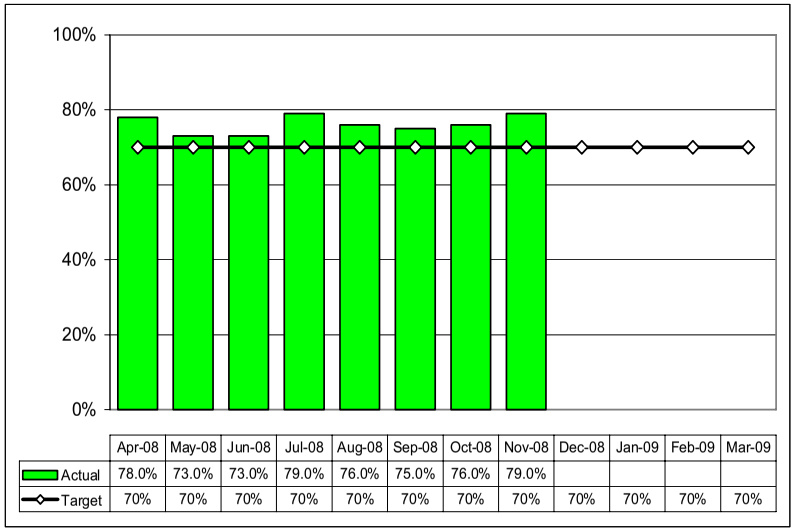
Breast screening uptake continues to meet the target. The Breast Screening programme is now looking to reach gold standard of 80%. The breast screening programme was previously not meeting round length target (90% of women screened in 36 months), but has now sustained this target.

Work with voluntary and community groups to promote screening has also begun, including with Women's Health Matters and Age Concern. One focus is on screening women over the age of 70, who presently self refer, given that risk increases with age.

Development of a locally enhanced GP service (LES) with practices is also being explored. A drug company is supporting a project to target practices that have low uptake and fall within the 10% highest deprivation areas.

Access to Cancer Services

Women offered breast screening



	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	78.0%	73.0%	73.0%	79.0%	76.0%	75.0%	76.0%	79.0%				
Target	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%

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.

There have been 11 cases of MRSA in January (to date). There have been 102 cases this financial year. Cases occurred within Critical Care Medicine, General Medicine, General Surgery, Elderly Medicine and Nephrology. This means that the total annual target of 72 cases has been breached.

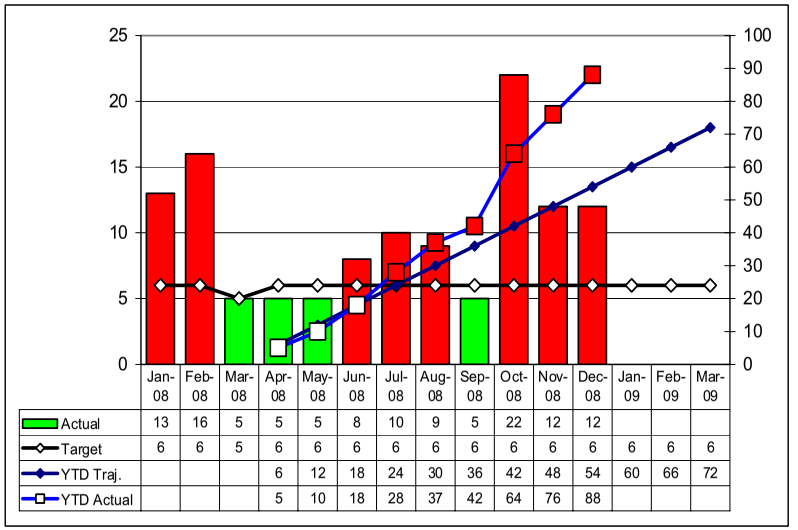
Recommendations for improving infection control processes were made following a further DH visit in December. A revised action plan has been developed and support (resources and staff) from the DH will be provided to improve staff compliance with infection control policies. There is a considerable amount of work being undertaken to reduce HCAIs, but the number of bacteraemia remains high. Disciplinary procedures are being invoked where agreed procedures are not being followed.

DH, SHA and NHS Leeds are working with LTHT to ensure a robust system of root cause analysis is in place across the health care community. Actions are being taken to ensure that policies are communicated effectively and they are followed by health care staff.

As reported at the last Board meeting, a Performance Notice was issued to LTHT in January in relation to HCAIs. The precise level of the financial penalty is currently being determined in conjunction with the process of finalisation of next year's LTHT contract.

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	5	5	5	8	10	9	5	22	12	12			
Target	6	6	5	6	6	6	6	6	6	6	6	6	6	6	6
YTD Traj.				6	12	18	24	30	36	42	48	54	60	66	72
YTD Actual				5	10	18	28	37	42	64	76	88			

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

Health care associated infections standards

Incidence of Clostridium Difficile

Target:

That NHS Leeds 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.

There have been 77 cases in the city in January to date, 14 from LPFT and the community and 63 from LTHT, an improvement from 94 in December. The level for the community has been constant during this year and the overall trend in LTHT is downward, most likely a positive result of increasing compliance with antibiotic protocols and the introduction of more isolation capacity. All community cases are investigated using root cause analysis techniques, which has found associations between antibiotic use and hospital admission.

Recommendations for improving infection control processes were made following a further DH visit in December 2008. A revised LTHT action plan has been developed and support (resources and staff) from the DH will be provided to improve staff compliance with infection control policies.

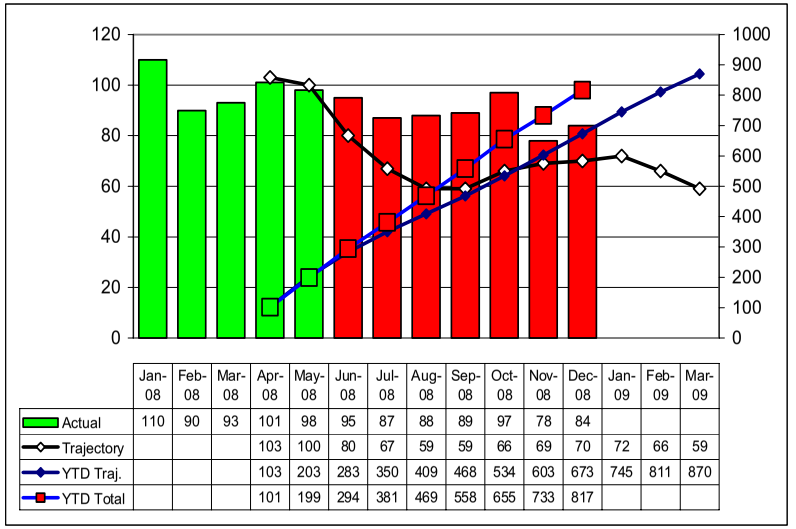
LTHT has a set of policies and procedures relating to HCAIs, including having in place procedures relating to antibiotic prescribing. There is a renewed emphasis on making sure these are followed, with a programme of feedback to clinicians, helping in the process of education and training and in identifying bad practice that can be eliminated.

For the community there is continued emphasis on implementation of rigorous infection control, and a community-level antibiotic policy is to be developed. As part of this, work is ongoing with LTHT to ensure a coherent approach to prescribing antibiotics across the health economy as well as to identify good practice from other PCTs.

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

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	87	88	89	97	78	84			
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	381	469	558	655	733	817			

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.

100% of practices met the target in the final quarterly survey of January 2009.

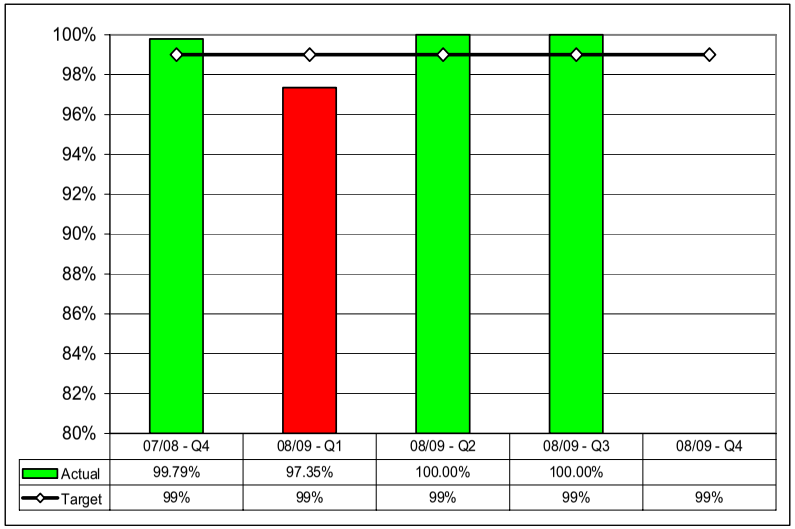
The way in which access to primary care is recorded and measured will change with effect from April 2009.

Further guidance is still awaited regarding the timescales and reporting mechanisms but it is clear there will no longer be a requirement to undertake the quarterly survey, as in the past.

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

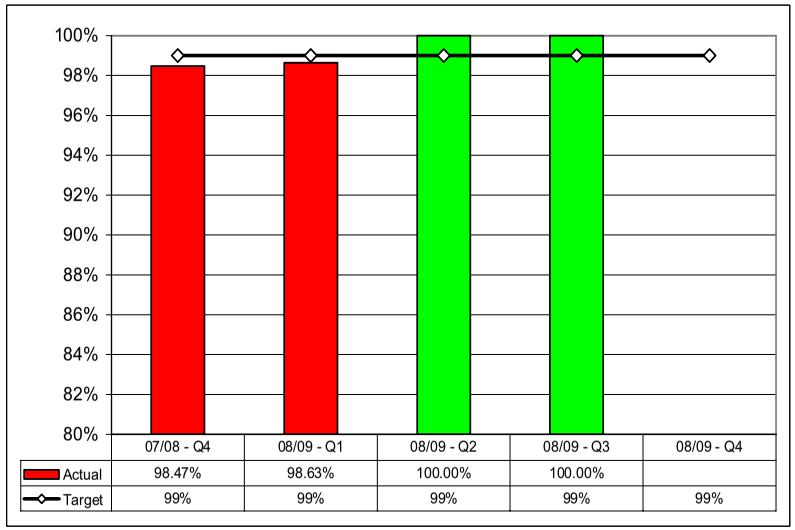
Primary Care Access

48 Hour Access to a GP



Primary Care Access

24 Hour Access to a PCP



Primary care access standards

Access to primary care

Target:

At least 50% of GP practices in NHS Leeds offer extended opening hours by December 2008.

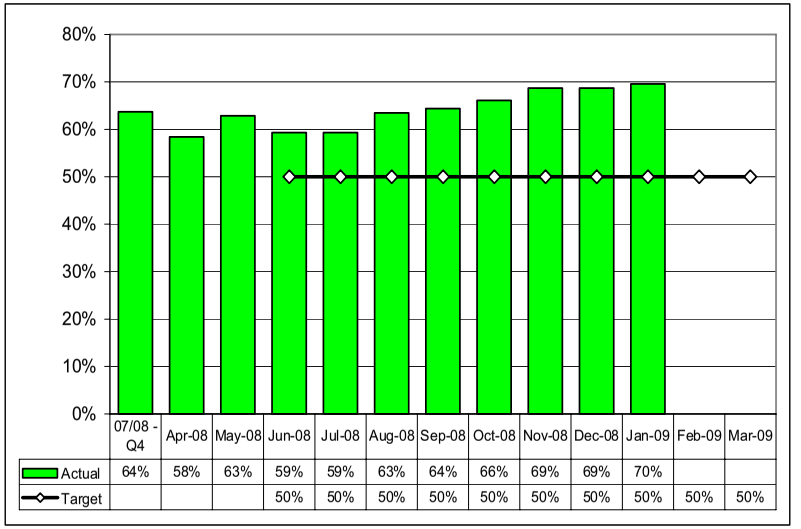
80 (69%)practices now offer extended opening to their patients, an increase of 1 since December 08.

NHS Leeds met the DH target of 50% practices offering extended hours by 31 December 2008, however a monthly submission is required until the end of the complete trajectory in March 2009.

A number of other practices have also indicated their wish to extend their opening hours in early 2009, which will improve the position still further.

Primary Care Access

Family Friendly Hours



	07/08 - Q4	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%	58%	63%	59%	59%	63%	64%	66%	69%	69%	70%		
Target				50%	50%	50%	50%	50%	50%	50%	50%	50%	50%

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

Primary care access standards

Access to primary dental services

Target:

To increase the number of patients receiving primary dental services across NHS Leeds to 415,000 during the year, from a baseline set in the 24 month period to March 2006 of 414,947.

The trajectory does not reflect events from Apr 2006, when a significant number of dentals left the NHS. The numbers of patients being treated in the previous 24 months dropped from a baseline of 414,947 in Mar 2006, to 394,359 in Jun 2008.

There is confidence that from 2010 targets can be achieved. 2008/09 however is proving to be extremely challenging.

A three pronged approach to increasing capacity is in place:

- The offer of additional activity to existing NHS dentists.
- The procurement exercise to offer all Leeds dentists (NHS and private) the opportunity to bid for additional NHS sessions for Leeds Dental Advice Line (LDAL) patients.
- The £2.75m proposal for new services in areas with high needs is approved, with procurement underway, with services in place by Sep 09.

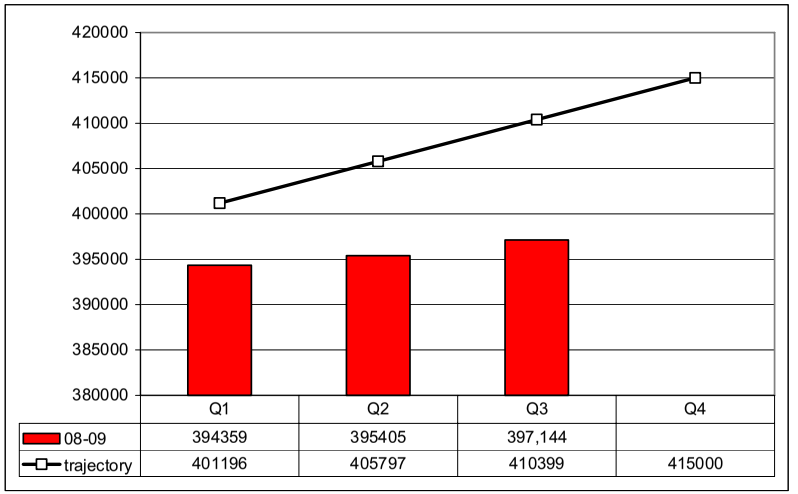
As a result of the new procurement activity, there has been a large increase in requests for NHS dentistry through LDAL. The increase in capacity means that additional demand has been met, without extending waiting times. There are currently 34 NHS dental practices across the city accepting new NHS patients – higher than at any stage since the new contracts were introduced.

Patients receiving treatment in the new services can only be counted in the data if they have not previously received NHS dental treatment in the previous 24 months. Despite this, numbers are already starting to recover. The figure for December 2008 was 397,144. It is anticipated that numbers will increase still further due to the additional capacity.

Lead Executive Director: Matt Walsh
Management Lead: Damian Riley
Operational Lead: Steve Laville

Primary Care

Access to primary dental services



	Q1	Q2	Q3	Q4
08-09	394359	395405	397,144	
trajectory	401196	405797	410399	415000

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

This indicator now includes screens carried out in primary care. The number of these screens tops-up the known validated number conducted within the national screening programme.

The Q3 trajectory was exceeded. The trajectory is 15535, and actual screens to date 18,264, representing 118% of final target.

There are some risks to performance, into next year including –

- Health Advisor post vacancy generating potential disruption to the clinical side of the service.
- Premises situation critical – very limited office space for programme staff.
- Introduction of the 'closed' NHS information system in April brings potential risks around data use for chlamydia programme.

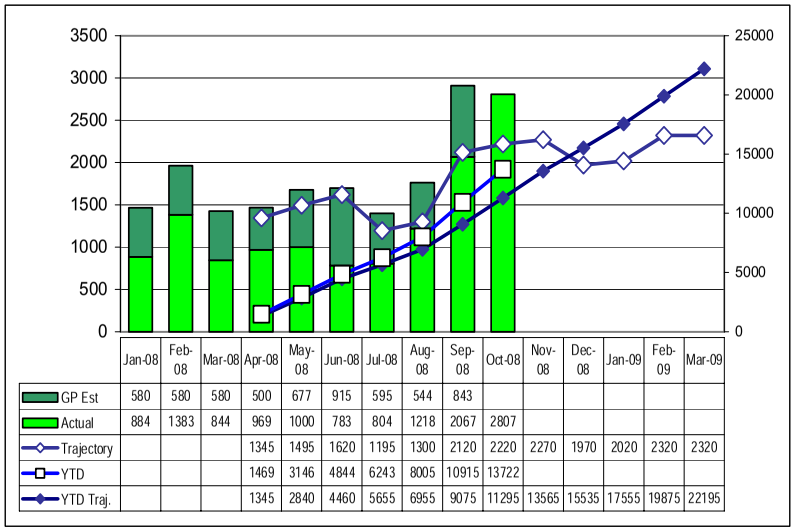
Actions to improve performance still further include:

- CaSH to manage clinical aspect of Chlamydia programme. Public health to lead and manage screening.
- Recruit to Health Advisor vacancy, temporary cover in place. .
- Working with H3+, and a locally enhanced GP service (LES) developed to incentivise GPs for chlamydia opportunistic testing. Planned launch March 09, LES to be operational from April.
- Service Level Agreement (SLA) with Leeds Prisons finalised.
- IT informed of potential risks to Chlamydia programme re closed system. Guidance sought from the Health Protection Agency on preferred option.
- Band 3 admin worker recruited to programme.

Lead Executive Director: Ian Cameron
Management Lead: Victoria Eaton
Operational Lead: Sharon Foster

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	500	677	915	595	544	843						
Actual	884	1383	844	969	1000	783	804	1218	2067	2807					
Trajectory				1345	1495	1620	1195	1300	2120	2220	2270	1970	2020	2320	2320
YTD				1469	3146	4844	6243	8005	10915	13722					
YTD Traj.				1345	2840	4460	5655	6955	9075	11295	13565	15535	17555	19875	22195

Sexual health programme standards

Access to Genitourinary Medicine (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). 84% of patients should be seen within 48hrs

The 'Offered an appointment' target remains at 100%.There has been a recent improvement in the 'Seen within' target, with achievement currently at 88.02%. Problems with sick leave for nursing staff in December led to the cancellation of nurse led clinics, meaning the seen target did not increase as much as expected.

The DNA rate was 10.23%, though seems now to be falling, now at 10%. Text reminders are being sent to all new appointments with a facility for patients to text into the department if they need to cancel which will be picked up by e-mail.

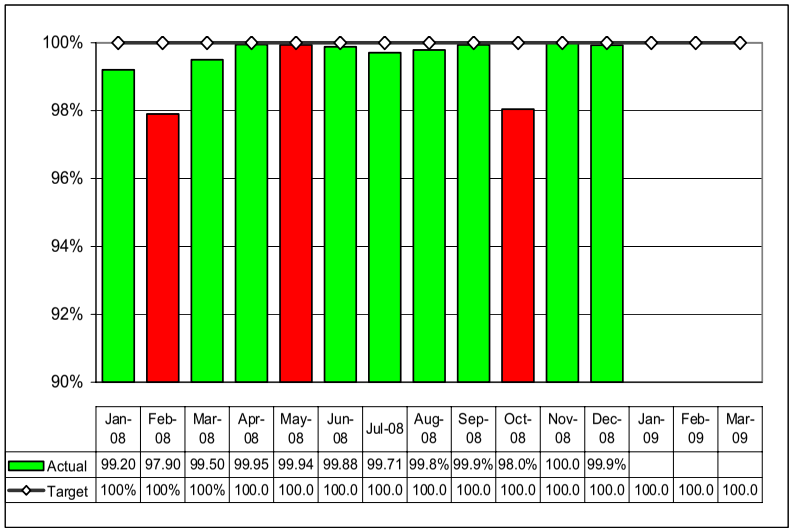
Points to improve the seen within target include –

- The Nurse situation has improved and the clinics are now up to full complement and able to accommodate any sickness
- Have just appointed 2 Band 5's plus a full time H/A
- Appointment to Band 6 has failed, but post will not be re-advertised. To recruit from previous applicants.
- Intending to be up to full establishment by March 09.
- Demand over the Xmas period fell.

Plans to address this target include aiming to sustainably achieve the 84% minimum seen by March 09.

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	99.95	99.94	99.88	99.71	99.8%	99.9%	98.0%	100.0	99.9%			
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

Please note that the data shown for Dec is preliminary data only and will be validated for the next version of this report

Lead Executive Director: Ian Cameron
Management Lead: Victoria Eaton
Operational Lead: Sharon Foster

Sexual health programme standards

Teenage pregnancy rates

Target:

The rate of under-18 conception rates should reduce by at least half by 2010, set against the 1998 baseline, locally by 55%.

The latest formally validated figure (for 2006) is 50.9; 0.9% above the 1998 baseline. This is a slight increase since the last report due to revalidation. This indicator has been highlighted as high risk of not being achieved. Further information is in the report 'Update on current interventions to reduce teenage pregnancy', also before the Board on this occasion.

The graph shows the rolling quarterly average rate for Q1 & Q3 of 2007 (the data shown is provisional and not fully validated). This data is used to give the best available picture of progress in the times between officially confirmed annual data becoming available. The next annual, fully validated figure will be published in Feb 2009, covering the whole of 2007.

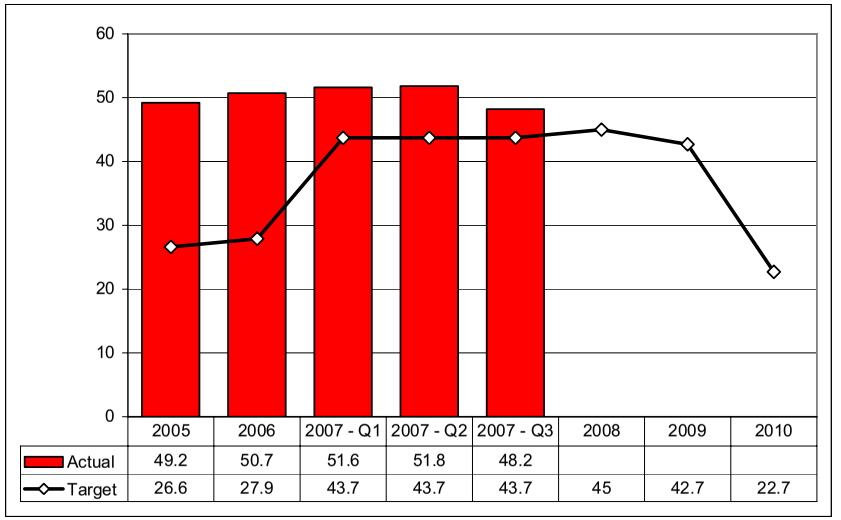
A development for the management of the service is that from 1 April 2008, data is collected on bookings for NHS services at LTHT, in line with the 'Maternity Matters' programme. This data makes information on teenage pregnancies available. Early use of this data shows it should allow comparison with previous data from other similar sources. The data itself is not directly comparable with the national data used in the chart, and which is used by DH and the Healthcare Commission for the purposes of monitoring NHS Leeds against the national target. However, as it builds up over time it will allow the appropriate management action in the targeting of resources.

It is hoped that as this data collection becomes more robust, and even though it is limited to information from LTHT, it could be used as an early indication of teenage conceptions and trends and could be used in conjunction with the national-level data.

Lead Executive Director: Jill Copeland
Management Lead: Sarah Sinclair
Operational Lead: Martin Ford

Sexual Health

Teenage pregnancy rates per 1000 females aged 15-17



	2005	2006	2007 - Q1	2007 - Q2	2007 - Q3	2008	2009	2010
Actual	49.2	50.7	51.6	51.8	48.2			
Target	26.6	27.9	43.7	43.7	43.7	45	42.7	22.7

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 cumulative performance as of 29 January is 98.43%, remaining above the minimum target standard. Performance during December and January has been on the decline.

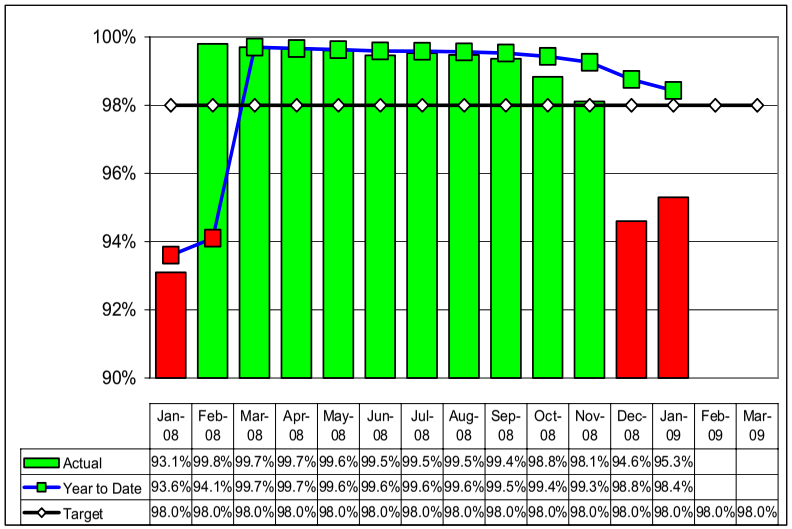
Reasons for this include high bed occupancy levels, high levels of partially and fully restricted wards in LTHT due to viral infections, staff sickness absences, and high levels of attendances within concentrated periods of the day (although overall attendances are not significantly high when benchmarked).

NHS Leeds has been in regular contact with the team at LTHT, and have co-ordinated the input of out-of-hours GPs into A&E to alleviate pressure at times of peak demand, in addition to sustaining a public communications campaign to promote alternatives to A&E for minor injury and illness needs. Further action plans to provide capacity increases in community and acute settings are currently being progressed via the Unplanned Care Board, to ensure that the YTD target remains above 98%.

The activity from the Commuter Walk-in Centre in The Light is now contributing towards the 4hr target and is now 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%	99.5%	99.5%	99.4%	98.8%	98.1%	94.6%	95.3%		
Year to Date	93.6%	94.1%	99.7%	99.7%	99.6%	99.6%	99.6%	99.6%	99.5%	99.4%	99.3%	98.8%	98.4%		
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 8 min & Cat A 19 min standards; Cat A defined as immediately life-threatening

Target:

A minimum of 75% of Cat A calls should receive an emergency response at the scene within 8 mins and 95% of Cat A calls should be met within 19 mins of a request for a vehicle capable of transporting the patient.

Performance on these indicators is based on the whole ambulance service returns. The recent decline in performance is down to the impact of Call Connect. The performance management framework implemented by the SHA, with key actions for PCTs and NHS organisations is ongoing.

- Latest Cat A month to date performance was 68.61% (at 13/1/09) against a trajectory of 77%
- Demand in January has been variable with no clear pattern emerging as yet, but with spikes on individual days
- In terms of latest national performance, Yorkshire Ambulance Service (YAS) was positioned back down in the bottom 2 performing trusts.

It has been accepted by both the DH and SHA that the year-end position will fall short of 75%. This affects the region in the Annual Health Check ratings.

Progress is made through the following actions -

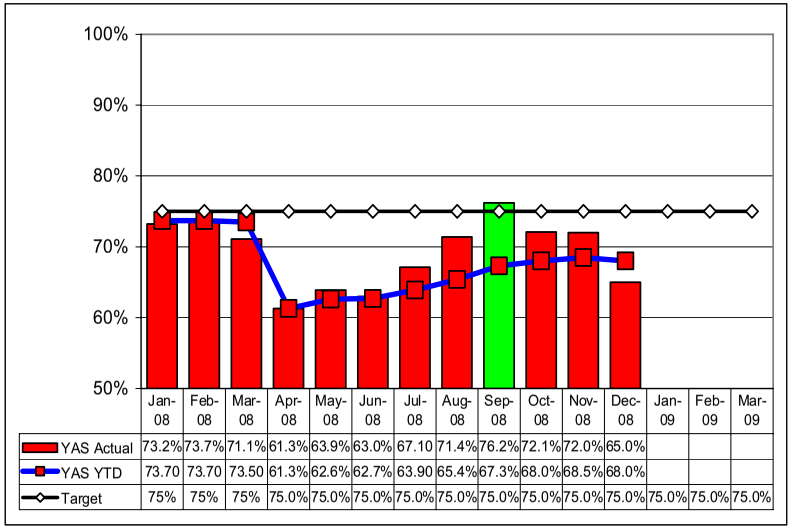
- A meeting is scheduled between PCT Chief Execs this week to agree PCT funding for the contract.
- The NHS Standard Contract meeting was held recently in London. The meeting reinforced actions still to be undertaken as part of finalising the contract and raised the issue of patient transport services (PTS) and contracting for 2010 onwards

The business case is being considered at the Chief Executive forum and is supported by NHS Leeds on the condition that it is linked to performance and is supported by a sustainability plan going into 2009/10.

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

Ambulance Response Times

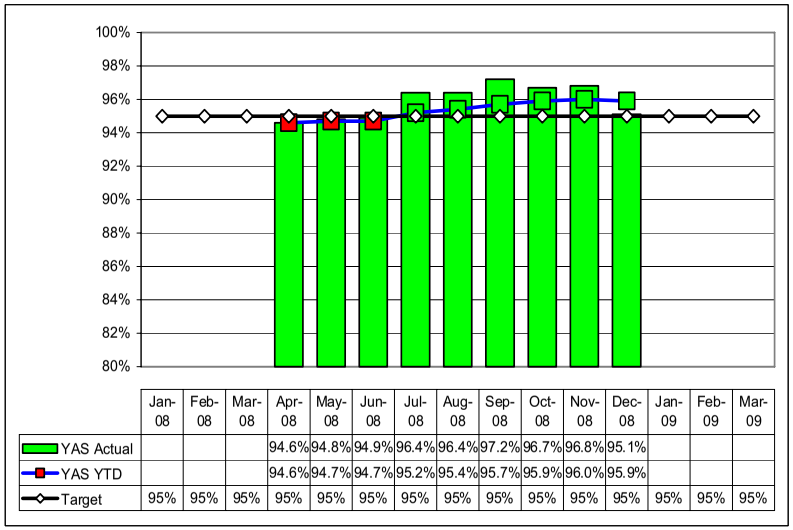
Category A calls receiving a first response within 8 minutes



	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%	61.3%	63.9%	63.0%	67.10	71.4%	76.2%	72.1%	72.0%	65.0%			
YAS YTD	73.70	73.70	73.50	61.3%	62.6%	62.7%	63.90	65.4%	67.3%	68.0%	68.5%	68.0%			
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 A 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				94.6%	94.8%	94.9%	96.4%	96.4%	97.2%	96.7%	96.8%	95.1%			
YAS YTD				94.6%	94.7%	94.7%	95.2%	95.4%	95.7%	95.9%	96.0%	95.9%			
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Urgent care standards

Ambulance response times: Cat B 19 min standards; Cat B defined as serious, but not immediately life-threatening

Target:

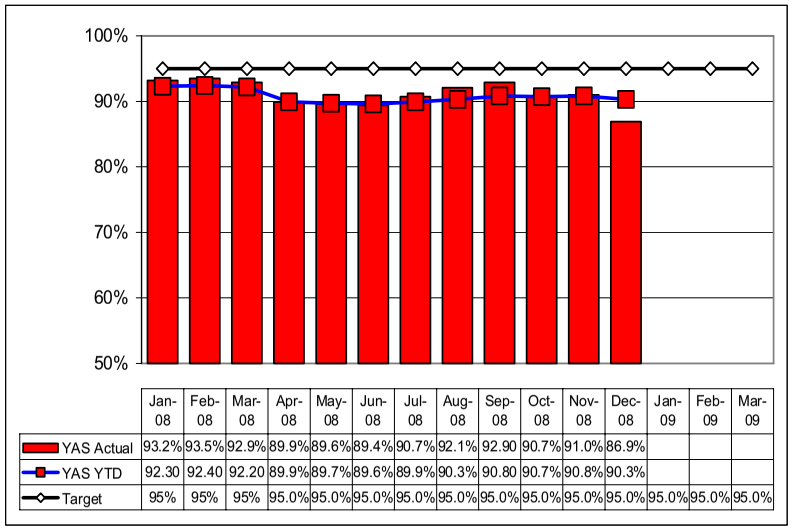
A minimum of 95% of Cat B calls should be met within 19 mins of a request for a vehicle capable of transporting the patient.

Performance on these indicators is based on the whole ambulance service returns.

On the Cat B target, Yorkshire Ambulance Service (YAS) performance as a whole is 90.3% year to date as of end of December 2008. Ongoing contract negotiations for 09-10 and the SHA performance management action plan will address this going forward, after the DH position on the future of this target has been confirmed, as there are discussions as to whether this target should be replaced by a more quality-focused indicator that takes account of clinical outcomes.

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%	89.9%	89.6%	89.4%	90.7%	92.1%	92.90	90.7%	91.0%	86.9%			
YAS YTD	92.30	92.40	92.20	89.9%	89.7%	89.6%	89.9%	90.3%	90.80	90.7%	90.8%	90.3%			
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%

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

Urgent care standards

Delayed transfers of care: Rate per 100,000 population

Target:

No identified target (beyond the Vital Sign trajectory used in the chart) at this time, with 2007/08 to be used to set a baseline in a method yet to be defined.

The indicator on delayed transfers of care (often known as delayed discharges) is under development. The plan is to move toward a system that measures the rate per 100,000 of the general population, as opposed to the rate per occupied acute bed day. The Healthcare Commission have not defined the indicator at the time of writing, but the direction of travel seems clear.

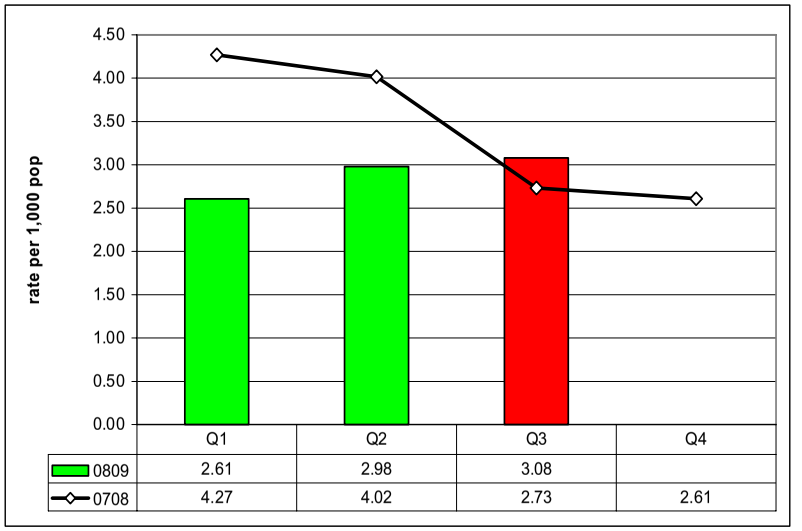
The number of delayed transfers of care in 2008/09 indicates a significant improvement on 2007/08, and performance against the trajectory in Q1-2 was well within the trajectory. However, the numbers of delayed transfers of care slightly increased in Q3 at the point when the trajectory reduced to 2.75 rate per 100,000.

The Unplanned Care Board has the discharge planning process as one of its key workstreams, and work will start in Jan 2009 to look at streamlining processes and examine how capacity is commissioned. Also from Jan, the Unplanned Care Operational Group will receive an information report collating numbers of bed days taken up with delays, as an accurate indicator of the impact. This Group continues to work on project areas to contain and reduce delays further. The commitment is to ensure that the target is delivered during Q4 through the work of these groups.

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

Urgent Care

Delayed transfers of care per 100,000 population



NHS Annual Health Check indicators reported by exception:

- **Commissioning of early intervention in psychosis services**
- **Proportion of individuals who complete immunisation by recommended ages**

Annual Health Check Standards

Commissioning of early intervention in psychosis services

Target:

To deliver the locally agreed share of the national target of 7,500 new cases of psychosis served by early intervention teams, 124 new cases as applied to Leeds PCT.

Additional funding of £220k was agreed in 2008/09 to enable the provider to meet the SHA target for Early Intervention (EI) Services by Mar 09.

The target for Leeds is 124; however the agreement with the provider was to deliver 111 new cases by Mar 09. This was based on what would be realistic, given the delay in funding (the provider only received increased funding in mid year, following a high level review by the PCT) and the historic uptake of the service which has been lower than the given target. The expectation was that there would be a minimum of 111 new cases by Mar 09.

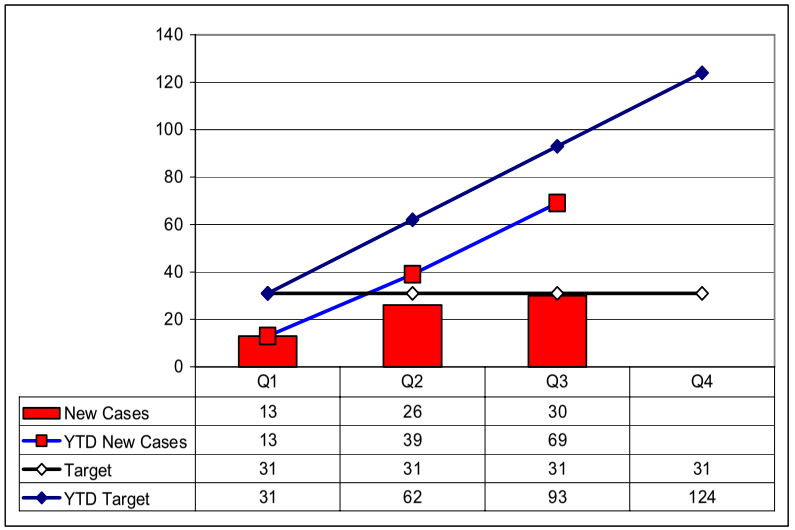
The target numbers are made up of two age groups, 14-25 and 25-35 years. The younger age group has been the group that has historically received the specialised service provided by Aspire. The older age group is the group that was expected to receive the service provided by the new money. Research showed that most of this group was within Leeds Partnership Foundation Trust (LPFT) teams. The plan was to move activity from LPFT to Aspire, though this has run into difficulty around the transfer of clients. This has adversely affected performance from Oct 08. Projected performance rates also show that it will be challenging to meet the target of 111 by Mar 09. Arrangements have been set up with the provider to ensure this target is met.

Aspire will reach the target number of 124 by Q1 09/10, if they deliver at current rates. This slip into 09/10 should be attributed to the delay in transfer of clients by LPFT. In the meantime, estimates of this delayed activity will be used, as in the past, which will see the target delivered by year-end 2008/09.

Lead Executive Director: Jill Copeland
Management Lead: Carol Cochrane
Operational Lead: Tabitha Arulampalam

Annual Health Check Standards

Commissioning of early intervention in psychosis services



	Q1	Q2	Q3	Q4
New Cases	13	26	30	
YTD New Cases	13	39	69	
Target	31	31	31	31
YTD Target	31	62	93	124

Annual Health Check Standards

Proportion of individuals who complete immunisation by recommended ages

Target:

To ensure that children are immunised in line with recommended levels of coverage, for a range of six key immunisation programmes

Child immunisation targets have not been achieved, due to lower than anticipated uptake and a discrepancy between actual and recorded childhood immunisation figures. In Q4, a concentrated effort is being made to achieve the national target. The Practice Development Team are targeting those due for vaccination. Also, health visitors who work part-time are to target hard to reach children and vaccinate in the home, where possible.

A piece of work to analyse the processes for immunisation and vaccination in terms of data collation and actual delivery is currently being scoped. It is anticipated that this study will highlight blockages or inadequacies in the process to allow improvements to be made.

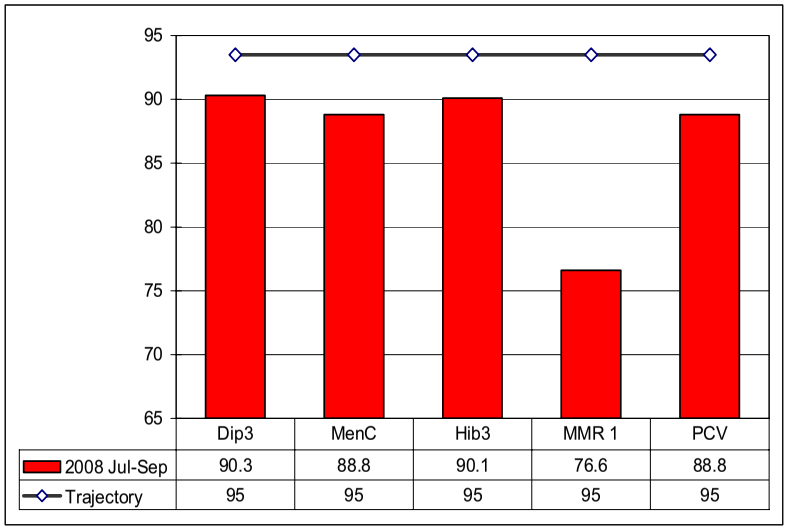
Work underway –.

- GPs are now undertaking the national MMR campaign which has been delayed due to the flu campaign
- Contract review is taking place with all practices, reviewing immunisation uptake
- A series of press communications have taken place highlighting the number of children not vaccinated against measles
- Health Visitors now targeting the lowest 10% SOA
- Plans being formulated to share immunisation data with schools
- System 1 implementation is anticipated February 09.
- 10 Community Organisations have been commissioned to provide health promotion work for childhood immunisation, flu and HPV.

Lead Executive Director: Ian Cameron
Management Lead: Simon Balmer
Operational Lead: Beryl Bleasby

Annual Health Check Standards

Percentage of childtren gven immunisations at the required age



	Dip3	MenC	Hib3	MMR 1	PCV
2008 Jul-Sep	90.3	88.8	90.1	76.6	88.8
Trajectory	95	95	95	95	95

Please note that the data shown in the chart is COVER data, which is used in the reporting of the national target. This data does not include some GP information – please see the narrative

National Indicators

	Performance Indicator Type	Reference	Title	Service	Frequency & Measure	Rise or Fall	Baseline	Last Year Result	Target	Qtr1	Qtr2	Qtr3	Predicted Full Year Result	Data Quality
1	Leeds Strategic Plan - Government Agreed	NI 187a	Tackling fuel poverty, % of people receiving income based benefits living in homes with a low energy efficiency rating (SAP < 35)	Fuel Savers	Annually %	Fall	4.02%	N.A.	3.46%	N.A.	N.A.	3.33%	3.33%	No concerns with data
		NI 187b	Tackling fuel poverty, % of people receiving income based benefits living in homes with a high energy efficiency rating (SAP >= 65)	Fuel Savers	Annually %	Rise	44.00%	N.A.	44.00%	N.A.	N.A.	48.56%	48.56%	No concerns with data
		These figures are yet to be validated against the Government's approved monitoring software (EnQuire) that was issued on 26th November. Initial preparatory work has shown that it would be beneficial to recalculate the baseline and subsequent targets using EnQuire as this would give greater confidence in the results and in so doing will align with the approved methodology tool. The Council has made a number of improvements to alleviate fuel poverty. 606 properties with a SAP rting <35 have been improved (a result of 3.33%) and over 1,000 properties with a SAP >65 have been improved. A new local indicator is being developed to highlight the council's impact in tackling fuel poverty, in terms of private sector improvements achieved via grant work and improvements made through capital on public sector dwellings (as improvements can be hidden by changed in the fuel market (e.g. increased gas prices/fuel bills etc.)											
2	Leeds Strategic Plan Partnership Agreed	NI 123a	16+ current smoking rate prevalence (City wide)	Leeds PCT	Quarterly % prevalence	Rise	N.A.	N.A.	TBC	N.A.	22.94%	N.A.	N.A.	No concerns with data
		NI 123b	16+ current smoking rate prevalence (10% most deprived SOAs)	Leeds PCT	Quarterly % prevalence	Rise	N.A.	N.A.	TBC	N.A.	29.24%	N.A.	N.A.	No concerns with data
		Quarter 3 results are not available. The latest data is for Quarter 2. The data that has been collected from GP practices allows us to monitor progress more accurately against prevalence rather than relying on synthetic estimates.												
3	Leeds Strategic Plan Partnership Agreed	NI 39	Rate of Hospital Admissions per 100,000 for Alcohol Related Harm	Community Safety	Quarterly Number	No	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	Checklist not completed
		The reporting organisation for this target is the Primary Care Trust. The definition includes both chronic health conditions linked to alcohol consumption, as well as crime related behaviour and accidents linked to alcohol. The information can be disaggregated and so a more useful local indicator might need to be developed.												
4	National Indicator	NI 51	Effectiveness of child and adolescent mental health (CAMHS) services	Leeds PCT	Quarterly Number	Rise	N.A.	N.A.	16	16	16	16	16	No concerns with data
		The target is made up of four proxy measures. All four proxy measures for this target have scored 4 giving the achievement of 16, the highest score attainable and meets the 2008/09 target that was set.												

	Performance Indicator Type	Reference	Title	Service	Frequency & Measure	Rise or Fall	Baseline	Last Year Result	Target	Qtr1	Qtr2	Qtr3	Predicted Full Year Result	Data Quality
5	National Indicator	NI 53A	Prevalence of breast-feeding at 6-8 wks from birth (Breastfeeding prevalence)	Leeds PCT	Quarterly %	Rise	N.A.	N.A.	40.6%	28.0%	29.0% (1,387)	37.0% (908 out of 2,466 children)	40.6%	No concerns with data
		Progress continues towards the year end target and work is ongoing to increase prevalence. Because of the increased recording the prevalence of breastfeeding has improved since last quarter. Much work is ongoing in encouraging breastfeeding, For example opening of additional facilities such as breastfeeding cafes and providing advice and information on the benefits of breastfeeding.												
6	National Indicator	NI 53B	Coverage of breast-feeding at 6-8 wks from birth (Breastfeeding coverage)	Leeds PCT	Quarterly %	Rise	N.A.	N.A.	85.2%	64.4%	71.0% (3,329)	84.9% (2,095 out of 2,466 children)	85.2%	No concerns with data
		Recording of breastfeeding information continues to increase and is close to achieving the year end target. During this quarter there has been significant improvement in the recording of the breastfeeding status. This is due to ensuring that the information is recorded by the health visitors as soon as possible after their visits and by the targeting of teams where recording had been identified as low.												
7	National Indicator	NI 55A	Coverage Obesity in primary school age children in Reception	Leeds PCT	Annually %	Fall	N.A.	N.A.	91.88%	N.A.			93.80%	No concerns with data
		Result for 07/08. There is an increase in the number of children measured. Please note this is the annual result for this indicator.												
8	National Indicator	NI 55B	Prevalence Obesity / overweight among primary school age children in reception. Return to national levels of year 2000.	Leeds PCT	Annually %	Fall	N.A.	N.A.	9.20%	N.A.			8.47%	No concerns with data
		Result for 07/08. There is an increase in the number of children measured. Please note this is the annual result for this indicator.												
9	National Indicator	NI 56A	Coverage Obesity in primary school age children in Year 6	Leeds PCT	Annually %	Fall	17.80%	N.A.	98.31%	N.A.			98.60%	No concerns with data
		Result for 07/08. As with NI 55 there has been an increase in the number of children measured.												

	Performance Indicator Type	Reference	Title	Service	Frequency & Measure	Rise or Fall	Baseline	Last Year Result	Target	Qtr1	Qtr2	Qtr3	Predicted Full Year Result	Data Quality
10	National Indicator	NI 56B	Percentage Obesity in primary school age children in Year 6.	Leeds PCT	Annually %	Fall	N.A.	N.A.	17.72%	N.A.			19.34%	No concerns with data
		Result for 07/08. As with NI 55 there has been an increase in the number of children measured.												
11	National Indicator	NI 113	Prevalence of Chlamydia in under 25 year olds	Leeds PCT	Quarterly %	Rise	N.A.	N.A.	17%	3.56%	N.A.	N.A.	N.A.	No concerns with data
		Comments provided in the main body of the report												
12	National Indicator	NI 125	Achieving independence for older people through rehabilitation/intermediate care	Leeds PCT	Quarterly %	Rise	New Indicator	N.A.	To be provided February 2009	See Comments				Under-development: checklist received but systems/ processes still being developed
		This indicator measures the benefit to individuals from intermediate care and rehabilitation following a stay in hospital. It captures the joint work of social services and health staff and services commissioned by joint teams. The measure is designed to follow the individual and not differentiate between social care and NHS funding boundaries. The measure covers older people aged 65 and over on discharge from hospital who: • Would otherwise face an unnecessarily prolonged stay in acute in-patient care, or be permanently admitted to long term residential or nursing home care, or potentially use continuing NHS in-patient care; • Have a planned outcome of maximising independence and enabling them to resume living at home; • Are provided with care services on the basis of a multi-disciplinary assessment resulting in an individual support plan that involves active therapy, treatment or opportunity for recovery (with contributions from both health and social care); • Are to receive short-term interventions, typically lasting no longer than 6 weeks, and frequently as little as 1-2 weeks or less. This new indicator relies on new data for which results will be available for reporting from February 2009 onwards.											
13	National Indicator	NI 126	Early Access for Women to Maternity Services	Leeds PCT	Quarterly %	Rise	N.A.	N.A.	85.00%	70.20%	78.70%	78.65% (1,887 out of 2,433 women)	85.00%	No concerns with data
		This result is slightly below last quarter. The number of bookings in October was higher than previous months, though due to time constraints, the data is yet to be fully validated. This validation may have a positive effect on the percentage figure. Work is continuing to ensure the year end target is reached.												

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Leeds CITY COUNCIL

Agenda Item 8

Originator:	Laura Nield
Tel:	395 0492

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 24th March 2008

Subject: NHS Annual Health Check

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

1.0 Introduction

1.1 In 2005/6, the Healthcare Commission introduced the new NHS performance assessment process 'Annual Health Check'. As part of the health check, NHS trusts must submit a self assessment declaration to the Commission by midday on 1st May 2009. These declarations are supplemented with comments from representatives of patients and other partners in the community, including Local Authorities' Overview and Scrutiny Committees.

2.0 The role of Scrutiny in the Annual Health Check

2.1 The Healthcare Commission invites Overview and Scrutiny Committees, and other bodies, to comment on how they think local Trusts are performing against the "core standards" set by Government. Core standards represent the minimum standards for services that must be met, for all patients, by all NHS bodies. The 24 standards were agreed by the Department of Health in July 2004 and published in the document 'Standards for Better Health', attached at Appendix 2. They are divided into 7 domains: Safety, Clinical and Cost Effectiveness, Governance, Patient Focus, Accessible and Responsive Care, Care Environment and Amenities, and Public Health.

2.2 Local NHS Trusts are required to ask this Board to comment on the Trust's performance against the core standards. However, the Board are not compelled to provide comments.

2.3 In accordance with Healthcare Commission guidance, where Scrutiny Board (Health) does provide comments to Trusts, such comments will need to be supported by evidence of work carried out by the Board and must also be relevant to the assessment period (this year that assessment period is April 2008 to March 2009). In view of this, the Commission acknowledges that the Board may wish to, but is not obliged to, limit comments to those areas where it has undertaken reviews or monitored services.

2.4 The Board is therefore invited to make comments on the information received from each of the NHS Trusts in Leeds. A report from Leeds Teaching Hospitals Trust is attached. Reports from NHS Leeds and Leeds Partnerships NHS Foundation Trust were not available at the time of agenda publication, but will be made available to board members prior to the meeting.

3.0 Briefings from Local NHS Trusts

3.1 Representatives from the Leeds Teaching Hospitals NHS Trust, Leeds Partnerships NHS Foundation Trust, and NHS Leeds will be attending today's meeting to brief the Board on the progress made by the Trusts in complying with the core standards.

3.2 Should the Board decide to formulate comments for submission to the Trusts as part of the Annual Health Check process, comments will need to be formally agreed and conveyed to the Trusts in time to meet their deadlines for submission to the Healthcare Commission.

4.0 Recommendation

4.1 The Board is are asked to:

(a) consider and comment on the progress made by the Trusts in complying with the core standards
(b) identify and discuss any areas relevant to the core standards, which it might like to provide comments on, based on the work of the Board over the last 12 months
(c) determine, in discussion with Trust representatives, the timescales for providing any comments to comply with their deadlines for submission to the Healthcare Commission.

Healthcare Commission

Your part in the annual health check 2008/09 update

A step-by-step guide for local authorities, strategic health authorities, local involvement networks (LINks), overview and scrutiny committees, local safeguarding children boards, learning disability partnership boards and foundation trusts' boards of governors

Tell us how you think your local trust is performing

The Healthcare Commission keeps a check on local healthcare organisations and provides information that is of interest to patients and the public about their local health services – safety and cleanliness, dignity and respect, standards of care, keeping people healthy, waiting to be seen, and good management.

By checking trusts' performance and providing information, we aim to help trusts to improve their services.

From April 2009, trusts will again be gearing up for the declaration part of the annual health check. We need your comments to make sure that we get the full picture about their performance in 2008/09.

Last year we invited patient and public involvement forums, overview and scrutiny committees, strategic health authorities (SHAs), local safeguarding children boards, and foundation trusts' boards of governors to comment and they responded well. We really appreciate the hard work that went into providing commentaries that produced so much useful intelligence. One way we used this information was to influence our decision on which trusts were inspected as part of our core standards assessment.

For 2008/09 we are also inviting local involvement networks (LINks) and learning disability partnership boards to tell us how they think their local trust is performing against the standards set by Government, and to give us the views and experiences of people in their community. We are determined to put the interests of patients and the public at the heart of our work, so your feedback is very important to us.

As in previous years, where you have sent comments to trusts for inclusion in their declaration, these must be included – word for word – in the declarations they submit to us. But if you are invited to comment and say no, neither you nor the trust will be penalised.

We recognise that LINks will be at different stages of establishment across the country and that not all will be able to contribute to the annual health check to the same degree. Therefore we have put in place options that recognise this and they are set out under heading 2 of this document.

1. Getting ready

The Government published *Standards for Better Health* in July 2004, which set out 24 core standards. These core standards describe a minimum level of service, which patients have the right to expect. We are again asking trusts to tell us how they have performed against the core standards this year through a declaration, which must be submitted by midday on 1 May 2009. As part of this process, trusts are responsible for inviting 'third parties' to comment on their performance. Third parties include local authorities, SHAs, LINks, overview and scrutiny committees, local safeguarding children boards and learning disability partnership boards and foundation trusts' boards of governors.

Your local trust should contact you in early 2009 to agree a timetable for including your comments in their declaration. You may also want to start discussing what you might say, so you are prepared.

You can comment on your trust's performance against any of these standards. You do not have to comment on all of them. Your comments should relate to your group's views on the performance of the trust during the period from 1 April 2008 to 31 March 2009. You are not expected to sign off or comment directly on the declaration given to us by your local trust.

If you agree to comment, you may want to set up regular meetings with your members as soon as possible, so that you have enough time to seek the views of others in your community. You may also want to contact the other third parties in your area, so that you can discuss your respective roles, exchange views about local trusts and coordinate your efforts.

You may find it useful to share your draft comments with your trust or with a regional assessor from the Healthcare Commission. You don't have to take their feedback into account, but working together may benefit everyone involved.

2. LINks

On 1 April 2008, new government legislation introduced local involvement networks (LINks), which aim to give local people a greater say in the way that health and social care services are commissioned and provided. Each local authority has until the end of September 2008 to appoint a LINk 'host' to support the set up and running of their LINk.

LINks effectively replace the former patient and public involvement forums but, in this first year, we recognise that not all LINks will be able to contribute to the annual health check to the same extent that third parties have done in previous years. In order to ensure your comments are included in the annual health check there are three options:

a) Where a LINk is fully operational, we advise that the LINk lead/host submits its comments to the trust for inclusion in the declaration. This will need to take place in early April; exact deadline will need to be agreed with the trust.

OR

b) If it is not fully established then the LINk lead/host is invited to coordinate the comments of up to ten voluntary organisations and submit these to the trust for inclusion in the declaration (timing as above).

OR

c) We have also developed a website for LINk leads and host organisations called **engage.** It will enable LINk host organisations to submit feedback on patient experiences throughout the year. We are suggesting, therefore, that if LINk lead/ hosts are not able to submit comments directly to the trusts concerned in time for submission with their declaration, then comments can be submitted via the engage website (**https://engage.healthcarecommission.org.uk**)

Please note LINk lead/ hosts will need to register via the 'contact us' section of the website. Comments must be submitted by **1 May 2009**.

Options a) and b) will enable us to include your comments with the trust's declaration when we publish it on our website. Unfortunately, we will not be able to publish comments submitted via the engage website (option c). They will, however, still be used to cross-check the declarations submitted by the relevant trusts.

We would also encourage overview and scrutiny committees and foundation trusts' boards of governors to contact their local authority to offer to work with the emerging LINks to identify the best way of feeding in their comments.

Further details are included in our LINks guide to working with the Healthcare Commission, which can be found at **https://engage.healthcarecommission.org.uk/static/handbook**

3. What's new in 2008/09

Primary care trusts (PCTs) currently have two functions: as commissioners (purchasers) and providers of care. Commissioning in the NHS is the process that ensures that the services provided most effectively meet the needs of the

local population. It is a complex process involving assessing population needs, prioritising health outcomes, procuring products and services and managing those who provide those services. Most PCTs will also be providers of some of the services. For 2008/09, the annual health check will reflect this by providing separate assessments on the provider and commissioning functions of PCTs. When drafting your commentary for PCTs it may be useful to consider these two separate functions.

4. How will your comments make a difference?

Your comments, if submitted through your trust's declaration, will be made publicly available. You could make a difference to your local health services just by putting your views on record.

Your comments (including those submitted via the engage website if the LINk has chosen option c) will be taken into account when we decide which trusts will receive a follow-up inspection. Comments supported by factual examples are more likely to be given greater weight.

5. Submitting your comments

There is no standard template for giving your comments to trusts – use a format that works best for you. Consider allowing the chair of your group to 'sign off' your comments. This could help you to finalise them more quickly.

It is important that trusts have enough time to include your comments in their declarations before the deadline. They must send us their declaration no later than midday on 1 May 2009, but can submit it before this date.

They should also send you a copy of their declaration once they have submitted it to us so that you can check your comments. They do not have to share the content of their declaration with you before it is submitted.

Tips to help ensure your comments make a difference

- Think about what matters most to you and the people in your community – what are the most important points you want to get across?
- Think about examples of good practice as well as problems and areas for improvement.
- Familiarise yourself with the core standards and guidance relating to them. Aim to match the standards with the points you want to make.
- Ensure that your examples are relevant to the 2008/09 annual health check, ie, they happened between 1 April 2008 and 31 March 2009.
- Try to find facts and examples to back up your comments. These may include notes of a meeting or visit to a trust, the results of a local survey, or personal stories from individuals with dates and supporting documents.
- Please note your comments must not include confidential or personal information, for example, names of individual patients or staff, or contact details.
- Do not submit the supporting documents with your comments, but be prepared in case we need to clarify some aspect of your comment.

6. Learning from last year's annual health check

When writing your comments for this year's annual health check, please note that we use them to identify and extract 'items of information'. These might consist of several paragraphs or a single sentence and will relate to one or more core standard.

In 2008, we received 1,930 comments from third parties. We extracted and coded 8,779 items of information from these comments because they related to one or more of the standards. Each coded item was weighted 'high', 'medium' or 'low':

- 'High' meant the item had a strong association with a particular standard, was closely aligned to the criteria in our inspection guides and provided clear information to support the opinions expressed.
- 'Low' meant the item related to a small aspect of a standard, or was about one department rather than a whole trust, or had little back-up information.
- In total, 451 (5%) of the items were weighted as 'high', 5,206 (59%) as 'low' and 3,122 (36%) as 'medium' weighting.

7. Cross-checking and follow up

Your comments will be one of the many sources of information that will be used to check the trust's declaration. This helps to ensure our assessments are as fair and accurate as possible. We will also carry out follow-up inspections with approximately 20% of trusts – some of these trusts will be chosen at random and some will have been identified as being most at risk of not meeting the core standards.

If your local trust gets a follow-up inspection, you may be contacted by one of our regional assessors to discuss your comments. We will want to see your supporting information at this point.

Key dates

- **Early 2009**
  Establish the deadlines for submitting comments to your trust.

  If you do not wish to submit any comments for the 2008/09 annual health check, it would be helpful if you could write formally to your trust advising them of this.
- **15 April 2009**
  Trusts can begin to submit their declaration to us.
- **Midday 1 May 2009**
  Deadline for trusts to submit their declaration to us.
- **22 May 2009**
  Trust declarations made public.
- **October 2009**
  Results of the annual health check published.

8. Find out more

Our LINks guide to working with the Healthcare Commission gives details of how LINks can contribute information for the annual health check in 2008/09. It is available from the engage website at:

https://engage.healthcarecommission.org.uk/static/handbook

A companion guide to working with the Commission for Social Care Inspection will be available in autumn 2008.

The annual health check in 2008/09: Assessing and rating the NHS gives further information about the annual health check and can be downloaded from the Healthcare Commission website at **www.healthcarecommission.org.uk**

We will shortly be publishing sets of criteria for NHS trusts to give them more information about the assessment of core standards for this year's annual health check. These will also be available to download from the Commission website once they are published.

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STANDARDS FOR BETTER HEALTH

STANDARDS FOR BETTER HEALTH

INTRODUCTION

1. The *NHS Improvement Plan*, published in June, set out the next stage of the Government's plans for the modernisation of the health service. It signalled three big shifts:
   - putting patients and service users first through more personalised care;
   - a focus on the whole of health and wellbeing not only illness; and
   - further devolution of decision making to local organisations.

2. All this requires much greater joint working and partnership between PCTs, LAs, NHS Foundation Trusts, other NHS, independent sector and voluntary organisations. This is happening in many parts of the country, but needs to be made more consistent.

3. A parallel shift is now required in the way improvements in people's health and care are planned and delivered. This means moving away from a system that is mainly driven by national targets to one in which:
   - *standards* are the main driver for continuous improvements in quality;
   - there are *fewer national targets*;
   - there is greater scope for addressing *local priorities*;
   - *incentives* are in place to support this system; and
   - all organisations locally play their part in *service modernisation*.

A STANDARDS DRIVEN SYSTEM

4. From April 2005 there will be a new performance framework for the NHS, driven by *Standards for Better Health* which set out the level of quality all organisations providing NHS care will be expected to meet or aspire to across the NHS in England.

5. *Standards for Better Health* [4] represents the Government's response to the consultation on the health care standards, which was launched in February 2004, and puts quality at the forefront of the agenda for the NHS and for private and voluntary providers of NHS care. The standards describe the level of quality that health care organisations, including NHS Foundation Trusts, and private and voluntary providers of NHS care, will be expected to meet in terms of safety; clinical and cost effectiveness; governance; patient focus; accessible and

[4] Section 46 of the Health and Social Care (Community Health and Standards) Act 2003 sets out the legislative basis for the health care Standards

responsive care; care environment and amenities; and public health. In each of these domains the individual standards fall into two categories:

- *core standards:* which bring together and rationalise existing requirements for the health service, setting out the minimum level of service patients and service users have a right to expect; and
- *developmental standards* – which signal the direction of travel and provide a framework for NHS bodies to plan the delivery of services which continue to improve in line with increasing patient expectations.

6. *Standards for Better Health* will form a key part of the performance assessment by the Healthcare Commission (HC) of all health care organisations. The Commission for Social Care Inspection (CSCI) inspects regulated care services, such as care homes, against minimum national standards drawn up by the Department of Health (DH) in consultation with the social care community and people using health and social care services. They are designed to drive up standards by identifying areas for improvement.

Why Standards?

7. The standards set out in this document have been developed with two principal objectives. First, they provide a common set of requirements applying across all health care organisations to ensure that health services are provided that are both safe and of an acceptable quality.

8. Second, they provide a framework for continuous improvement in the overall quality of care people receive. The framework ensures that the extra resources being directed to the NHS are used to help raise the level of performance measurably year-on-year.

9. The scope of the new quality programme which is emerging in the NHS is bold and broad-based. Underpinning this has been the concept of clinical governance – a unifying concept for quality which provides organisations with a systematic means for ensuring that they comply with their statutory duty. It aims to effect a change of culture in NHS organisations to one where:

> *"openness and participation are encouraged, where education and research are properly valued, where people learn from failures and blame is the exception rather than the rule, and where good practice and new approaches are freely shared and willingly received."*
>
> (Sir Liam Donaldson, Chief Medical Officer)

Overall aims

5. *Standards for Better Health* sits at the heart of the new relationship between central Government and the NHS, under which it is the role of the Department of Health to set broad, overarching standards defining the Government's high level expectations of the health service. These should be comprehensive but at a level of detail that allows scope for local determination of what works best and for the new

independent inspectorate to make judgments about what levels of performance are acceptable at any one time.

6. A strong underlying theme is the need to reduce the burden of unhelpful standards and guidance on the NHS over time. We are conscious of the large number of requirements that have (in the past) been set centrally, either directly from the Department itself or by its Arm's Length Bodies. Some of the Department's own standards are currently under review and the review of Arm's Length Bodies will provide an opportunity to rationalise either standards themselves or some of the reporting requirements that they currently impose. The development of the new high level standards set out here represents the first step toward simplifying and rationalising the expectations on the service. The review also provides an excellent opportunity to reduce the burden of current requirements, although the process of doing so will necessarily take some time to evolve. While *Standards for Better Health* will synthesise a large number of existing rules and guidance, NHS bodies will continue to be subject to the wider regulatory framework, such as health and safety legislation.

7. The final but key aim of these standards is to underpin the delivery of high quality services which are fair, personal and responsive to patients' needs and wishes, which are provided equitably and which deliver improvements in the health and well-being of the population. This aim can only be achieved if these benefits are delivered to **all** groups within our society. The standards must therefore be interpreted and implemented in ways which:

- Challenge discrimination
- Promote equality of access and quality of services
- Support the provision of services appropriate to individual needs, preferences and choices
- Respect and protect human rights
- Further the NHS's reputation as a model employer
- Enable NHS organisations to contribute to economic success and community cohesion.

NHS Improvement Plan

8. The new standards reflect the direction set by the *NHS Improvement Plan*. In particular, the core standards will underpin patient choice by determining which health care organisations may provide care under the NHS.

9. Furthermore, the developmental standards describe the framework for quality improvement that have been taken forward in the *NHS Improvement Plan*. There is, in particular, a new focus on public health. These standards, in line with the *NHS Improvement Plan*, stress the importance of reducing inequalities and of organisations working together to provide a whole systems approach to care, tailor made for the individual patient. Raising standards in this way will deliver more personalised care and ensure that all patients, including those from disadvantaged groups, are able to benefit.

Taxonomy

10. A key element in simplifying and rationalising the approach to standards setting will be the adoption of a common framework for all matters related to performance and a common language so that terms such as “standards” have a clearly understood, shared meaning. It is our clear intention that the domain structure set out in this document should become the common framework, not only for standards set by the Department and for the inspection process itself, but also for the whole performance agenda whether national or local.

11. From now on, the Department of Health will define the most frequently used terms in the following way:

Standards
Standards are a means of describing the level of quality that health care organisations are expected to meet or to aspire to. The performance of organisations can be assessed against this level of quality.

Quality Requirements
Quality requirements will be established through the National Service Frameworks. They describe the care which clinicians and others will use to guide their practice.

Criteria
Criteria are ways of demonstrating compliance with, and performance relevant to, a standard. They establish specific, objective expectations, drawing on such evidence and indicators as the Healthcare Commission may establish.

Targets
Targets refer to a defined level of performance that is being aimed for, often with a numerical and time dimension. The purpose of a target is to incentivise improvement in the specific area covered by the target over a particular timeframe.

Benchmarks
Benchmarks are used as comparators to compare performance between similar organisations or systems.

Who the standards are for

12. The standards themselves will be taken into account by those providing NHS care directly, no matter what the setting, those managing the health service, those commissioning health care and, most importantly, for the general public.

13. The standards apply to the provision of all NHS services in the full variety of settings, including NHS Foundation Trusts, and the voluntary and private sectors insofar as they provide care to NHS patients.

14. They are also for the Healthcare Commission who have responsibility for assessing the quality of health and health care provided in England. The Commission’s role is set out more fully below.

Response to consultation

15. The standards published here were subject to a full twelve-week public consultation. A summary of the main points made in response to the consultation will be available on the DH website – www.dh.gov.uk

How the standards framework is structured

16. The standards set out in this document are organised within seven "domains", which are designed to cover the full spectrum of health care as defined in the Health and Social Care (Community Health and Standards) Act 2003. The domains encompass all facets of health care, including prevention, and are described in terms of outcomes. The seven domains are:

- Safety
- Clinical and Cost Effectiveness
- Governance
- Patient Focus
- Accessible and Responsive Care
- Care Environment and Amenities
- Public Health

Outcomes for each domain are specified.

17. Within these domains there are two types of standards, core and developmental.

Core standards

18. The core standards do not of themselves set out new expectations of the NHS, but are based on a number of standards or requirements that already exist. They describe a level of service which is acceptable and which must be universal. **Meeting the core standards is not optional. Health care organisations must comply with them from the date of publication of this document.**

Developmental standards

19. Service provision which only meets the core standards will be no more than acceptable at the date of publication of this document. The focus of attention, both on the part of the Healthcare Commission in its annual reviews and on Trusts themselves, will be on progress against the developmental standards. These are broad-based and comprehensive in their scope and are framed so as to provide a dynamic force for continuous improvement over time. Through the annual review process they will enable health care organisations themselves, health care professionals and, most importantly, the public to see progress made year-on-year.

20. The developmental standards are designed for a world in which patients' expectations are increasing. The levels of investment now being made in the NHS make achievements against these standards realistic. Progress is expected to be made against the developmental standards across much of the NHS as a result of the *NHS Improvement Plan* and the extra investment in the period to 2008. **The Healthcare Commission will, through its criteria for review, assess progress by health care organisations towards achieving the developmental standards.**

21. The core standards will therefore serve a platform or "bottom rung" for progress against the developmental ladder. They serve as a marker for where the service is now. They also serve to assure the public that all services, wherever provided, will be safe and of an acceptable quality.

National Service Frameworks and NICE Guidance

22. National Service Frameworks (NSFs) and National Institute for Clinical Excellence (NICE) guidance are integral to a standards-based system. They have a key role in supporting local improvements in service quality. Organisations' performance will be assessed not just on how they do on national targets but increasingly on whether they are delivering high quality standards across a range of areas, including NSFs and NICE guidance.

23. We will continue to develop NSFs and other national strategies where these are needed. There are already NSFs on coronary heart disease, diabetes, mental health, older people's services and paediatric intensive care, as well as the NHS Cancer Plan, the national strategy for sexual health and HIV, and a major programme of work to implement recommendations from the Shipman inquiry. There are forthcoming NSFs for children, renal services and long-term conditions, and a national strategy on sexual health. NSFs should be considered as part of the developmental standards. Over the course of the three-year planning period for the Planning Framework, the NHS together with Local Authorities will need to be able to demonstrate that they are making progress towards achieving the levels of service quality described in the NSFs and national strategies. Both the Healthcare Commission and CSCI will undertake thematic reviews of progress, jointly where appropriate.

The inspection function

24. As well as establishing the power for the Secretary of State for Health to set standards, the Health and Social Care (Community Health and Standards) Act 2003 also established the Healthcare Commission and set out its functions. These include undertaking an annual review of the provision of health care by (and for) each NHS body in England, including Foundation Trusts. Its judgements will be based on criteria, which it is charged with developing and which have to be agreed with the Secretary of State. These criteria have to take account of the standards set out in this document.

25. In undertaking its reviews, the Commission will focus on achievement against the developmental standards. However, it will also need to be satisfied that all trusts are meeting the core standards. The Commission will be responsible for determining *how* it assesses core performance, although the process will need to take account of targets that the Department has set and which are now assumed to be achieved. For this reason, we are including one core standard (C7 f) that cross refers to a number of existing requirements (as listed in Appendix 1 to these standards) which are currently being met and must continue to be met.

26. The outcome of the Healthcare Commission's review will therefore enable the public to identify progress against the standards by individual organisations. The

reviews will also help to determine which Trusts are to be considered for Foundation Trust status. If, exceptionally, a Trust fails to satisfy the Commission that it meets the core standards, then consideration will need to be given to how performance should be improved. In such cases, it will normally be for the Trust to develop proposals for improvement in negotiation with its Strategic Health Authority. Exceptionally, the legislation gives powers to the Commission to recommend to the Secretary of State, or in the case of Foundation Trusts the Independent Regulator, that they take special measures in relation to any significant failings. It should be noted that the Independent Regulator has additional powers to intervene in the case of Foundation Trusts which are failing to discharge their responsibilities in other ways

The independent sector

27. The standards apply with immediate effect to services provided under the NHS, whether within NHS bodies or within the independent or voluntary sector. As foreshadowed in the consultation document, there will be an appropriate phasing in of the applications of these standards to cover other services provided entirely by the independent sector.

28. At present the requirements of the Care Standards Act mean that the Healthcare Commission is required to undertake inspections of all registered independent establishments once every year against the National Minimum Standards for Independent Health Care. The Healthcare Commission intends to harmonise and align its inspection and review methodologies for the independent and NHS sectors. The Government will also make legislative changes as necessary to enable an equal approach to inspection of the independent and NHS sectors against the same standards, when Parliamentary time allows.

29. Until then, independent providers will continue to be regulated against the Care Standards Act, its Regulations and National Minimum Standards. Those commissioning NHS services from the private sector must also take compliance with the *Standards for Better Health* into account before commissioning contracts are made. However, in practice, the Government has already taken the National Minimum Standards fully into account when setting the *Standards for Better Health*, and the Healthcare Commission will seek to avoid creating additional or inconsistent requirements during this transitional period through its adaptation of assessment methods, commissioning and harmonisation work.

30. The application of these standards to the independent sector and the timing of integration will be undertaken in consultation with representative organisations of the independent sector. This will include consultation on final proposals for these directions and initiatives.

Partnership working

31. While these standards are confined to the provision of NHS health care, they recognise the need to develop services in a co-ordinated way, taking full account of the responsibilities of other agencies in providing comprehensive care. In particular, they must be read and interpreted to allow for the statutory duties of partnership on all NHS bodies and Local Authorities established under the Health Act 1999 and the

Health and Social Care (Community Health and Standards) Act 2003. This introduced requirements on both the NHS and Local Authorities to work together to achieve the co-operation needed to bring about improvements in health care.

32. In particular, there is a considerable emphasis within the developmental standards to adopting a whole system approach to health service provision.

Core and Developmental Standards

The outcome for these standards is specified for each domain. The core standards set out below are not optional. They should be met from the date of publication. Progress is expected to be made against the developmental standards across much of the NHS as a result of the NHS Improvement Plan and the extra investment in the period to 2008. Demonstrating improvements against the developmental standards will be essential to achieve an overall high performance rating.

First Domain - Safety

Domain Outcome

Patient safety is enhanced by the use of health care processes, working practices and systemic activities that prevent or reduce the risk of harm to patients.

Core standard

		Related Developmental Standard:
C1	Health care organisations protect patients through systems that a) identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents; and b) ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required time-scales.	D1
C2	Health care organisations protect children by following national child protection guidance within their own activities and in their dealings with other organisations.	
C3	Health care organisations protect patients by following NICE Interventional Procedures guidance.	
C4	Health care organisations keep patients, staff and visitors safe by having systems to ensure that a) the risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in MRSA; b) all risks associated with the acquisition and use of medical devices are minimised; c) all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed; d) medicines are handled safely and securely; and e) the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to	

the health and safety of staff, patients, the public and the safety of the environment.

Developmental standard

D1 Health care organisations continuously and systematically review and improve all aspects of their activities that directly affect patient safety and apply best practice in assessing and managing risks to patients, staff and others, particularly when patients move from the care of one organisation to another.

Second Domain – Clinical and Cost Effectiveness

Domain Outcome

Patients achieve health care benefits that meet their individual needs through health care decisions and services based on what assessed research evidence has shown provides effective clinical outcomes

Core standards

C5 Health care organisations ensure that
a) they conform to NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care;
b) clinical care and treatment are carried out under supervision and leadership;
c) clinicians continuously update skills and techniques relevant to their clinical work; and
d) clinicians participate in regular clinical audit and reviews of clinical services.

Related Developmental Standard: D2

C6 Health care organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met.

Developmental standard

D2 Patients receive effective treatment and care that:

a) conform to nationally agreed best practice, particularly as defined in National Service Frameworks, NICE guidance, national plans and agreed national guidance on service delivery;

b) take into account their individual requirements and meet their physical, cultural, spiritual and psychological needs and preferences;

c) are well co-ordinated to provide a seamless service across all organisations that need to be involved, especially social care organisations; and

d) is delivered by health care professionals who make clinical decisions based on evidence-based practice.

Third Domain – Governance

Domain Outcome

Managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices ensure that probity, quality assurance, quality improvement and patient safety are central components of all the activities of the health care organisation.

Core standards

C7 Health care organisations
- a) apply the principles of sound clinical and corporate governance;
- b) actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources;
- c) undertake systematic risk assessment and risk management;
- d) ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources;
- e) challenge discrimination, promote equality and respect human rights; and
- f) meet the existing performance requirements set out in the annex.

Related Developmental Standard: D3

C8 Health care organisations support their staff through
- a) having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services; and
- b) organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups.

Related Developmental Standard: D7

C9 Health care organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.

Related Developmental Standard: D6

C10 Health care organisations
a) undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies; and
b) require that all employed professionals abide by relevant published codes of professional practice.

Related Developmental Standard: D7

C11 Health care organisations ensure that staff concerned with all aspects of the provision of health care
a) are appropriately recruited, trained and qualified for the work they undertake;
b) participate in mandatory training programmes; and
c) participate in further professional and occupational development commensurate with their work throughout their working lives.

C12 Health care organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied.

Related Developmental Standard: D3

Developmental standards

D3 Integrated governance arrangements representing best practice are in place in all health care organisations and across all health communities and clinical networks.

D4 Health care organisations work together to
a) ensure that the principles of clinical governance are underpinning the work of every clinical team and every clinical service;
b) implement a cycle of continuous quality improvement; and
c) ensure effective clinical and managerial leadership and accountability.

D5 Health care organisations work together and with social care organisations to meet the changing health needs of their population by
a) having an appropriately constituted workforce with appropriate skill mix across the community; and
b) ensuring the continuous improvement of services through better ways of working.

D6 Health care organisations use effective and integrated information technology and information systems which support and enhance the quality and safety of patient care, choice and service planning.

D7 Health care organisations work to enhance patient care by adopting best practice in human resources management and continuously improving staff satisfaction.

Fourth Domain - Patient Focus

Domain Outcome

Health care is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient well-being.

Core standards

C13 Health care organisations have systems in place to ensure that
a) staff treat patients, their relatives and carers with dignity and respect;
b) appropriate consent is obtained when required for all contacts with patients and for the use of any patient confidential information; and
c) staff treat patient information confidentially, except where authorised by legislation to the contrary.

C14 Health care organisations have systems in place to ensure that patients, their relatives and carers
a) have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services;
b) are not discriminated against when complaints are made; and
c) are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.

Related Developmental Standard: D8

C15 Where food is provided, health care organisations have systems in place to ensure that
a) patients are provided with a choice and that it is prepared safely and provides a balanced diet; and
b) patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day.

C16 Health care organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after-care.

Related Developmental Standard: D9

Developmental standards

D8 Health care organisations continuously improve the patient experience, based on the feedback of patients, carers and relatives.

D9 Patients, service users and, where appropriate, carers receive timely and suitable information, when they need and want it, on treatment, care, services, prevention and health promotion and are
a) encouraged to express their preferences; and

b) supported to make choices and shared decisions about their own health care.

D10 Patients and service users, particularly those with long-term conditions, are helped to contribute to planning of their care and are provided with opportunities and resources to develop competence in self-care.

Fifth Domain - Accessible and Responsive Care

Domain Outcome

Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or of the care pathway.

Core standards

C17 The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving health care services.

C18 Health care organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.

C19 Health care organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services.

Related Developmental Standard: D11

Developmental standard

D11 Health care organisations plan and deliver health care which
a) reflects the views and health needs of the population served and which is based on nationally agreed evidence or best practice;
b) maximises patient choice;
c) ensures access (including equality of access) to services through a range of providers and routes of access; and
d) uses locally agreed guidance, guidelines or protocols for admission, referral and discharge that accord with the latest national expectations on access to services.

Sixth Domain - Care Environment and Amenities

Domain Outcome

Care is provided in environments that promote patient and staff well-being and respect for patients' needs and preferences in that they are designed for the effective

and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients.

Core Standards

C20 Health care services are provided in environments which promote effective care and optimise health outcomes by being
a) a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation; and
b) supportive of patient privacy and confidentiality.

C21 Health care services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.

Related Developmental Standard: D12

Developmental standard

D12 Health care is provided in well-designed environments that
a) promote patient and staff well-being, and meet patients' needs and preferences, and staff concerns; and
b) are appropriate for the effective and safe delivery of treatment, care or a specific function, including the effective control of health care associated infections.

Seventh Domain - Public Health

Domain Outcome

Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.

Core standards

C22 Health care organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by

a) co-operating with each other and with local authorities and other organisations;
b) ensuring that the local Director of Public Health's Annual Report informs their policies and practices; and
c) making an appropriate and effective contribution to local partnership arrangements including Local Strategic Partnerships and Crime and Disorder Reduction Partnerships.

Related Developmental Standard: D13

C23 Health care organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service Frameworks and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections.

Related Developmental Standard: D13

C24 Health care organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations which could affect the provision of normal services.

Developmental standard

D13 Health care organisations

a) identify and act upon significant public health problems and health inequality issues, with primary care trusts taking the leading role;
b) implement effective programmes to improve health and reduce health inequalities, conforming to nationally agreed best practice, particularly as defined in NICE guidance and agreed national guidance on public health;
c) protect their populations from identified current and new hazards to health; and
d) take fully into account current and emerging policies and knowledge on public health issues in the development of their public health programmes, health promotion and prevention services for the public, and the commissioning and provision of services.

Appendix 1: GLOSSARY

Access: the extent to which people are able to receive the information, services or care they need.

CHI: The Commission for Health Improvement was, until April 2004, the independent, inspection body for the NHS. Its functions were transferred to the Healthcare Commission

CHAI: The Commission for Health, Audit and Inspection was established by the Health and Social Care (Community Health and Standards) Act 2003 and is now known as the Healthcare Commission.

Clinical audit: a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against specific criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in health care delivery.

Clinical governance: a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.

Clinical network: connections across disciplines which provide integrated care across institutional and professional boundaries, raising clinical quality and improving the patient experience.

Clinician: professionally qualified staff providing clinical care to patients.

Crime and disorder reduction partnerships: partnerships between the police, local authorities, probation service, health authorities, the voluntary sector, and local residents and businesses which work to reduce crime and disorder in their area.

Criteria: criteria devised and published by the Healthcare Commission, and approved by the Secretary of State, with reference to which the Healthcare Commission must each financial year conduct a review of the provision of health care by and for each English NHS body, and each cross-border SHA.

Cross-border SHA: a special health authority performing functions in respect of both England and Wales.

English NHS body: a primary care trust, strategic health authority or NHS trust, all or most of whose hospitals, establishments and facilities are situated in England, or an NHS foundation trust or special health authority performing functions only or mainly in respect of England.

Foundation trust: a public benefit corporation established by the Health and Social Care (Community Health and Standards) Act 2003 which is authorised to provide goods and services for the purpose of the health service.

Governance: a mechanism to provide accountability for the way an organisation manages itself.

Healthcare Commission: established in April 2004 as the independent body encompassing the work of the Commission for Health Improvement (CHI). The Healthcare Commission also took on functions transferred from the national NHS value for money work of the Audit Commission and the independent health care work of the National Care Standards Commission (NCSC).. It inspects health care provision in accordance with national standards and other service priorities and reports directly to Parliament on the state of health care in England and Wales.

Health care organisation: English NHS bodies, cross-border SHAs and other organisations and individuals, including the independent and voluntary sectors, which provide or commission health care for individual patients and the public.

Health care professional: a person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.

Health care: services provided for or in connection with the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.

Health care associated infection: all infections acquired as a direct or indirect result of health care.

Health inequalities: differences in people's health between geographical areas and between different groups of people.

Health promotion: includes the provision of information on healthier lifestyles for patients, and how to make the best use of health services, with the intention of enabling people to make rational health choices and of ensuring awareness of the factors determining the health of the community.

Local strategic partnerships: non-statutory bodies intended to bring together the public, private, voluntary and community sectors at a local level. Their purpose is to improve the delivery of services and quality of life locally.

Medical devices: all products, except medicines, used in health care for diagnosis, prevention, monitoring or treatment. The range of products is very wide: it includes contact lenses and condoms; heart valves and hospital beds; resuscitators and radiotherapy machines; surgical instruments and syringes; wheelchairs and walking frames.

National Service Frameworks:
NSFs

- set national standards and identify key interventions for a defined service or care group;
- put in place strategies to support implementation; and
- establish ways to ensure progress within an agreed time-scale.

The NSFs published to date cover:
- mental health
- coronary heart disease
- older people
- diabetes

NSFs on children, renal services and long term conditions (focusing on neurological conditions) are in preparation.

NICE: a special health authority for England and Wales. Its role is to provide patients, health professionals and the public with authoritative, robust and reliable guidance on current "best practice". The guidance covers both individual health technologies (including medicines, medical devices, diagnostic techniques, and procedures) and the clinical management of specific conditions.

NICE guidance: guidance includes:
- **Clinical guidelines** cover the appropriate treatment and care of patients with specific diseases and conditions within the NHS in England and Wales.
- **Technology appraisals** cover the use of new and existing medicines and treatments within the NHS in England and Wales.
- **Interventional procedures** cover the safety and efficacy of interventional procedures used for diagnosis or treatment.
- **Public health guidance.**

Patient: those in receipt of health care provided by or for an English NHS body or cross-border SHA.

Primary care: first-contact health services directly accessible to the public.

Primary care trust: a local health organisation responsible for managing local health services. PCTs work with local authorities and other agencies that provide health and social care locally to make sure the community's needs are being met.

Public health: Public health is concerned with improving the health of the population, rather than treating the diseases of individual patients. Public health functions include:
- Health surveillance, monitoring and analysis
- Investigation of disease outbreaks, epidemics and risk to health
- Establishing, designing and managing health promotion and disease prevention programmes
- Enabling and empowering communities to promote health and reduce inequalities
- Creating and sustaining cross-Government and intersectoral partnerships to improve health and reduce inequalities

- Ensuring compliance with regulations and laws to protect and promote health
- Developing and maintaining a well-educated and trained, multi-disciplinary public health workforce
- Ensuring the effective performance of NHS services to meet goals in improving health, preventing disease and reducing inequalities
- Research, development, evaluation and innovation
- Quality assuring the public health function

Public Service Agreement: The PSA for the Department of Health sets out the priorities for the Department's spending programme and, for each priority, the target it is expected to achieve.

Quality assurance: a systematic process of verifying that a product or service being developed is meeting specified requirements.

Research governance framework: defines the broad principles of good research governance and is key to ensuring that health and social care research is conducted to high scientific and ethical standards and applies to all research undertaken within the remit of the Secretary of State for Health.

Risk management: covers all the processes involved in identifying, assessing and judging risks, assigning ownership, taking actions to mitigate or anticipate them, and monitoring and reviewing progress.

Service user: an individual who uses a health care service, including those who are not in need of treatment, such as blood donors, carers or those using screening services.

Strategic health authority: responsible for:
- developing plans for improving health services in its local area;
- making sure local health services are of a high quality and are performing well;
- increasing the capacity of local health services so they can provide more services; and
- making sure national priorities are integrated into local health service plans.

Systematic risk assessment: a systematic approach to the identification and assessment of risks using explicit risk management techniques.

Appendix 2: Extracts from the Health and Social Care (Community Health and Standards) Act 2003

The "Duty of Quality":

45 Quality in health care

(1) It is the duty of each NHS body to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care provided by and for that body.

(2) In this Part "health care" means-

(a) services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and

(b) the promotion and protection of public health.

(3) In subsection (2)(a), "illness" has the meaning given by section 128(1) of the 1977 Act.

The Power for the Secretary of State to prepare and publish standards, and the duty of upon every English NHS body and cross-border SHA to take account of the standards:

46 Standards set by Secretary of State

(1) The Secretary of State may prepare and publish statements of standards in relation to the provision of health care by and for English NHS bodies and cross-border SHAs.

(2) The Secretary of State must keep the standards under review and may publish amended statements whenever he considers it appropriate.

(3) The Secretary of State must consult such persons as he considers appropriate-

(a) before publishing a statement under this section;

(b) before publishing an amended statement under this section which in the opinion of the Secretary of State effects a substantial change in the standards.

(4) The standards set out in statements under this section are to be taken into account by every English NHS body and cross-border SHA in discharging its duty under section 45.

CHAI's annual reviews, reviews and investigations, their use of set criteria and the requirement upon CHAI to take into account the standards:

50 Annual reviews

(1) In each financial year the CHAI must conduct a review of the provision of health care by and for-

(a) each English NHS body, and

(b) each cross-border SHA,

and must award a performance rating to each such body.

(2) The CHAI is to exercise its function under subsection (1) by reference to criteria from time to time devised by it and approved by the Secretary of State.

(3) The CHAI must publish the criteria devised and approved from time to time under subsection (2).
(4) In exercising its functions under this section in relation to any health care the CHAI must take into account the standards set out in statements published under section 46.

51 Reviews: England and Wales
(1) The CHAI has the function of conducting reviews of-
(a) the overall provision of health care by and for NHS bodies;
(b) the overall provision of particular kinds of health care by and for NHS bodies;
(c) the provision of health care, or a particular kind of health care, by and for NHS bodies of a particular description.
(2) If the Secretary of State so requests, the CHAI must conduct-
(a) a review under subsection (1)(a);
(b) a review under subsection (1)(b) of the overall provision of a kind of health care specified in the request; or
(c) a review under subsection (1)(c) of the provision of health care, or health care of a kind specified in the request, by or for NHS bodies of a description so specified.
(3) The Secretary of State must consult the Assembly before making a request under subsection (2).
(4) In conducting a review under this section in relation to any health care the CHAI must take into account-
(a) the standards set out in statements published under section 46, where the health care is provided by or for an English NHS body or cross-border SHA;
(b) the standards set out in statements published under section 47, where the health care is provided by or for a Welsh NHS body.

52 Reviews and investigations: England
(1) The CHAI has the function of conducting other reviews of, and investigations into, the provision of health care by and for English NHS bodies and cross-border SHAs.
(2) The CHAI may in particular under this section conduct-
(a) a review of the overall provision of health care by and for English NHS bodies and cross-border SHAs;
(b) a review of the overall provision of a particular kind of health care by and for English NHS bodies and cross-border SHAs;
(c) a review of, or investigation into, the provision of any health care by or for a particular English NHS body or cross-border SHA.
(3) The CHAI has the function of conducting reviews of the arrangements made by English NHS bodies and cross-border SHAs for the purpose of discharging their duty under section 45.
(4) If the Secretary of State so requests, the CHAI must conduct-
(a) a review under subsection (2)(a);
(b) a review under subsection (2)(b) of the overall provision of a kind of health care specified in the request;

(c) a review or investigation under subsection (2)(c), or a review under subsection (3), in relation to the provision of such health care by or for such body as may be specified in the request.

(5) In exercising its functions under this section in relation to any health care the CHAI must take into account the standards set out in statements published under section 46.

THE LEEDS TEACHING HOSPITALS NHS TRUST

BRIEFING NOTE FOR OVERVIEW AND SCRUTINY COMMITTEE 24 MARCH 2009

The Leeds Teaching Hospitals NHS Trust's declaration for 2007/8 indicated that all of the core standards were met with the exception of just 4 elements (see attached schedule) and had no significant lapses. 2 of these elements were compliant by 31st March 2008. Action plans were put in place for achieving compliance with the remaining 2 elements in 2008/09. We intend to declare compliance with both these standards at 31 March, subject to Board review.

In addition to these 2 non-compliant elements, the Trust has been focusing attention in 2008/09 on a further 3 elements which we feel need particular attention, as can be seen on the attached schedule. This is due to changes in the guidance for achieving these particular standards, requiring additional actions in order to be compliant.

A meeting was held between Trust Executive Directors and representatives from the Healthcare Commission on 30 January 2009 to review progress and agree the position in terms of compliance against these standards for 2008/09 and confirm the actions in those areas that will be declared non-compliant. Standard Domain Leads (Executive Directors) met on 12 February 2009 to review risk areas and agree the current position in relation to compliance with each of the standards, including specific actions required for 2008/09. The Trust Board will reassess the position against all the core standards on 26 March 2009 and review progress against the action plans to determine the current position for the full year declaration in 2008/09 and projections for 2009/10.

The Trust continues to develop detailed planning guidance each year for each of the standards to ensure the current position is maintained and improvements are made in relation to compliance with each of the standards and this remains core to our business planning processes.

We believe we have developed a robust process enabling our Trust Board to be assured of the standards we are achieving, which has the added value of external validation by the HCC.

Hugo Mascie-Taylor
Medical Director

Craig Brigg
Director of Quality

Domain	Core Standard	2007/08 Compliant Y/N	Specific focus in 2008/9
Safety	**Generic**		
C1: Healthcare organisations protect patients through systems that:	**a) identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents**	Y	
	b) ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required timescales.	Y	
C2: Healthcare organisations:	**protect children by following national child protection guidelines within their own activities and in their dealings with other organisations.**	Y	
C3: Healthcare organisations:	**protect patients by following National Institute for Clinical Excellence (NICE) interventional procedures guidance.**	Y	
C4: Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that:	**a) the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in MRSA**	N	*
	b) all risks associated with the acquisition and use of medical devices are minimised	Y	*
	c) all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed	N	*
	d) medicines are handled safely and securely	Y	
	e) the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.	Y	
Clinical and Cost Effectiveness	**Generic**		
C5: Healthcare organisations ensure that:	**a) they conform to National Institute for Clinical Excellence (NICE) technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care**	Y	
	b) clinical care and treatment are carried out under supervision and leadership	Y	
	c) clinicians continuously update skills and techniques relevant to their clinical work	Y	
	d) clinicians participate in regular clinical audit and reviews of clinical services	Y	*
C6: Healthcare organisations:	**cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met**	Y	
Governance			
C7: Healthcare organisations:	**a) apply the principles of sound clinical and corporate governance**	Y	
	b) actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources	Y	
	c) undertake systematic risk assessment and risk management (including compliance with the controls assurance standards)	Y	
to be assessed outside declaration process	**d) ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources**	Not assessed	
	e) challenge discrimination, promote equality and respect human rights	Y	
to be assessed outside declaration process	**f) meet the existing performance requirements (list of targets)**	Not assessed	
C8: Healthcare organisations support their staff through:	**a) having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services**	Y	
	b) organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups	Y	
C9: Healthcare organisations:	**have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required**	N	
C10: Healthcare organisations:	**a) undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies**	Y	
	b) require that all employed professionals abide by relevant published codes of professional practice	Y	
C11: Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare:	**a) are appropriately recruited, trained and qualified for the work they undertake**	Y	
	b) participate in mandatory training programmes	Y	
	c) participate in further professional and occupational development commensurate with their work throughout their working lives	Y	

C12: Healthcare organisations:	**which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied**	Y	
Patient Focus	**Generic**		
C13: Healthcare organisations have systems in place to ensure that:	**a) staff treat patients, their relatives and carers with dignity and respect**	Y	
	b) appropriate consent is obtained when required, for all contacts with patients and for the use of any confidential patient information	Y	
	c) staff treat patient information confidentially, except where authorised by legislation to the contrary	Y	
C14: Healthcare organisations have systems in place to ensure that patients, their relatives and carers:	**a) have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services**	Y	
	b) are not discriminated against when complaints are made	Y	
	c) are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery	Y	
C15: Where food is provided healthcare organisations have systems in place to ensure that:	**a) patients are provided with a choice and that it is prepared safely and provides a balanced diet**	Y	
	b) patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day	Y	
C16: Healthcare organisations:	**make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after care**	Y	
Accessible and responsive care			
C17:	**The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services**	Y	
C18: Healthcare organisations:	**enable all members of the population to access services equally and offer choice in access to services and treatment equitably**	Y	
C19: Healthcare organisations: to be assessed outside declaration process	**ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services**	Not assessed	
Care environment and amenities	**Generic**		
C20: Healthcare services are provided in environments which promote effective care and optimise health outcomes by being:	**a) a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation**	Y	
	b) supportive of patient privacy and confidentiality	Y	
C21: Healthcare services are provided in environments which promote effective care and optimise health outcomes by being:	**well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises**	Y	*
Public health			
C22: Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by:	**a) cooperating with each other and with local authorities and other organisations**	Y	
	b) ensuring that the local Director of Public Health's annual report informs their policies and practices	Y	
	c) making an appropriate and effective contribution to local partnership arrangements including local strategic partnerships and crime and disorder reduction partnerships	Y	
C23: Healthcare organisations:	**have systematic and managed disease prevention and health promotion programmes which meet the requirements of the national service frameworks (NSFs) and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections**	Y	
C24: Healthcare organisations:	**protect the public by having a planned, prepared and, where possible, practiced response to incidents and emergency situations which could affect the provision of normal services**	Y	

Note: C7d, e and C19 are not assessed by the Healthcare Commission as part of the Declaration process

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Leeds CITY COUNCIL

Originator JOHN LENNON

Tel: 24 78665

Report of the Director of Adult Social Services

Scrutiny Board:(Health)

Date: 24 March 2009

Subject: Inquiry into Hospital Discharges

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

1 BACKGROUND

1.1 The Scrutiny Board (Health) meeting on the 20 January 2009 amended the terms of reference for this inquiry and resolved for the next meeting on the 24 March 2009 to have reports on the following matters:

1. Clarification of the number of referrals for assessment from out of boundary hospitals.
2. Confirmation of the discharge policy/ protocol review process and timing.
3. Details of the total number of complaints received (across all agencies) relating to hospital discharge and associated support arrangements.
4. Provide more detailed outline of actions to address hospital discharge issues identified in the Independence, Well-being and Choice inspection report.
5. Provide copies of current discharge protocols (i.e. Leeds Hospitals and West Yorkshire hospitals).
6. Provide copies of 'patient information pack' issued to patients on admission.

These issues cover the functions of several statutory agencies and it has been agreed that two separate but complementary reports will be provided by the NHS agencies in Leeds and Leeds Adult Social Care

2 CLARIFICATION OF THE NUMBER OF REFERRALS FOR ASSESSMENT FROM OUT OF BOUNDARY HOSPITALS

2.1 Scrutiny Board requested information on the number of out of area hospital referrals received. For the period April - December 2008 there were 110 out of boundary referrals for assessment. Most of these were referred by Harrogate Hospital, with a few from Dewsbury and a handful elsewhere. To put the number of out of area hospital referrals leading to assessment in perspective, for the total number of referrals during the period April - December 2008 there were 7165 assessments – the full breakdown is described below.

Out of Leeds Hospital referrals:

Bradford Hospitals	1
Harrogate Hospital	89
Pinderfields Hospital	1
Dewsbury Hospital	19
Total	**110**

2.2 For in-Leeds secondary health sources there were 2,622 referrals leading to assessment in the same period. Of these 74 of were from hospices and 2,548 were from hospitals. The main sources were:

St James Hospital - Bexley Wing	778
St James Hospital – Other	771
LGI	531
Hospital/Unit - Psychiatric	181
Chapel Allerton Hospital	146
St Mary's Hospital	57
St Gemma's Hospice	44
Wharfedale Hospital	42
Others (all 30 or less referrals)	72
Total	**2622**

2.3 Out of area hospital referrals leading to assessment in this period (110) thus represent around 4% of the total hospital referrals leading to assessment.

3 CONFIRMATION OF THE DISCHARGE POLICY/ PROTOCOL REVIEW PROCESS AND TIMING

3.1 The Leeds protocol is being reviewed with the input of managers from Leeds Teaching Hospitals Trust (LTHT), NHS Leeds and Leeds Adult Social Care Services (ASC) with contributions from Leeds Environment and Neighbourhoods and the partnership leads for Continuing Health Care – the first draft is now out for comment and amendment within these various organisations. Editorial responsibility has been accepted by the main commissioner of Hospital care, NHS Leeds who have dedicated a member of their team to the task.

3.2 The core group have agreed to look at neighbouring authorities procedures to help the development of this document and benchmark best practice issues. The NHS lead officer will be involving the Older Persons Reference Group to gain input from their perspective to ensure a patients view of how these new procedures support their safeguarding and dignity requirements.

3.3 Although the current work is related to the inspection outcome it will be used to inform and "dovetail" with further work commissioned by NHS Leeds regarding hospital discharges generally. A project initiation document (PID), to better describe the scope and detail of this work, is being prepared for consideration by the Planned and Urgent Care workstream of the Joint Strategic Commissioning Board, who have identified hospital discharges as one of their workstream priorities in this coming year. NHS Leeds have also commissioned a piece of work as a study of activity around admissions and patient pathways, to improve the patient experience, reduce delays in discharge and avert hospital admissions. This work is on target to be completed in March 2009.

3.4 There is a similar but separate workstream relating to the revision of the protocol as it relates to Leeds residents placed in out of Leeds hospitals and this is due for completion in November 2009.

4 DETAILS OF THE TOTAL NUMBER OF COMPLAINTS RECEIVED BY ADULT SOCIAL CARE RELATING TO HOSPITAL DISCHARGE AND ASSOCIATED SUPPORT ARRANGEMENTS

4.1 From 1st April 2008 to 31 December 2008 Adult Social Care have received five complaints relating to hospital discharges.

4.2 In summary, one complaint relating to a delay in hospital discharge was upheld. The patient had been in a Community Intermediate Care (CIC) bed for 5 weeks following hospitalisation after a stroke. The patient had been assessed and equipment delivered to his home. Despite wanting to return home, he could not, because the home care package could not be commissioned from one of our regular home care providers. The budget holder as a contingency arrangement agreed to pay for a spot contract from another agency to provide the homecare.

4.3 Four complaints related to care plans not started and/or incomplete care plans – three were upheld

- One related to the fact that the Care Plan, at the time the patient was ready for discharge, had not been completed and had insufficient information regarding medication to be provided when they returned home.
- One related to an incomplete Care Plan – the patient had been living in a nursing home for 7 months. A failure to review the Care Plan following discharge led to their nursing home being unable to clearly identify what was now to be expected or care to be provided.
- One related to an incomplete Care Plan – the patient argued the inadequacy of the original assessment conducted by hospital staff led to an incomplete Care Plan. The patient was re-assessed and the Care Plan revised accordingly.
- One complaint related to having no Care Plan - a service user was discharged from hospital following an operation. The Hospital and GP made a referral to Adult Social Care for support but that having returned home no support was offered. This complaint was not upheld as Social Care Services assessment concluded the patients needs were not substantial and therefore, not eligible to receive services from Social Services. The patient was signposted to alternative providers for support.

5 PROVIDE MORE DETAILED OUTLINE OF ACTIONS TO ADDRESS HOSPITAL DISCHARGE ISSUES IDENTIFIED IN THE INDEPENDENCE, WELL-BEING AND CHOICE INSPECTION REPORT

5.1 There is a detailed action plan relating to the outcome of the Independence, Well-being and Choice Inspection and those specifically relating to the hospital discharges are listed below:

- The Council and partners should strengthen hospital discharge procedures by focusing on the quality of peoples experiences.
- The Council and its partners should strengthen its hospital discharge procedures by setting out clear reciprocal responsibilities with procedures in place to ensure compliance.
- The Council and partners should strengthen hospital discharge procedures by agreeing a process for resolving and learning from concerns about the quality of multi-disciplinary work.

5.2 The Council and partners should strengthen hospital discharge procedures by focusing on the quality of people's experiences.

5.2.1 In addition to the detailed description of this work provided in 3.1, these actions have been split – the first priority is to complete a signed protocol for within Leeds hospitals and that is on target to be completed by March 2009. The second action is to have a protocol signed and agreed for the out of Leeds hospitals listed under 1.1 – that work is to commence in March 2009 for completion in November 2009.

5.2.2 The remit of the existing Planned and Urgent Care Group (which has representatives from NHS Leeds, LTHT and Leeds ASC) has been extended to oversee the revision of the current protocol, procedures and practice relating to hospital discharges. Regular monitoring reports will be prepared for the Planned and Urgent Care Group and submitted to the Joint Strategic Commissioning Board (JSCB). The first of these reports are planned for the May 2009 Board meeting

5.3 The Council and its partners should strengthen its hospital discharge procedures by setting out clear reciprocal responsibilities with procedures in place to ensure compliance

5.3.1 There will be in place signed protocols between ASC and Health partners covering all hospital discharge procedures, continuing care issues and a disputes resolution process for all hospitals in and out of Leeds which have Leeds residents as patients. These protocols will more properly reflect the requirement to have dignity and safeguarding principles and values at the forefront of any arrangements that effect patient care and their hospital discharge arrangements.

5.4.1 **The Council and partners should strengthen hospital discharge procedures by agreeing a process for resolving and learning from concerns about the quality of multi-disciplinary work**.

5.4.2 Regular monitoring and reports will be prepared by the Planned and Urgent Care Group and submitted to the Joint Strategic Commissioning Board. The first such report will be provided in May. Agreement has been reached with our partners on the need to establish a baseline audit for complaints and capture the patients experience following discharge from hospital discharge. Data and information will be drawn from:

- Adult Social Care reviews of service users following hospital discharge.
- Complaints received from NHS Leeds and Leeds Adult Social Care arising from hospital discharge.
- User experience surveys conducted by NHS Leeds.

5.4.3 This action commenced in January 2009 and is due for completion in April 2009. Some data concerning the patient experience of hospital discharge has already been collected and these will be included in the reports to the Planned and Urgent Care Board in May 2009.

6 PROVIDE COPIES OF CURRENT DISCHARGE PROTOCOLS (I.E. LEEDS HOSPITALS AND WEST YORKSHIRE HOSPITALS)

6.1 A copy of the current Delayed Transfer of Care Protocol is provided as an attachment. Scrutiny are advised that this is the protocol we are seeking to amend with our partners, in the first instance for hospitals in Leeds and subsequently with the out of area hospitals described above -see appendix 1

7 PROVIDE COPIES OF 'PATIENT INFORMATION PACK' ISSUED TO PATIENTS ON ADMISSION

7.1 LTHT will provide any additional patient information provided above and beyond that which is already included in the current Joint Protocol which is attached as appendix 1.

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Joint report from NHS Leeds and Leeds Teaching Hospitals Trust

Leeds Overview and Scrutiny Committee - Health Services

Briefing report into Hospital Discharges - March 2009

1. INTRODUCTION

Discharge from hospital refers to people who no longer need to be cared for in a hospital setting. The person either

1. No longer has any ongoing care needs and can return home.
2. Has an ongoing care need which can be met at home with additional support.
3. Has an ongoing care need which may be more appropriately met in a different setting

The aim of the hospital discharge process is to identify if a person has an ongoing care need which is likely to require additional support on discharge. The objective is then to ensure that the additional support is available when the person is medically fit for discharge and no longer requires inpatient services. Care needs are identified by a process which involves the person concerned and assessment by combination of LTHT (Leeds Teaching Hospitals Trust), NHS Leeds and Leeds Adult Social Care staff. Care needs can vary from arranging frozen meal delivery, provision of a home care package to permanent placement in a care home.

Discharge Facilitators.

The Discharge Facilitators are a team of five nurses two employed by NHS Leeds and three employed by LTHT. The team works within LTHT to primarily provide advice, guidance, education and support to hospital staff and patient carers with regards to the discharge process. The team also acts as a point of liaison with staff from NHS Leeds and with Adult Social Care. The discharge facilitators also monitor record and disseminate the reasons for delayed discharges within LTHT and through the Multi Agency Operational Discharge Group (MAODG) resolve and learn from concerns raised regarding discharge of patients.

Multi Agency Operational Discharge Group (MAODG)

This is an operational group with representation from LTHT, NHS Leeds and Adult Social Care. This group meets weekly to discuss delayed discharges from hospital and also the difficulties that exist with individual discharges. The group also provides a forum to discuss and address issues arising with the discharge process, and to problem solve any reasons for delay in discharge and also to improve the quality of the patient experience. The group is able to monitor and review the process and work in partnership with colleagues to facilitate safe and effective discharges. (Terms of Reference of MAODG at Appendix 1)

2. SUMMARY OF THE DISCHARGE PROCESS FORM ADMISSION TO HOSPITAL AND SUBSEQUENT DISCHARGE FROM HOSPITAL

From 1st April 2008 until 31st Dec 2008 there were 162,489 adult inpatients discharged from LTHT.

In the 12 month period January to December 2008, there were 10,798 referrals received by NHS Leeds discharge referral point (DRP) requesting an assessment from Local Authority Adult Social Care or NHS Leeds to facilitate a supported discharge. Not all of these referrals originate from LTHT some originate from neighbouring NHS Trusts. These referrals are called Section 2 (S2) and comply with the Community Care (Delayed Discharge Act) 2003 requiring hospitals to notify the community when an assessment is required to facilitate a supported discharge.

The process for discharging patients from hospital follows the LTHT discharge policy first published in November 2006 The LTHT discharge policy and Joint Protocol were developed collaboratively by LTHT, Local Authority Adult Social Care and NHS Leeds, and are currently under review.

Discharge from hospital is not an isolated process and is specific to the individual concerned. The trigger for instigating additional assessment can come from a variety of sources (patient, family, friends, health professionals, local authority staff and voluntary agencies). The need for ongoing support can be identified at any time during the person's hospital admission pathway.

Discharge Pathway for a person following an acute hospital admission (see appendix 2)

- On admission to a hospital ward, a nurse will complete a Contact Easy Care document. The aim of this document is provide a picture of the patient on admission. The document clarifies biographical details this also identifies existing care provision and gives the patient / carer opportunity to identify any difficulties they may have been experiencing prior to admission.
- The hospital nurse will complete a nursing specialist assessment identifying the patients existing care needs.
- If appropriate referrals will be made to Allied Health Professionals such as Occupational Therapy, Physiotherapy and Speech and Language Therapy to assist with the patient's rehabilitation and also to identify any ongoing care needs.
- If the patient and /or the Multi Disciplinary Team identify care needs that will be ongoing once the patient no longer needs to remain in Hospital. A referral will be made to the Adult Social Care Team or NHS Leeds requesting an assessment of the patients care needs (S2).
- The documentation for a referral to Adult Social Care Team or NHS Leeds comprises of a Contact Easy Care document, nursing specialist assessment and a Continuing Health Care Checklist.

- On receipt of the referral a social worker or joint care manager is allocated and will work with the patient, carer and MDT to identify specific ongoing care needs.

- Once the patient no longer needs to remain in hospital and there is no more therapy or investigations required as an inpatient, the social worker or joint care manager will be informed. This is done by sending a Section 5 (S5) notification. This is a requirement within the Community Care (Delayed Discharge Act) 2003 whereby the hospital has to inform the local authority of a potential discharge date.

- Once provision to meet the patients ongoing care needs are in place and it is safe for them to be discharged a discharge date will be planned.

3. ASSESSMENT AND CARE MANAGEMENT

Adults with eligible social care needs can receive assessment and on going care management from a number of services depending on their presenting needs.

In summary these services are

Initial Response Teams (community-based)
Initial Response Teams (hospital-based)
Area Care Management Teams
Joint Care Management - Learning Disability Teams
Joint Care Management - Older People Teams
Disability Service Teams
Mental Health Teams

Each team has defined “entry” criteria which describes the circumstances in which they work with an individual (see appendix 3), and also “exit” criteria.

4. COMPLAINTS RECEIVED IN RELATION TO PATIENT DISCHARGES

Leeds Teaching Hospital Trust

From 1st April 2008 until 31st Dec 2008 LTHT received a total of 1,001 complaints which were recorded by patient relations. Of these complaints 51 refer in some way to discharge. These can be further broken down as:

Discharge Planning	14
Communication / Information	13
Transport	7
Early Discharge	5
Aftercare	5
Medication on Discharge	4
Discharge Delayed	2
Time of Discharge	1

NHS Leeds

NHS Leeds Investigated	1
LTHT investigated	3
NHS Leeds/LTHT Joint Investigation	2

Re-admissions of patients discharge to Intermediate Care /CIC beds

May 2008	10
June 2008	7
July 2008	12
August 2008	11
September 208	10
October 2008	9
November 2008	12
December 2008	11

The number of complaints identified above may reflect patient perceptions of expected support and also breakdown in care provided by specific agencies.

5. LEEDS UNPLANNED CARE - DISCHARGE REVIEW

Significant progress has been mad on reducing delayed transfers of care and improving the overall quality of the discharge process and patient/carer experience.

However it is acknowledged that more work on ensuring quality discharge for patients and streamlining the process would provide further improvements.

A Discharge Review has been proposed with the major deliverables.

- Agreement to work collaboratively across the health and social care interface
- Production of a discharge action plan - including process mapping/full system
- Satisfying the requirements of the CSCI report

It is proposed that recommendation from the review will be implemented by September 2009.

Andrea North
Head of Intermediate Tier
NHS Leeds

Judith Lund
Directorate Manager
Speciality Medicine
Leeds Teaching Hospitals

January 2009

Appendix 1

THE LEEDS TEACHING HOSPITALS NHS TRUST

Multi Agency Operational Discharge Group

TERMS OF REFERENCE

PURPOSE

The Multi Agency Operational Discharge Group (MAODG) will provide a forum for multi agency members to meet, identify and resolve operational issues regarding patient discharge.

Membership

Membership will be from the following agencies

- Leeds Teaching Hospitals Trust (LTHT)
- Leeds Adult Social Care
- Leeds PCT

Membership is not limited and other departments can, or may be invited to, attend as required

Chair

Directorate Manager - LTHT

Deputy Chair

Service Manager - Leeds PCT
Service Delivery Manager - Leeds Adult Social care

SECRETARIAT

The Chair will coordinate & circulate papers including note taking and transcribing

REPORTING & ACCOUNTABILITY

The Multi Agency Discharge Operational Group is an operational group to identify and resolve issues. Any items requiring corporate /strategic decision making will be taken by the appropriate group member and / or the Chair of the group to the relevant senior manager of the appropriate agency.

FREQUENCY & COMMUNICATIONS

- The MAODG will meet weekly
- Minutes will be circulated to group members for action/information
- Members of the MAODG have responsibility for communicating discussions, actions and decisions to their relevant staff group or forum as per individual Agency communication structures

KEY OBJECTIVES

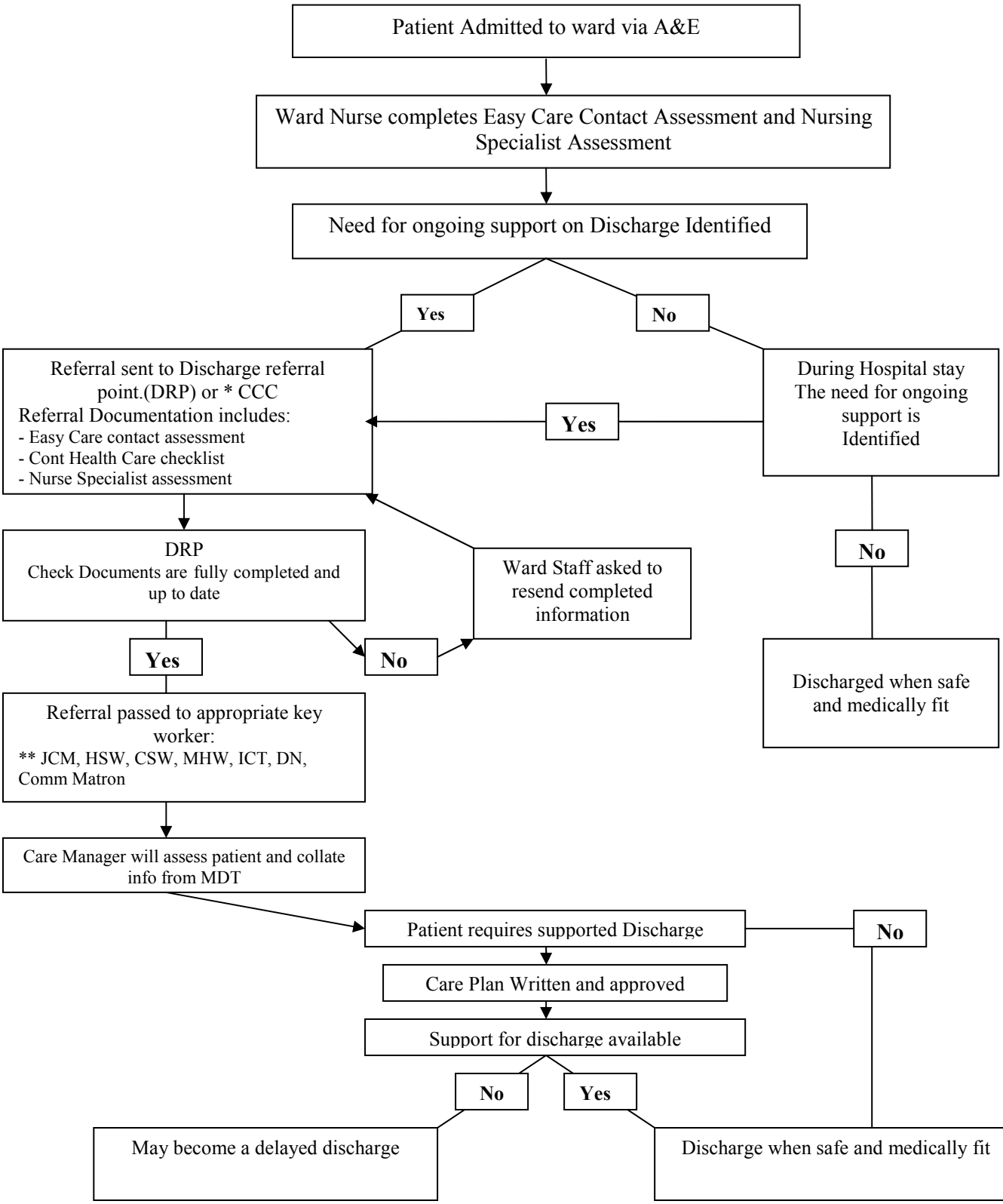
To address cross cutting issues and initiatives to ensure consistency of approach and maximize capacity through shared working.

RESPONSIBILITIES

- To advise group members on potential or actual patient discharge operational issues.
- To reduce the numbers and length of stay of delayed transfers of care in the Leeds healthcare system.
- To consider the Escalation process for specific patients as appropriate.
- Record, monitor and interrogate statistical information regarding delayed transfers of care.
- To ensure there are robust communications of operational cross cutting issues and decisions between agencies regarding delayed discharge.
- To identify and discuss issues impacting on the operational delivery of services agreeing solutions, appropriate escalation and review of effectiveness.
- To receive updates on initiatives/projects relevant to the MAODG
- To provide a forum to discuss and influence the development of future relevant policies, procedures and processes
- To ensure operational systems and processes are developed to support efficient and effective service delivery

Appendix 2

Discharge Pathway for Leeds residents



** Key Worker: JCM - Joint Care Manager HSW Hospital Social - Worker CSW - Community Social Worker
MHW - Mental Health Worker DN - District Nurse ICT - Intermediate Care Team
Comm Matron - Community Matron

* Care Communication Centre if Leeds Resident is being discharge from out of Leeds Hospital. eg: Harrogate

Appendix 3 Extracted from document agreed 11/2006
(Updated 14/01/20090

LEEDS SOCIAL SERVICES DEPARTMENT
ADULT ASSESSMENT AND CARE MANAGEMENT SERVICE

ENTRY CRITERIA

1. Initial Response Teams (community-based)

- Introduction
  Initial Response Teams (community-based) provide a screening and assessment service, sign posting to and/or commissioning services as appropriate.

- Entry criteria

  The Initial Response Teams (community-based) provide services to people:

  1. Aged 18 and over.

  2. For whom the Local Authority has a duty to provide an assessment as they appear to be in need of Community Care services.

  3. Whose current case episode is not active to another worker in the city, i.e. they are new to the Department or passive.

  1. The 'within 3 month review' identifies that the service user no longer requires support from the Department or is no longer eligible. The case will be closed and involvement with the Initial Response Team will cease (see point 1 above).

  2. The person referred does not appear to be in need of community care services. No formal assessment of need will be undertaken, information or advice, including signposting to others services may be offered. Exceptions to this include the provision of statutory responses under the National Assistance Act (Section 50 Burials, Section 48 Protection of Property, etc).

2. Initial Response Teams (hospital-based)

- Introduction
  Initial Response Teams (hospital-based) provide a screening and assessment service, sign posting to and/or commissioning services as appropriate.

  Hospital Social Workers will:-

  1. Work jointly with workers from other services to assess and provide for people's needs e.g. JCM Learning Disability or Head Injury Teams.
  2. Liaise with workers from other Local Authorities concerning patients in hospital from Authorities outside Leeds.
  3. Review (reassess) needs on those people already living in residential care.

Leeds Teaching Hospital Trust directly funds some Social Workers to provide a service to specific 'specialist' units in LTHT e.g. Liver Unit, Renal Unit, Haematology Unit. Social workers will provide 'specialist' assessments as required by the Units for people from Leeds and other Local Authority areas addressing psychosocial issues and decision making regarding treatment/transplantation. They will also signpost, offer advice, carry out any level of assessment, commission services, and review their needs under the FACS criteria where appropriate. Social Workers will provide assessment and care management until the overall package is stable and active care management is no longer required or where there are no further tasks for the service to undertake. Access to these services is via the relevant Consultants.

- Entry Criteria for people not receiving a service from specialist units in LTHT

  The Initial Response Team (hospital-based) provides services to people:

  1. Aged 18 and over.

  2. For whom the Local Authority has a duty to provide an assessment as they appear to be in need of Community Care services.

  3. Whose current case episode is not active to another worker in the city, i.e. they are new to the Department or passive.

  4. Who are patients of the LTHT on the following sites: - Leeds General Infirmary, St James' Hospital, Chapel Allerton Hospital and Cookridge.

  For people who are aged 65 years and over, in addition to the above, they must also have needs that can be met through a less-intensive package of care or transfer from one type of care home to another.

3. Area Care Management Teams

- Introduction
  Area Care Management Teams provide on-going monitoring and reviewing of Care Plans for people in receipt of services from the Department who do not require a specialist team to provide this. They will undertake assessment where the need for longer-term care management has been identified through the IRT screening processes.

- Entry criteria

  The Area Care Management Teams provide services to people:

  1. Aged 18 and over.

  2. Where an Initial Response Team has determined the service user is eligible for services.

  3. Where a care plan is in place and the active input of a care manager to support its implementation is required.

4. Joint Care Management - Learning Disabilities Teams

- Introduction

  The Joint Care Management – Learning Disabilities Teams are specialist teams who provide assessment and care management services. Service users who meet the entry criteria will be considered for either allocation or joint working.

  The Teams can provide support to an adult worker holding the case where this is appropriate, rather than taking the case. Team members will be available to offer advice to workers involved with service users with any level of need associated with a learning disability through the 'specialist learning disability advice line' which operates on 0113 **247 8880**. Lines are open:

Monday -Thursday	9.00am to 12.00 and 2.00pm to 5.00pm
Friday	9.00am to 12.00 and 2.00pm – 4.30pm

  Involvement in an advisory capacity to workers in Children's Teams supporting young people in transition will be offered where appropriate.

  NB A learning disability is:

  "A significantly reduced ability to understand new or complex information or to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood, with a lasting effect on development" (from the National Framework for NHS Continuing Healthcare, 2006). This may have its onset before birth or during infancy and is associated with an IQ of 70 or below.

- Entry criteria

  The Joint Care Management - Learning Disabilities Teams provide services to people **who meet all of the following criteria**:

  1. Aged 18 and over.

  2. Where an Initial Response Team has determined the service user is eligible for services.

  3. Whose primary presenting need is associated with their Learning Disability?

  4. With complex needs which require a Specialist Multi–Disciplinary Team Assessment* or Comprehensive Assessment (as defined under SAP).

     *A Specialist Multi-Disciplinary Team in the learning disability (LD) context is one that includes more than one LD professional.

5. Joint Care Management (Older People Teams and Continuing Health Care) (OP and CHC)

- Introduction

  Joint Care Management – Older People Teams are specialist teams who provide assessment and care management services and work primarily with older people who have intermediate care or continuing health care needs.

- Entry Criteria

The Joint Care Management – (OP and CHC) provides services to people:

1. Aged 65 and over.
   Adults aged 18-65 years who are eligible/likely to be eligible for CHC funding.

2. Resident within Leeds City Council boundaries.

3. Registered with a Leeds General Practitioner but living outside the Leeds City Council boundaries where the person is eligible/likely to be eligible for CHC funding.

And where one or more of the following are met:-

1. Health needs which meet the 'critical' level of FACS eligibility and/or are of such complexity they are likely to meet Continuing Health Care criteria.

2. A community based healthcare professional identifies a patient who is at immediate risk of admission to hospital.

3. A patient requiring discharge from hospital where a specialist assessment is required and either interagency coordination of an intensive care package or an admission to a care home for the first time or chronic disease management is required.

4. There is a requirement to co-ordinate an on-going multi-disciplinary/inter-agency assessment to either facilitate an early discharge from hospital or avoid a long-term placement by ensuring all avenues have been explored.

5. Have an identified need for a Community Intermediate Care bed.

6. Disability Service Teams

- Introduction

  The Disability Service Teams are specialist teams who provide assessment and care management services, signposting to and/or commissioning services as appropriate for disabled people.

  Disability Service Teams have a range of specialist staff within them and do not operate as a multi-disciplinary team in relation to service users they work with. Therefore entry and exit criteria are related to each area of the service in order to best reflect the specific services available to people with differing needs and circumstances.

- Entry criteria

  The Disability Service Teams provide services to people:

1. Aged 18 years and over.

2. Where an Initial Response Team has determined the service user is eligible for services.

And where one or more of the following are met:-

<u>For Specialist Social Work – Physical Impairment</u>

1. The service user is newly diagnosed with a neurological long-term condition.

2. The service user is at a transitional life stage and requires specialist and detailed planning.

3. The service user is experiencing a stepped change in their level of impairment.

   Note: Specialist Social Workers can provide support to adult workers holding the case, where this is appropriate, rather than taking the case.

   For Rehabilitation Officers Visual Impairment

1. The service user requires mobility/orientation assessment and training e.g. long cane.

2. The service user needs to learn adapted communication skills, including Braille, Moon or ICT.

3. The service user requires to develop and/or maintain personal and/or domestic skills related to sight loss.

4. The service user has experienced sudden sight loss.

5. The service user also has a significant hearing loss.

6. The SSD has received a CVI/BD8 for the service user.

For Occupational Therapy

1. The service user is experiencing environmental barriers which cannot/no longer be overcome by simple equipment and/or minor adaptations.

2. Risk assessment has identified moving and handling issues that cannot be resolved by the locality manager/unit manager/service provider.

3. The service user needs Occupational Therapy assessment and intervention to develop/maintain independent living skills.

4. The carer requires Occupational Therapy intervention to prevent breakdown of the care package.

5. A SSD building used by disabled person/people has barriers which prevents inclusion.

6. A new building/service for disabled people is being planned by or in partnership with SSD.

7. Mental Health Teams

- Introduction
  The Mental Health Unit is the section of Social Services Department that covers social work staff working in a variety of adult mental health settings. Many of these services are provided and managed by LMHT (see 'secondary services' below).

Primary mental health services

- Approved Social Work service

Access to this service is via a request from a professional for an assessment under the Mental Health Act and subsequent screening undertaken by the Mental Health Unit who can be contacted on 0113 **295 4440**, lines are open:

Monday – Thursday	8.30am to 5.00pm
Friday	8.30am to 4.30pm

Secondary mental health services

If a secondary mental health service may be useful to a service user, this should be discussed with their GP in the first instance who can access these services directly. All of the following are secondary mental health services provided by LMHT. Each service has specific entry and exit criteria, which are taken into account during the screening process for the service.

- Acute General Mental Health Services for people aged over 65 (CMHT)

- Acute General Mental Health Services for people aged 18 – 65 (CMHT)

CMHT Acute services are accessed via referral through from the person's GP and are made to the CMHT in that geographic area.

- Specialist Mental Health Services including

  - Community Rehab – Long-term support for people with serious and enduring mental health problems.*
  - Assertive Outreach Team – Intensive support to 'hard to reach' people.*
  - Continuing Treatment and Recovery Service – In-patient rehabilitation service for people with severe and enduring mental health problems.*
  - Early Onset Dementia – Psychiatric assessment consultancy & treatment service
  - Forensic Service – Citywide service for people needing secure care or referred via the Courts.
  - Special Care Services – Short-term intensive care for people too disturbed for normal wards.
  - Liaison Psychiatry – Psychiatric assessment and follow-up service for people at LGI or St James's
  - Self-harm Service – Psychiatric assessment and follow-up service for people who self-harm and present at A & E at LGI & St James's.

- These services only accept referrals for people already known to secondary mental health services.

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Appendix 1

Reviewed and Updated Version March 2008 for the Multi-Agency Discharge Steering Group

Joint Protocol for the Transfer of Care under the Community Care (Delayed Discharge) Act 2003

An Agreement between:

Leeds City Council

- Social Services
- Housing Services

Leeds Teaching Hospitals NHS Trust

Leeds Primary Care Trust

Harrogate and District NHS Foundation Trust

Mid Yorkshire Hospitals NHS Trust

1. Purpose

1.1 This protocol is intended to eliminate all delays in the transfer of care of acute patients:

- It sets out the principles of reimbursement and the health economy agreement on the expenditure for purposes of joint investment.

- It ensures that people are cared for in the most appropriate environment.

- It recognises that a whole system agreement is necessary to eliminate delayed transfers of care.

1.2 Whilst the major focus is upon acute beds the protocol also supports the 4 hour A&E standard and ensures best use of overall bed capacity, which in turn supports a well organised admission and discharge process.

1.3 This protocol recognises that systems and processes may be slightly different for out of Leeds hospitals, however the principles remain the same.

2. Principles

The protocol is based on the following principles:

- That joint working and the sharing of responsibility across agencies is key to eliminating delayed transfers of care.

- All health and social care organisations are committed to a whole systems approach, whereby responsibility for effective patient care and the discharge process is a shared responsibility across organisational boundaries.

- Planning patients' transfer/discharge should commence on or before the day of admission to hospital.

- The transfer of care process will focus on the persons needs and both they and their carers should be involved and kept informed of what is happening at all times.

- The management (including assessment) of a person's health and social care needs should be a single process. Duplication of effort is time consuming for professionals and frustrating for patients.

- That people will receive the right type of care in the right place at the right time.

- A commitment to the development of community resources to avoid inappropriate hospital admissions and to prevent A&E being used as the main gateway to health and social care services.

- Optimum use of bed capacity resources

- Acute hospital beds are for people with acute medical care needs. People who do not have acute medical care needs should not be admitted to acute beds and those who have acute medical care needs on admission should be transferred as soon as they are medically fit and safe for discharge.

- On transfer from acute care the first consideration should be for the patient to return home, safely and with the appropriate support. If necessary a transitional/interim placement will be offered whilst appropriate support or adaptations are put in place.

- Only in exceptional circumstances should patients transfer directly to long term residential or nursing home care. In the majority of cases the community care assessment should be completed in a non acute environment.

- Reimbursement is a catalyst for change not an excuse for more bureaucracy.

3. Definitions

Whilst the principles apply to all patients the legislation only applies to patients in receipt of acute care. Acute care is:

"Intensive medical treatment provided by or under the supervision of a consultant which is for a limited time after which the patient no longer benefits from that treatment".

Reimbursement may apply to all delayed acute adult patients who qualify for services under the NHS and Community Care Act 1990 – irrespective of their age.

4. For the purposes of this protocol acute care does not include any of the following:

- Care in respect of which the patient has given an undertaking to pay (or for whom such an undertaking has been given)

- Maternity care, that is care of expectant and nursing mothers

- Mental health care (defined as psychiatric services or other services provided to a patient for the purposes of the prevention, diagnosis or treatment of illness where the person primarily responsible for arranging those services is a consultant psychiatrist).

- Palliative care

- Intermediate care (a structured programme of care provided for a limited period of time to assist a person to maintain or regain the ability to live in his home)

- Care provided for the purposes of recuperation or rehabilitation.

4.1 Patients whose primary reason for admission to hospital is an acute physical condition but where there is a secondary condition relating to mental health or learning disability **are** included in the reimbursement category.

4.2 Patients receiving non acute care or rehabilitation within an NHS hospital and those waiting to transfer from acute care to Intermediate Care services **will not** be counted for purposes of reimbursement.

4.3 Non acute care will be determined by the individual patient's needs.

4.4 However, the principles of the discharge process will apply to non-acute care equally and the joint assessment process will address **all** delays.

5. Liability under the Community Care (Delayed Discharges) Act

5.1 Adult Social Care Authorities will be deemed liable to make delayed discharge payments where they have the **sole** responsibility for the delay in discharge of acute patients in the following circumstances:

See Appendix 1 for list of codes and definitions

- Where notice of a patient's case under Section 2 of the Act and notice of proposed discharge under Section 5 (3) have both been given and are in force.

- The Adult Social Care Authority has not carried out an assessment of a patient's needs with a view to identifying any community care services that need to be made available in order for it to be safe for the patient to be discharged.

- The Adult Social Care Authority has not made available for the patient a community care service which it decided under Section 4 (2) (b) to make available to him

- The Adult Social Care Authority has not carried out an assessment of needs of any carer identifying services which:

  a) May be provided under Section 2 of the Carers Disabled Children Act 2000 and

  b) Needs to be made available to the carer in order for it to be safe to discharge the patient

- The Adult Social Care Authority has not made available services which may include:

- Equipment and Adaptations

  Where social care equipment is awaited from the Leeds Equipment Service or adaptations to a patient's home are required before the person can return home.

5.2 Housing/Homelessness

Vulnerable people of no fixed abode, asylum seekers (where the local authority has duties under the Human Rights Act, National Assistance Act, and NHS Community Care Act) are the responsibility of the local authority from which the patient was admitted and the appropriate Adult Social Care Department will be held accountable for any delays in the assessment or provision of service.

Leeds City Council, Neighbourhoods and Housing will provide a specialist assessment service and will provide advice and support to health and social work professionals involved in the discharge process, where it has been identified that the patient is unable to be discharged to their current home, or where discharge to their current home would prove detrimental to their heath. Primarily this will be achieved through referral via EasyCare to the Medical Rehousing Team (see **Appendix 8**). In the interim discharge processes and, if necessary, the Escalation Policy will apply.

If a patient is waiting for accommodation only, rather than for adaptations to existing accommodation or other community care services to be arranged or provided by the local authority, then reimbursement will not apply, as housing is not a community care service.

5.3 Self Funders

Where an assessment and/or arrangement to place or provide community services is undertaken by Adult Social Care this means that Adult Social Care are liable, under reimbursement, even though the person may fully fund their own care.

Self funding patients and their families/carers refusing to participate in finding discharge placements into permanent/interim/transitional care will be subject to the implementation of the **Escalation Policy** (see below and **Appendix 2**).

5.4 Community Intermediate Care Beds/Community Unit - Seacroft V Ward

Assessment for Community Intermediate Care (CIC) tier beds will be determined by Leeds PCT. Patients assessed as suitable for a Community Intermediate Care Beds will be offered a placement from a city wide bed base. Patients cannot refuse a CIC bed based on the geography of the placement. Every effort will be made to ensure placement close to the patient's home, however, remaining in an acute hospital bed is not an option and a vacancy in a CIC bed in other areas of the city will be pursued.

Patient's refusing discharge to a CIC bed will be subject to the Escalation Policy (Appendix 2). Patients awaiting access to Community Intermediate Care Beds/services are not currently liable for reimbursement.

5.5 **Choice**

Remaining in an acute hospital bed is **not** an option. Adult Social Care are liable, under reimbursement, for patients who remain in an acute bed whilst waiting for a care home of their choice. In these circumstances the patient will be moved to an interim placement. If they refuse to move from the ward then the **Escalation Policy** will apply (see appendices for Choice, Escalation Policy and patient information details).

5.6 There will be no liability for delayed discharge payments from Adult Social Care in the following circumstances:

Where a patient does not agree to be referred to Social Services and they plan to make their own care arrangements on discharge. If discharge is not achieved in a timely manner, and within the prescribed timescales the **Escalation Policy** will be instigated, see appendices for details.

- When the discharge assessment process is awaiting the contribution of a health care professional/clinician (e.g. consultant psychiatrist). However, it is expected that all contributions to the assessment will be completed and available in a timely manner. Should there be an unreasonable delay in the process the issue will be immediately brought to the attention of the Lead Director.

- The non availability or delay in accessing non acute health services; primary health care services, palliative care services or intermediate tier services. Any unreasonable delay in accessing services will be brought to the attention of the Lead Director.

- Where there is a disagreement within the multi-disciplinary team that a patient is either not fit or safe to discharge. These patients will transfer into the Medically Unwell (M1) category and the Section 5 will be held in abeyance until the patient is well.

- Where Adult Social Care has arranged and funded an alternative placement or community care service but the patient or their relative refuses to allow them to leave an acute hospital bed. In this instance the **Escalation Policy** will be activated.

- Where the patient is eligible for Continuing Health Care funding and services.

- Where notices under Section 2 and Section 5 (3) of the Act have not been properly served and / or are not still in force pursuant to regulation 4 and 5 of the Delayed Discharge (England) Regulations 2003.

- Where circumstances set out in Regulation 9 apply. In these instances the decision on reimbursement will be dependent upon the decision of the Appeals Panel. (See 20.2).

5.7 Liability for delayed discharge payments commences the day after the relevant day as referred to in Section 5 (6) of the Act and Regulation 8 (1) of the Delayed Discharge (England) Regulations 2003

5.8 Notice under Section 2 and Section 5 (3) shall be deemed to have been served pursuant to Regulation 10 of the Delayed Discharge (England) regulations 2003

5.9 The period of reimbursement will end on the day that the Local Authority has completed the assessment and/or made available the resources to meet assessed needs or if, according to the MDT, the patient is no longer fit for transfer. Patients discharged before 11am will be treated as though discharged the preceding day.

5.9.1 Once reimbursement has been triggered every day a patient is delayed in acute care is counted.

6. Information Sharing

6.1 The pan-Leeds information sharing policy will apply to all aspects of this protocol. This is based on the premise that information on a person can only be shared if they give their informed consent.

7. Multi Disciplinary Assessment

7.1 A patient is ready for transfer when:

- A clinical decision has been made that the patient is ready for transfer AND
- A multi-disciplinary team decision has been made that the patient is ready for transfer AND
- The patient is safe to discharge/transfer

7.2 A multi-disciplinary team in this context includes nursing and other health and social care professionals, who are caring for a patient in an acute setting.

7.3 An MDT assessment requires a minimum of three members; a clinician a therapist and a Hospital/Community Social Worker/Joint Care Manager.

7.4 See appendix 4 for flowchart with triggers for S2 and S5 documentation.

8. NHS Continuing Care

On 1st Oct 2007 a new National policy came into effect called the National framework for NHS continuing healthcare and NHS – funded nursing care. This introduces three new national tools to aid decision making.

8.1 It is important that the NHS can demonstrate that it has been considered
whether a patient may be eligible for NHS Continuing Health Care (CHC)funding prior to an assessment notification being issued?

8.2 To fulfil this need a **NHS Continuing Healthcare Needs Checklist** should be completed by any member of the professional Multi Disciplinary Team. This will indicate whether there is a need for full eligibility consideration by the PCT. The outcome of this screening process should be notified to the patient and documented in the patients' records.

8.3 Where full assessment is indicated the **Checklist** should be sent to the Discharge Referral Point (DRP) along with the;

- SAP Contact Assessment,
- Specialist Nursing Assessment,
- Fax Cover Sheet
- S2 notification.

The case will then be allocated to the appropriate care manager and Continuing Care Team. A care manager can be a Joint Care Manager, a Hospital Social worker or a Community Social Worker.

8.4 Where a full assessment is **not** indicated MDT members, including ward staff, should be aware that if a patient's health condition deteriorates prior to discharge the above **Checklist** process should be repeated and the original Section 2 withdrawn.

8.5 The Care Manager will then facilitate the completion of the national **Decision Support Tool** taking account of all the MDT assessment information, including all relevant clinical information provided by ward staff, as evidence to inform the recommendations.

8.6 Where indicated the **Decision Support Tool** recommendation will be presented to the next City wide CHC Panel to determine a patient's eligibility for CHC funding.

8.7 Where a patient has a rapidly deteriorating condition, which may be entering a terminal phase, an urgent referral for care planning should be made. This will require the completion of a **Fast Track Tool** by an authorised clinician.

8.8 The discharge planning process, including any choice directive or escalation issues, should proceed as normal whilst CHC eligibility is determined.

8.9 At any point in the process the patient or their representative can appeal the decision and ask for a review. The CHC team will offer advice and support in this circumstance.

The National Framework document and decision support tools are available on Leeds Health Pathways, or they can be found at:

http://www.dh.gov.uk/en/Policyandguidance/SocialCare/Socialcarereform/Continuingcare/index.htm

9. Transfer / Discharge Assessments

9.1 The SAP Contact Assessment, along with the Specialist Nursing Assessment, is used to share information about the patient and their needs on transfer/discharge. The assessment will then continue in the most appropriate setting which may be the person's own home, an interim care arrangement or an intermediate care service.

9.2 The transfer/ discharge assessment should include carers needs but as these will relate specifically to the patients discharge, a more detailed assessment may be required as part of the ongoing assessment process.

10. Medical Transfer of Care

10.1 Patients considered by the Multi Disciplinary Team to be ready and safe to transfer will do so subject to a continuity of medical care. This will follow the current practice i.e. :-

- If a patient is relocated, but remains within their practice area, they will be retained on their own GP's list.

- If a patient is relocated, outside of their practice area, they will be a temporary resident and included on the list of a G.P. in the host area.

- If a patient is relocated for longer than 3 months then they should transfer to a G.P. in the new area

10.2 Communication relating to the continuity of medical care will follow the existing practice and procedures.

10.3 The G.P. practice responsible for a patient's care would normally be identified to the hospital by the patient / relative / carer. In the event of there being a difficulty the acute hospital should contact the West Yorkshire Central Services Agency (WYCSA) Tel 0113 295 2500, who would have the responsibility to arrange GP cover in order to ensure a safe discharge.

11. Process Unplanned Admissions:

11.1 Discharge planning begins on a patient's admission to hospital.

11.2 On admission the Senior Nurse/Lead Nurse on the ward will complete the admission details using Single Assessment Process (SAP) documentation (or the local alternative for out of Leeds hospitals) and begin to identify any potential need for services on transfer/discharge.

11.3 The patient's admission details will, with their consent, be forwarded to the relevant PCT Discharge Referral Point (DRP) and/the Adult Social Care Communication Centre (CCC), based at the Seacroft site.

11.4 The Senior Nurse/Lead Nurse will discuss the discharge process including the possibilities of transitional care with the patient and their carer and this will be reinforced through the provision of the LTHT Transfer/Discharge letter and other relevant information regarding the assessment, care planning and transfer/discharge process.

11.5 The patient and carer will be advised of the likely discharge/transfer date and timescales for completing the discharge process.

11.6 Where a patient is identified as likely to need support on transfer/discharge the Senior Nurse/Lead Nurse will submit a Section 2 notification to the relevant PCT Discharge Referral Point and Care Communication Centre as soon as possible after admission. This will require a transfer/discharge assessment, identifying needs and services to facilitate a safe transfer/discharge. Adult Social Care have a minimum period of three days to carry out an assessment and arrange services.

11.7 As a matter of good practice the assessment will be completed within 48 hours of notification and services arranged where appropriate. The outcome will be communicated to the patient and reiterated by the Senior Nurse/Lead Nurse.

11.8 Following confirmation by the multi-disciplinary team, that the patient is fit and safe for transfer/discharge, the Senior Nurse/Lead Nurse will submit a Section 5 notification to the relevant PCT Discharge Referral Point and/or Care Communication Centre giving notice of the proposed discharge date. The Senior Nurse/Lead Nurse will inform the patient and carer of this date.

11.9 The Section 5 notification will give a minimum period of 24 hours for services to be made available. For reimbursement purposes this period excludes the 48 hour minimum period for assessment.

11.10 Any patient/carer dispute regarding the planned transfer/discharge will be reported to the relevant PCT Discharge Referral Point and/or Care Communication Centre and referred in accordance with the **Escalation Policy** (see appendix 2).

11.11 All patients are monitored on a daily basis and the Senior Nurse/Lead Nurse will immediately inform the relevant Discharge Referral Point and/or Care Communication Centre of patients whose needs have changed. This will include those who now require an assessment under Section 2 notification and patients who have been referred and whose condition has deteriorated making them unfit for transfer / discharge, (this will be as a withdrawal of the Section 5 notification).

12. Specific Requirements for Planned Admissions

12.1 Where a pre-admission assessment identifies that a patient is likely to need social care support after transfer from acute care, the admission assessor has the responsibility to notify Adult Social Care, via the relevant Discharge Referral Point and Care Communication Centre of this need. This Section 2 notification must not occur earlier than 8 days prior to admission and not later than 3 days prior to transfer/discharge.

On receipt of the Section 2 notification the process will be as an unplanned admission.

13. Documentation

13.1 Transfers of care are subject to the Single Assessment Process (SAP). EASYcare (or a local adaptation of it) amended to include essential reimbursement data, will be used as the agreed Contact and Overview SAP documentation.

13.2 It is acknowledged that SAP will be introduced in stages across the patch (see list on cover); in the interim, systems will be deployed that are both compatible with SAP and create the minimum of disruption.

13.3 On admission a patient's details will be entered onto the Contact Assessment.

13.4 The Contact Assessment will be used by the ward as the formal notification under Section 2. This will require that the "Section 2" box is completed on the form which will be forwarded, along with the Specialist Nursing Assessment and the NHS Continuing Healthcare Needs Checklist, either as a fax or as an attachment to an e-mail to the appropriate Discharge Referral Point and Care Communication Centre.

13.5 Ward staff will complete the Ward Fax Cover Sheet, indication potential services required. This will be faxed to the relevant Discharge Referral Point and Care Communication Centre who will signpost appropriately.

13.6 The receiving team will contact the ward staff immediately on receipt of the referral information in order to provide a named contact and contact details.

13.7 The assessment of need will use the appropriate SAP documentation (Contact, Overview, Specialist or Comprehensive).

13.8 The proposed outcome of the assessment will be entered onto the computer held record system (ESCR), where this is not possible it should be e-mailed / faxed back to the Care Communication Centre (as a minimum requirement this will be the Care Plan Summary) who will record the information and inform the ward.

13.9 The Section 5 notification will be e-mailed / faxed by the ward staff to the Care Communication Centre / Discharge Referral Point who will inform the relevant Care Management Team or Service Provider of the discharge date and confirm the provision of a service.

13.10 For the purposes of reimbursement it is essential that all forms are **signed** and include the **date** and **time** of referral and are legible.

14. The Care Communication Centre

14.1 This service is located within LTHT and provides a centralised administrative function in relation to the requirements of reimbursement, brokering of Homecare, Bed Bureau for the independent sector (residential and nursing) and the processing of invoices in relation to these tasks. The team collate information from the five single Discharge Referral Points in the PCTs.

14.2 The Care Communication Centre is the clearing house for all documentation with regard to the above and is responsible for tracking the process flow and recording the details. It undertakes an administrative role in following but not determining care pathways. In this respect it acts as an extension of the bed management function.

14.3 The Care Communication Centre operates between 8.00am and 6pm, 5 days each week, closed weekends, Bank Holiday cover will be advised. CCC staff immediately search for a provider for the required service, placement of homecare.

14.4 For reimbursement purposes the Care Communication Centre should be advised, by care management teams and ward staff, of any delays / discrepancies in the discharge process and the reasons for these. This aids the reconciliation of the invoices with the activity.

15. Discharge Referral Points

15.1 The Discharge referral point (DRP) is primarily for Leeds residents being discharged from LTHT who require services to support them on discharge. There are separate care pathways for patients who are independent, reside outside the Leeds boundary, or for patients on wards with Trust funded social workers. Each Leeds PCT wedge has a separate contact number. The service is available Monday – Friday from 8am – 8pm, and 9am – 5pm at weekends and Bank Holidays.

The documentation used by the DRP is the SAP Contact Assessment documents, the Specialist Nursing Assessment and NHS Continuing Healthcare Needs Checklist. Further assessments may be required once the referral has been received. The referrer is asked to clearly indicate the reason for the referral and only fully completed documentation will be accepted.

The LTHT Discharge Information Pack contained within the LTHT Adult Discharge Policy (http://nww.lhp.leedsth.nhs.uk/common/guidelines) has been circulated to all teams and discharge advisors containing key contacts and specific referral pathways, including palliative care, NFA, restart existing packages, and readmission to care home.

16. Finance

16.1 The finance to support reimbursement will be managed in an open and transparent way and will be used to facilitate the timely discharge of patients who might otherwise be delayed.

16.2 All partners will be informed, in agreement and involved in the decisions made relating to use of reimbursement monies.

16.3 During 2006/07 a portion of reimbursement monies will be utilised to support the continuation of the Task Force and a member of the team of Discharge Advisors.

16.4 Information flow in respect of Section 5 notices and invoicing will be as detailed in **Appendix 7**

16.5 All organisations/partners are committed to a shared approach to managing discharge and as such will produce a Joint Investment Plan which details expenditure specifically targeted towards eliminating delayed discharges. Once completed and agreed, the JIP will replace the finance section of this document.

17. Education / Training

17.1 All relevant staff will be briefed on this protocol and the implications for their working practice. It will also be included in the ongoing induction for new starters within LTHT, Adult Social Care and the PCT. Specialised training will be provided as appropriate. Staff from out of Leeds hospitals will be briefed appropriately.

18. Patient Disputes

18.1 Where patients or carers are in dispute regarding an assessment and proposed outcome this will be dealt with under the **Escalation Policy**. This will require an immediate decision whether or not to "stop the reimbursement clock" and a follow up plan on how to resolve the issue. In all cases the patient will be expected to move to a more appropriate setting whilst the dispute is resolved.

19. Inter – Agency Disputes

19.1 Where there is a dispute between LTHT and Leeds Adult Social Care and /or the PCT, regarding reimbursement, that cannot be resolved as per Appendix 7, then the matter will be referred to the local dispute panel. The membership of this will be:

- Divisional General Manager - Medicine Division (LTHT)
- Head of Service Delivery (Adults) (Adult Social Care)
- Head of Intermediate Tier (Leeds PCT)

19.2 If the dispute cannot be resolved locally, it will be referred to the panel established and chaired by the West Yorkshire Strategic Health Authority. The decision of the panel is binding to all parties.

19.3 Disputes between Leeds Social Services and an out of Leeds hospital will be dealt with by appropriate director level staff.

20. Cross Boundary Issues

Leeds residents in out of Leeds acute hospital care but within England will be the responsibility of Leeds Social Services. In these circumstances the acute hospital involved should send the statutory notifications to the Care Communication Centre. It is the responsibility of the Care Communication Centre to direct any relevant referrals to the appropriate Discharge Referral Point.

Out of Leeds residents who are in acute care in Leeds Teaching Hospital Trust are the responsibilities of the Local Authority where the patient normally resides. In these circumstances the Care Communications Centre will instigate the assessment process and has the responsibility to notify and liaise with the relevant authority.

21. Appendices

- Delayed Discharge codes
- Escalation Policy
- Escalation Flowchart
- Flowchart for S2 and S5 process
- Patient information letter 1
- Patient letter 2
- Responsibilities on issue of Section 5
- Referral process to Housing Services

Ratified February 2006
Ratified February 2007
Review February/March 2008 for Ratification

Sue Jones Discharge Taskforce LTHT
Margaret Faulkner Discharge Taskforce Adults Social Care
Leslie Petrie Leeds PCT

Appendix I

DELAYED DISCHARGE CODES

DELAYED DISCHARGE CODES

Version 1 - March 2008

Leeds Delayed Discharge Codes	Description of Delay	Reimbursement YES/NO		Links to National Delay Code
A1	Family not provided information for financial assessment	YES		A
A2	Unallocated case i.e. SW/Community SW/JCM	YES		A
A3	Assessment not completed by JCM/SW	YES		A
A4	Continuing Care Assessment not completed by SW/JCM		NO	A
A5	Ward Staff not completed their part of the assessment		NO	A
A6	Continuing Care Assessment not yet completed by health staff		NO	A
C1	Patient/Carer/Family choosing Residential home	YES		D1
C2	Awaiting Assessment by Residential home	YES		D1
C3	Agent not report patient on any waiting lists	YES		G
C4	Patient/Carer/Family choosing a Nursing Home replacement	YES		D2
C5	Awaiting Assessment by Nursing Home	YES		D2
E1	Home Care availability	YES		E
E2	Equipment – Social	YES		F
E3	Patient of no fixed abode		NO	I
E4	Home adaptations	YES		F
E5	Equipment – Health		NO	F
F1	Patient awaiting LA funding for chosen placement /Complex package of care	YES		B
I1	Awaiting action within LTHT (e.g. investigation, therapy. referral to consultant)		NO	N/A
I1a	Therapy (inc OT and Physio)		NO	N/A
I1b	Care Planning Meeting		NO	N/A
I1c	Review by another Consultant		NO	N/A
I1d	Investigations		NO	N/A
I2	Delayed in non-acute/rehab bed		NO	N/A
MI	Medically Unwell		NO	N/A
N1	Awaiting Continuing Care placement		NO	C
N2	Awaiting action by Hospital Trust outside Leeds		NO	C
N3	Awaiting action by Mental Health (including assessment)		NO	C
N4	Awaiting action by ICT (including assessment)		NO	C
O1	Disputed discharge e.g. family disagree with professionals		NO	H
O2	Professional disagreement		NO	H
O3a	Self Funding for Residential/Nursing Placement		NO	G
O3b	Self Funding for EMI Residential/Nursing Placement		NO	G
O3c	Declined Interim Placement whilst awaiting Home Care Package		NO	G
O3d	Declined Block Placement		NO	G
O3e	Legal issues/guardianship signing with Solicitor		NO	H
O3f	Carer/Family issues		NO	G
O4	Patient/Carer/Family exercising choice		NO	G
V1	Awaiting vacancy in Residential Care	YES		D1
V2	Awaiting vacancy in Nursing Home	YES		D2
V3	Awaiting vacancy in Residential EMI Care	YES		D1
V4	Awaiting vacancy in Nursing EMI Care	YES		D2
V5	Awaiting vacancy in Local Authority Part 3	YES		D2
V6	Awaiting interim placement (housing patient)	YES		D2
V7	Awaiting transfer to Residential Home	YES		D1
V8	Awaiting transfer to Nursing Home	YES		D2

All level codes mapped to National Sitrep codes A - I
These are:-
A – Awaiting completion of Assessment
B – Awaiting public funding
C – Awaiting further (non acute services) NHS Care (including ICT, Rehabilitation).
D – (i) Awaiting Residential Home Placement or availability
(ii) Awaiting Care Package in own home
F – Awaiting Community Equipment and Adaptations
G – Patient or Family Choice
H – Disputes
I – Housing – Patient not covered by NHS and Community Care Act

Appendix 2

Choice on Discharge (taken from LTHT Discharge Policy)

DISPUTED DISCHARGE/ESCALATION PROCESS

For the successful discharge/transfer of patients to take place it is essential that there is good communication in an appropriate format/language between all parties involved. Discharge planning is not a single event at the end of a stay in hospital but is a continuous process which begins on admission to the hospital, if not before. The Leeds Teaching Hospitals NHS Trust along with its partners in Primary Care and Social Services are committed to providing a high quality service for all patients.

With this in mind it is essential that the smooth transition from the hospital back into the community be achieved to allow access to the hospital for acutely ill patients who require its services.

For a small group of individuals the transition into the community becomes delayed for numerous reasons. This escalation policy is intended to aid the resolution of any difficulties that patients are experiencing with being discharged from hospital in a timely manner.

Where discharge planning does become problematic and the escalation plan is implemented patients, families and carers will be encouraged to seek an advocate (See Section 12 below) or appropriate independent advice.

11.1 **TYPES OF DISPUTES**

Discharge disputes which may require escalation fall into a number of categories. The examples given below are to guide staff when questioning the need for further support in discharging patients.

- Patients/families/carers repeatedly refuse offers of permanent/interim nursing/residential home placements.
- Patients who will be self funding and their families/carers refuse to participate in finding discharge placements for permanent/interim care.
- Patients refusing/delaying participation in financial assessments.
- Patients/families/carers refusing outcome of financial assessments/continuing care assessments, etc.
- Patients/families/carers refused Level 5 Continuing Care Funding and alternatives not accepted.
- Staff perceptions of individual's/families as being unreasonable in their behaviour and expectations.

12 *ESCALATION POLICY FOR DISPUTED DISCHARGES*

Discharge planning will continue throughout the stay in hospital whilst the patient is in receipt of treatment from the ward team.

12.1 If during this time it is identified that the patient will be unable to return directly (if at all) to their previous accommodation, the Social Worker / Joint Care Manager will work with the patient/family/carers and the multi disciplinary team (MDT) to identify a suitable alternative, with a current vacancy, including residential or nursing home placement.

12.2 The MDT reaffirms the procedure and process and gives the patient/family/carers a Confirmed Date of Discharge 12-24 hours prior to leaving.

For patients who have been assessed as fit for discharge and all arrangements are in place staff planning the discharge will complete a discharge planning check list and plan for a morning discharge. On St James University Hospital and Leeds General Infirmary sites patients will await final discharge arrangements in the Hospital Discharge Lounge.

12.3 If there is not an agreed discharge date the patient/family/carer will be provided with a letter regarding planning for discharge and support / advice services available for patients/family/carers.

12.4 If the patient/family/carer disputes the discharge arrangements or discharge date and members of the multi-disciplinary team feel they have explored all possibilities, the escalation process will be instigated. Escalation has been designed as a four stepped approach. This endeavours to support staff, patients and their carers/families in timely resolution of disputes.

12.5 **ESCALATION POLICY – LEVEL 1**

All multi-disciplinary attempts to facilitate discharge in conjunction with the Discharge Facilitation Team and relevant community staff have failed to elicit a discharge plan or date. The Team Leader for the Leeds Teaching Hospital's Discharge Facilitation Team will contact the Locality Matron and Matron for Specialty Medicine to advise of the situation both verbally and in writing. A way forward will be proposed with the Team Leader for Discharge Management enacting the plan on behalf of the Locality Matron.

The Team Leader for the Discharge Facilitation Team, Team Leaders for ASC*/JCM*/Community Services will meet with the patient, relatives/carers together within one week of referral. The escalation process will be explained. Information regarding assessments, within the bounds of confidentiality, can be explored. Discussion regarding options for on going care within local/national policies can be expected. The team can use this opportunity to re-iterate patient's rights including access to continuing health care review, independent advocacy and second medical opinions. The Team Leader for the Discharge

Management Team will keep accurate records of meetings and all other communications with patient and family.

If required advice regarding discharge and any proposed plans can be discussed with LTHT Risk Management Department.

If no resolution, ie no date for discharge, or discharge action plan made Escalation continues to Level 2.

***ASC/JCM may delegate roles to named discharge liaison staff, to act on behalf of Team Leaders. These individuals will have the authority to enact procedures for discharge for their organisations.**

12.6 ESCALATION POLICY – LEVEL 2

The Team Leader for the Discharge Facilitation Team will report to the Matron for Specialty Medicine, outlining the case, the action taken so far and the issues that still remain unresolved.

The Matron for Specialty Medicine will contact the family requesting an urgent meeting, and outlining the issues that need to be resolved. The meeting is to take place within a week of referral to Level 2. Adult Social Care* (Health Teams Manager)/JCM representatives (Team Manager Level*) will also attend the meeting if appropriate. If patient Advocacy/Independent Mental Capacity Advocates (IMCA) are required these should be present at the meeting.

If required advice regarding discharge and any proposed plans can be discussed with LTHT Risk Management Department.

Following the meeting the Matron for Speciality Medicine will write to the patient / family / carers to clarify the agreement reached or to explain the next steps in the process.

*** ASC/JCM may delegate roles to named discharge liaison staff, to act on behalf of Team Leaders. These individuals will have the authority to enact procedures for discharge for their organisations.**

12.7 ESCALATION POLICY - LEVEL THREE

The Matron for Speciality Medicine will send a report to the Divisional General Manager and Directorate Manager for Medicine. This report will be copied to the relevant PCT Director, and Service Delivery Manager (Adults) within Adult Social Care, outlining the case and the process which has taken place.

The Divisional General Manager for Medicine (who may delegate the to Directorate Manager) will decide on an outcome, or if further information is required contact the family requesting an urgent meeting and outlining the issues needing to be resolved. Any further meeting will take place within a week of referral to Level 3. Adult Social Care

Service Delivery Manager and /JCM representatives will also attend the meeting.

Following the meeting the Divisional General Manager will write to the patient/family/carers to clarify the agreement reached or to explain the next and final step in the escalation process. If no discharge outcome is arrived at then The Divisional General Manager for Medicine will brief the Chief Executive in order for him/her to decide on an outcome and discuss with partner agency colleagues.

12.8 ESCALATION POLICY - LEVEL FOUR

The LTHT Chief Executive or his/her representative will agree a course of action within a maximum of one week of receiving the Divisional General Manager's report. The LTHT Chief Executive will ensure any related agency is briefed and aware of the outcomes of all discussions.

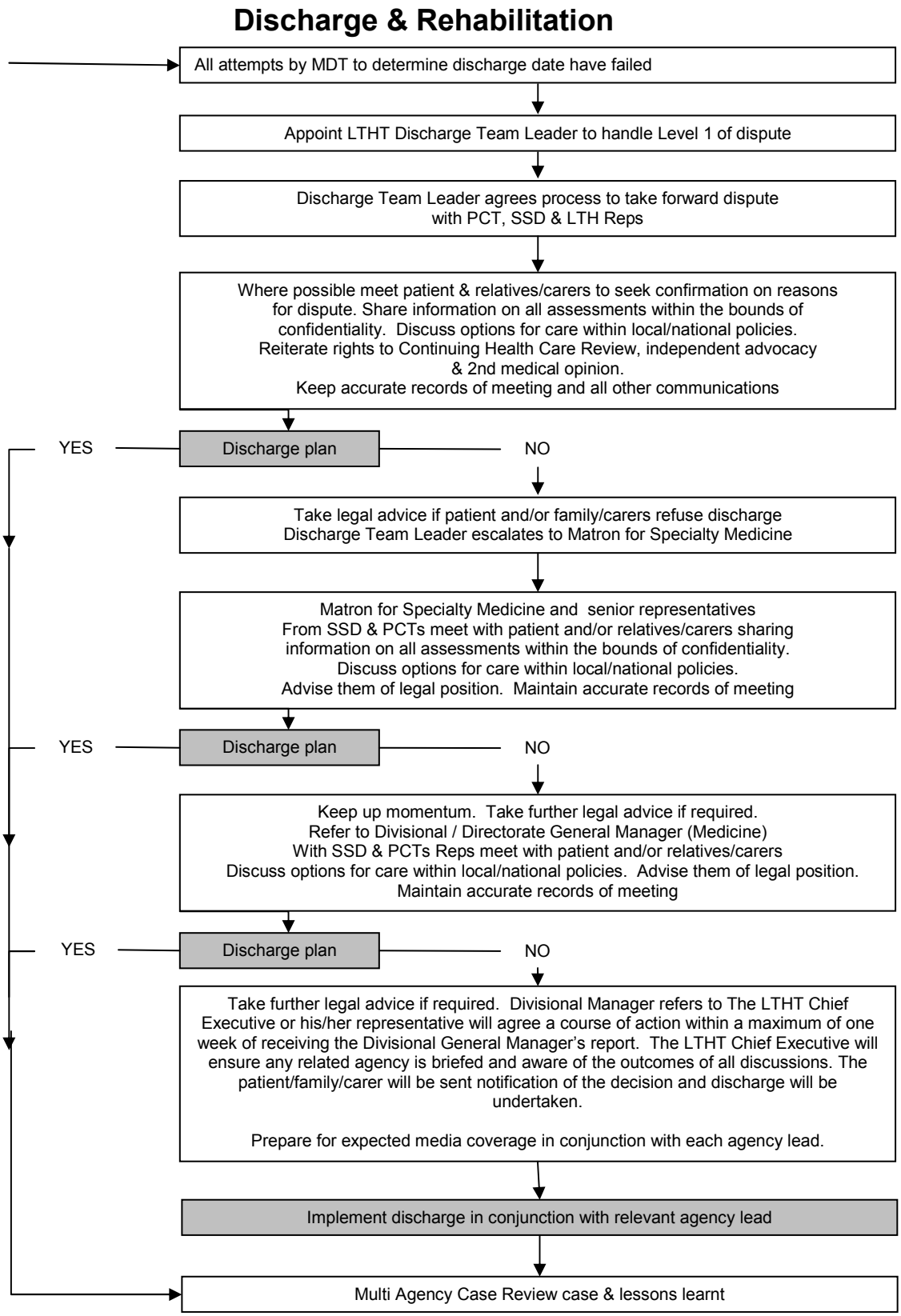
The family will be sent written notification of the decision, which has been reached.

All Agencies involved via their Chief Executives Office will prepare for relevant media coverage as the ultimate sanction will be to Discharge without patient/families/carers consent. Rarely this may involve the use of Security Staff or Police to support removal from LTHT premises.

It is anticipated that between each level of escalation report writing and briefing will take no more than 48 hours.

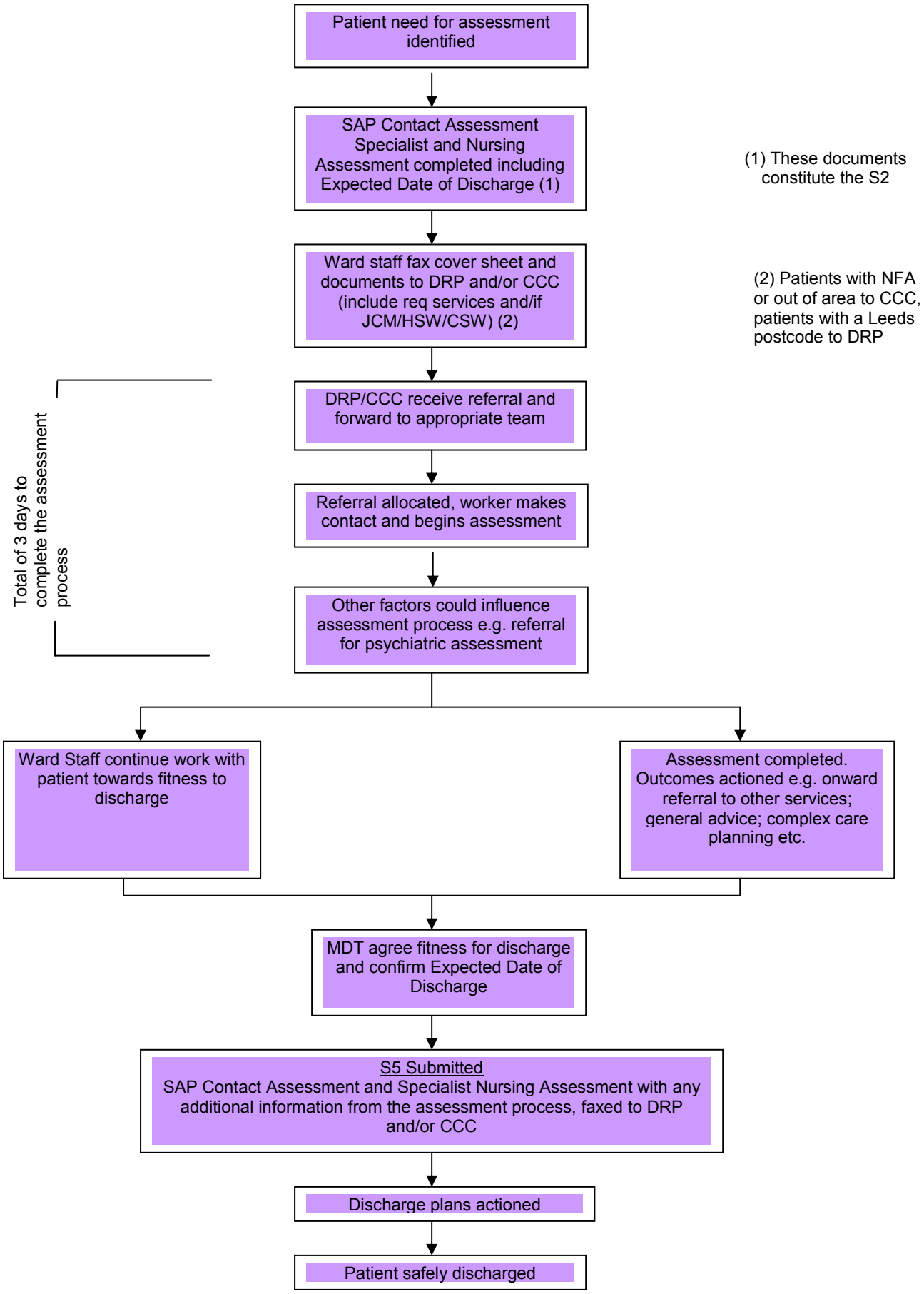
Appendix 3

Escalation Flowchart
(Discharge & Rehabilitation)



Appendix 4

Flowchart and Triggers for S2 and S 5



Appendix 5

Patient Information Letter 1

To be given to patient on admission and reiterated later

Dear Patient

Patient Information (Delayed Discharge Act 2003)

During your stay in hospital, health and social care services are here to help you and are required to follow national legislation on discharge planning.

This letter explains the policy that has been agreed by Leeds Adult Social Care, Leeds Primary Care Trust and Leeds Teaching Hospitals NHS Trust.

From the day of your admission into hospital we will ask you and your relatives/carer about your needs in order to support a safe discharge. When your consultant decides that you can be safely discharged from hospital, we will aim to move you as soon as possible. This could be to your own home or somewhere such as rehabilitation or a short stay unit in another hospital, residential or nursing home.

Most patients will be discharged straight home. Sometimes an immediate return home is not possible and you may need extra support. In these situations ward staff will arrange a referral to a social worker/care manager. The social worker/care manager will work with you and your family/carer so that the team in charge of your care can identify your needs and arrange the most appropriate help with your agreement.

If the assessment shows that you need residential or nursing home care to meet your long term needs, you and your family will be able to choose the home you wish to live in. **If this home does not have a vacancy and you choose to wait for a place to become available in your first choice home, you will be moved to a temporary place elsewhere which social services will arrange until your preferred choice is available, there may be a charge for this.**

Should you choose not to be referred to Adult Social Care or to fund your own care, then once you can be safely discharged from hospital you will be responsible for ensuring you have made appropriate arrangements and can be discharged.

If the assessment shows that you require a stay in a Community Intermediate Care bed (CIC bed in a residential/nursing home or the Community Unit - V ward at Seacroft) you will be advised of where a bed is available. You cannot refuse a CIC bed based on the geography of the placement and, whilst every effort will be made to place you in a CIC bed as near to your own home as possible, remaining in an acute hospital bed is not an option when CIC beds in other areas of the city are available.

If you have concerns about how you will manage after you are discharged, and ward staff have not yet discussed this with you, please speak with the Ward Sister or Nurse-in-Charge.

Dear

Your Choice of Care Home

The outcome of your assessment for your future care needs on discharge from hospital is that these can be met in a Care Home. Now that you no longer require an acute hospital bed we need to plan for your move to a care home placement.

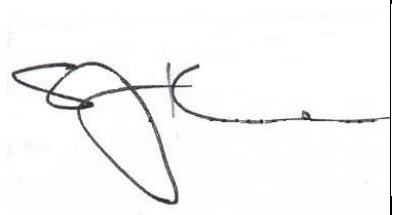
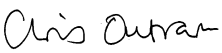
We hope your first choice of home is able to offer you a placement. However, many nursing and residential homes are full and you may be placed on a waiting list. If your chosen home is unlikely to have a bed within seven days of the issue of this letter we will plan for your discharge to an alternative care home placement, pending a vacancy becoming available in your home of choice.

This interim placement may be in any Care Home able to meet your care needs and with whom Adult Social Care Department has a contractual arrangement.

You will be financially assessed to contribute to the cost of care in any care home placement from the date of admission whether this is your home of choice or an interim arrangement.

If you have any queries about this advice please contact the social worker or care manager named above.

Yours sincerely

		
SANDIE KEENE Director Adult Social Services Leeds City Council	MAGGIE BOYLE Chief Executive Leeds Teaching Hospitals NHS Trust	CHRISTINE OUTRAM Chief Executive Leeds PCT

Dear

Advice on Transitional Placements

The assessment for your future care needs on discharge from hospital is that these can be met at home with the support of home care services.

As you no longer require an acute hospital bed and because the home care service is not available at the moment we need to plan for your discharge to a Care Home in what we call a transitional placement.

A transitional placement is a bed in a Care Home arranged by the Adult Social Care Department and provided to people who need a placement where their long term needs can be assessed and where support can be given to aid their recovery and independence.

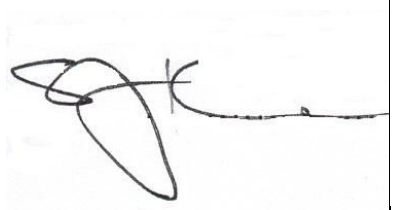
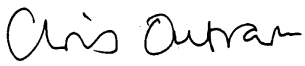
Such placements can also be used as a short term arrangement for people awaiting their home care service, so they can return to their own home once this is available.

If your home care service is still not available within seven days of the issue of this letter we will plan for your discharge to a Care Home.

There is no charge for this service for four weeks and within that time we will make every effort to have services in place for you to return to your home as soon as possible. Should your stay extend beyond the four week period then there will be a charge. You will be advised of this rate by your Social Worker/Joint Care Manager.

If you have any queries about this advice please contact the social worker or care manager named above.

Yours sincerely

		
SANDIE KEENE Director Adult Social Services Leeds City Council	MAGGIE BOYLE Chief Executive The Leeds Teaching Hospitals NHS Trust	CHRISTINE OUTRAM Chief Executive Leeds PCT

Appendix 7

LTHT, Leeds and Social Services Joint Protocol for Inter-Agency Responsibilities Upon the Issue of Section 5 (S5) January 2007

This protocol seeks to achieve inter-agency working to effect and expedite patient centred care.

It aims to ensure that a patient's discharge with social support is not delayed, but underpinned by the administration process which facilitates trusted and reliable flows of information.

1.1 Section 5 is faxed by the Ward within the Leeds Teaching Hospital Trust to the Care Communication Centre (CCC) or Discharge Referral Point (DRP). The Date of Section 5 issue is registered by CCC/DRP and on a daily basis date of issue and receipt is confirmed/cross-checked by Discharge Facilitation Administration Assistant. Cross checking includes reviewing the existence of a Section 2 to match the Section 5. The CCC/DRP will continue to inform the Discharge Facilitation Team of all S2s and S5s.

1.2 The Section 5 is dispatched by the CCC/DRP to the appropriate Care Manager. The Care Manager will issue a commencing Delay Discharge Code (Appendix 1), via a daily log sheet, sent to the Discharge Facilitation team by 10am each morning. This code will be logged by the Discharge Facilitation Team on the Delayed Discharge Database. *Community Social Workers will submit their coding via the appropriate PCT Joint Care Management Team. Hospital Social Workers will submit their coding via an independent daily log sheet.* **If the Discharge Facilitator does not agree with the commencing code, a telephone dialogue will be held to verify/determine a suitable code.**

1.3 Any disputes between Discharge Facilitator or Care Manager for patient coding will be referred to the Discharge Facilitation Team Leader and relevant Care Management Team Leader. If no agreement can be reached then escalation should be made to Matron for Specialty Medicine (Medicine) and Adult Services Manager (Hospital Services Adult Social Care). **NB If the Matron for Specialty Medicine and Adult Services Manager remain in dispute then escalation for arbitration is expected, as per the Joint Protocol for Transfer of Care, Interagency Disputes, Section 19.**

1.4 The Care Manager works with the appropriate external agencies and LTHT multi-disciplinary team to effect patient assessment and plan of care for a timely discharge. The Care Manager will continue to notify The

Discharge Facilitation Team of any perceived code changes. This will take place on a daily log sheet submitted to the Discharge Facilitation team by 10 am. *Community Social Workers will submit their coding via the appropriate PCT Joint Care Management Team. Hospital Social Workers will submit their coding via an independent daily log sheet.* The code will be logged on the Delayed Discharge Database and will record on an individualised reimbursement charge sheet (Appendix II). **If the Discharge Facilitator does not agree with the daily update coding, a telephone dialogue will be held to verify/determine a suitable code.**

Any disputes regarding on-going coding will be dealt with as per point 1.3

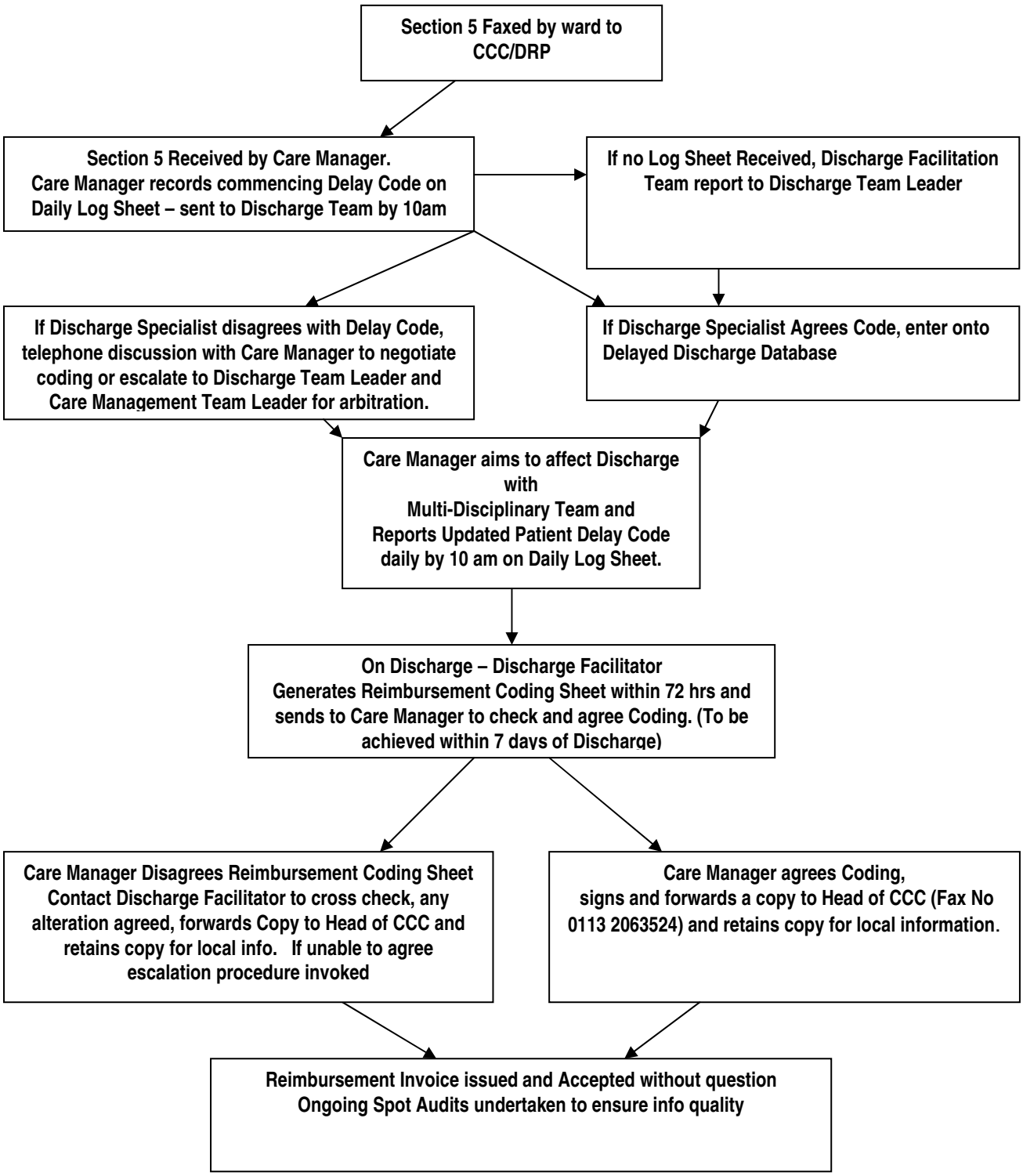
At the point of Discharge, if a patient has incurred a reimbursement charge the Discharge Facilitation Team Administration Assistant will fax the Care Manager a copy of the Individualised Reimbursement Coding Sheet checked and signed by the Discharge Facilitation Team. All Delay Codes for the patient, whether reimbursable or non reimbursable, will be clearly displayed and dated. The Care Manager must crosscheck his/her records and sign to confirm this information is correct for invoicing purposes. This must occur within 72 hours of discharge and be forwarded to the Head of CCC (on Fax Number 0113 2063524). If the Care Manager disagrees then he/she must contact the Discharge Facilitator and liaise to review the patients' coding period. This must occur within 7 days of issue. Any agreed changes must be made and an altered Reimbursement Coding Sheet signed by the Discharge Advisor and Care Manager. The Care Manager will forward the amended Reimbursement Coding Sheet to Head of CCC (on Fax Number 0113 2063524) to hold pending any queries regarding charges. If Care Manager and Discharge Advisor are unable to agree coding then escalation will occur as per 1.3.

1.5 For LTHT the Discharge Facilitator will forward the original or altered copy via LTHT channels to advise finance of changes. Within LTHT reimbursement information is sent to the PA for the Directorate Manager of Medicine for monthly collation and thereby forwarded to LTHT Finance for invoice issue.

1.6 Reimbursement invoices should at this stage be issued quarterly by the Trust Based on the Reimbursement Coding Sheet and accepted as true with spot audits established to ensure information/data quality.

Reviewed January 2007
Next Review January 2008 for Ratification March 2008

Reviewed by:
Sue Jones Matron Discharge LTHT
Diane Massey Discharge Matron Leeds PCT on behalf of Discharge Facilitation Team


Section 5 Faxed by ward to CCC/DRP
Section 5 Received by Care Manager. Care Manager records commencing Delay Code on Daily Log Sheet – sent to Discharge Team by 10am
If no Log Sheet Received, Discharge Facilitation Team report to Discharge Team Leader
If Discharge Specialist disagrees with Delay Code, telephone discussion with Care Manager to negotiate coding or escalate to Discharge Team Leader and Care Management Team Leader for arbitration.
If Discharge Specialist Agrees Code, enter onto Delayed Discharge Database
Care Manager aims to affect Discharge with Multi-Disciplinary Team and Reports Updated Patient Delay Code daily by 10 am on Daily Log Sheet.
On Discharge – Discharge Facilitator Generates Reimbursement Coding Sheet within 72 hrs and sends to Care Manager to check and agree Coding. (To be achieved within 7 days of Discharge)
Care Manager Disagrees Reimbursement Coding Sheet Contact Discharge Facilitator to cross check, any alteration agreed, forwards Copy to Head of CCC and retains copy for local info. If unable to agree escalation procedure invoked
Care Manager agrees Coding, signs and forwards a copy to Head of CCC (Fax No 0113 2063524) and retains copy for local information.
Reimbursement Invoice issued and Accepted without question Ongoing Spot Audits undertaken to ensure info quality

Private & Confidential

Discharge Facilitation Team
Inpatient Placement Service
B Floor Medical Out Patients
Leeds General Infirmary
Leeds
LS1 3EX

Fax:
LGI – 0113 3922660
SJUH – 0113 2066404
www.leedsteachinghospitals.com

Date: 16 March 2009

Dear Colleague

Your patient has recently been discharged from Leeds Teaching Hospitals Trust and during their hospital stay a reimbursement charge has been incurred.

As per the LTHT Leeds and Social Service Joint Protocol for Inter Agency Responsibilities upon the Issue of a Section 5, dated May 2006, I enclose a copy of the Individual Patient Reimbursement Charge Sheet signed by the relevant Discharge Specialist Worker.

As per protocol you are obliged to check the codes allocated by the Discharge Management Team for your patient. If you are in agreement with these please sign, retain a copy for your records, and forward a copy to the Head of CCC on Fax Number 0113 2063524.

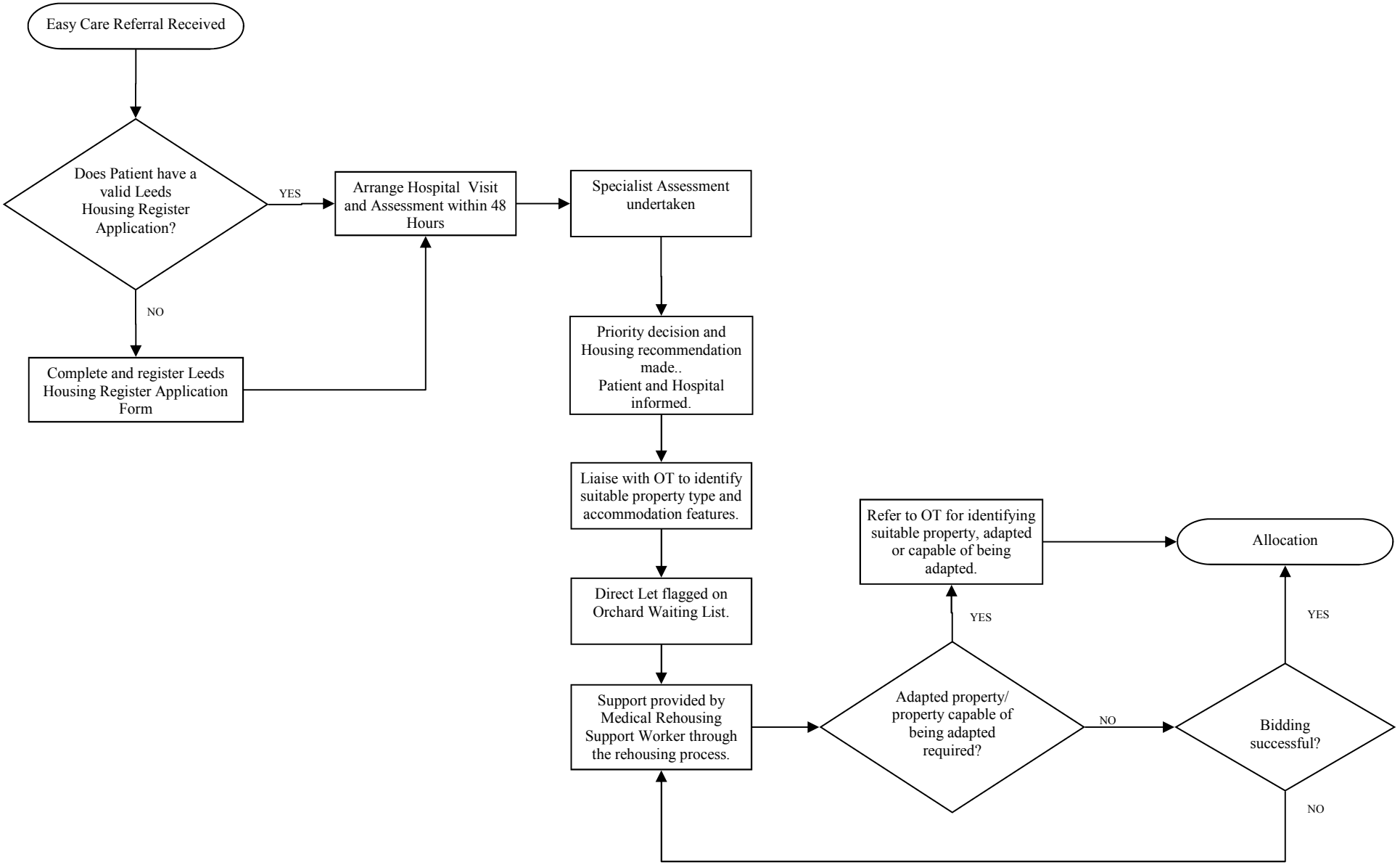
If you are unable to agree the codes allocated by the Discharge Management Team please contact them on 66391 (for St James) or 26891 (for LGI, Chapel Allerton and Wharfedale) within 7 days of the charge sheet being issued. Any agreed changes must be made and an altered reimbursement sheet signed by the Discharge Specialist Worker and yourself. Once signed by both parties, retain a copy for your records, and forward a copy to the Head of CCC on Fax Number 0113 2063524.

On going coding disputes about codes should be escalated as per the protocol retained within your department.

Any further questions, please do not hesitate to contact the Discharge Management Team on the numbers above.

Discharge Management Team
Leeds Teaching Hospitals Trust
Enc

APPENDIX 8 Medical Re-Housing Flowchart



Leeds CITY COUNCIL

Originator: Laura Nield

Tel: 395 0492

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 24th March 2009

Subject: Recommendation Tracking

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

1.0 Introduction

1.1 Last year Overview and Scrutiny Committee agreed to adopt a new, more formal system of recommendation tracking, to ensure that scrutiny recommendations were more rigorously followed through.

1.2 As a result, each Scrutiny Board now receives a quarterly report on any recommendations from previous inquiries which have not yet been completed.

1.3 This will allow the board to monitor progress and identify completed recommendations; those progressing to plan; and those where there is either an obstacle or progress is not adequate. The board will then be able to take further action as appropriate.

1.4 A standard set of criteria has been produced, to enable the board to assess progress. These are presented in the form of a flow chart at Appendix 1. The questions should help to decide whether a recommendation has been completed, and if not whether further action is required.

1.5 For each outstanding recommendation, a progress update is provided. In some cases there will be several updates, as the board has monitored progress over a period of time.

1.6 To assist members, the Principal Scrutiny Adviser has given a draft status for each recommendation. The board is asked to confirm whether these assessments are appropriate, and to change them where they are not.

1.7 In deciding whether to undertake any further work, members will need to consider the balance of the board's work programme.

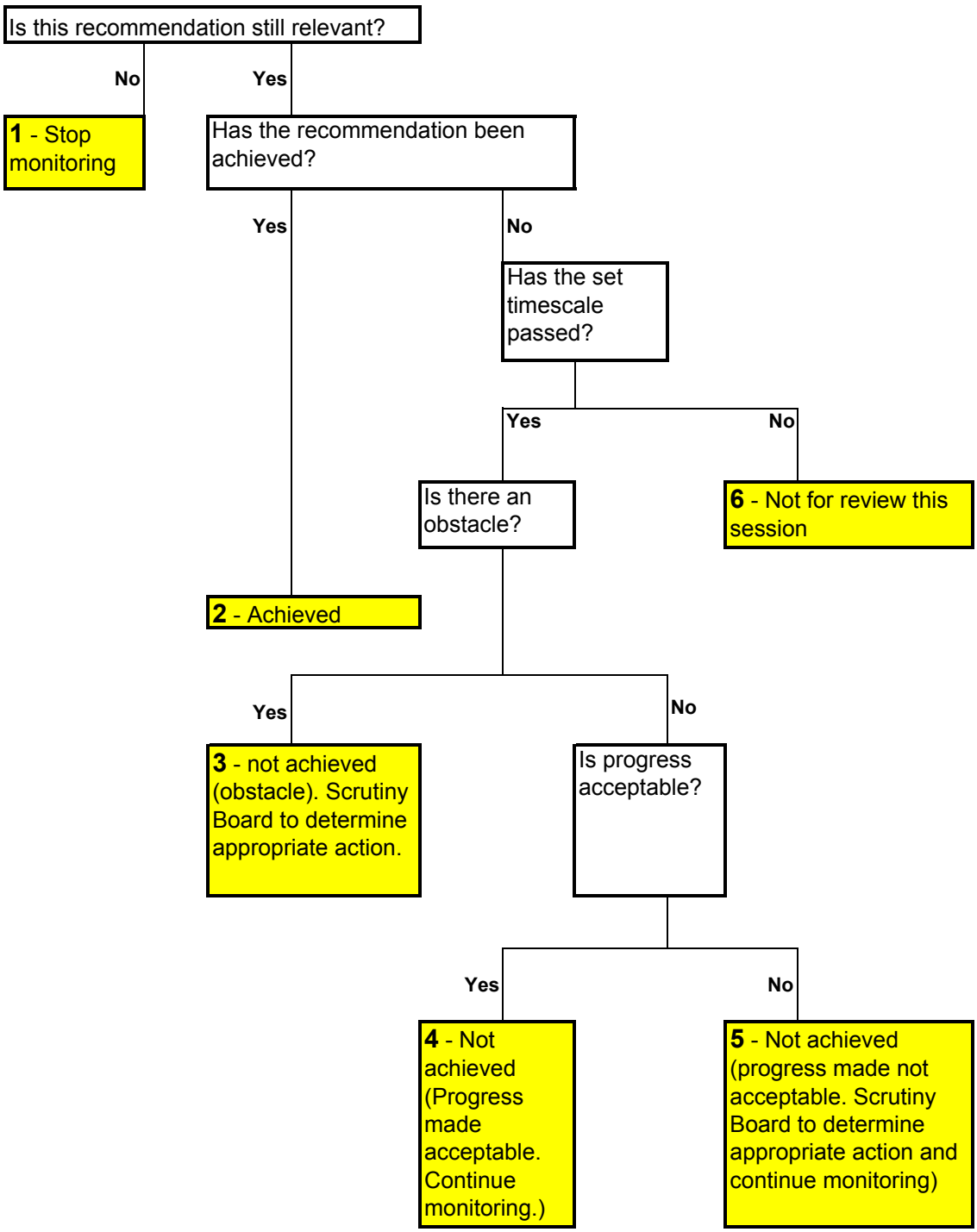
1.8 In accordance with the wishes of the chair, no officers have been invited to attend this meeting to discuss the progress made against recommendations. However, a full written response will be requested in relation to any issues raised by the board.

2.0 Recommendations

2.1 Members are asked to:

- Agree those recommendations which no longer require monitoring;
- Identify any recommendations where progress is unsatisfactory and determine the action the board wishes to take as a result.

Recommendation tracking flowchart and classifications:
Questions to be Considered by Scrutiny Boards



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Community Development **Report published July 2007** **Last update received March 2008**

	Recommendation	Where we are up to	Stage	Complete
2	**We recommend that the Local Strategic Partnership proactively challenges the level of commitment and investment made from all partners towards community development and develops an action plan aimed at further embedding community development values and principles across the partnership.**	March 2008 position The Leeds Initiative Programme Manager for Harmonious Communities started in post in January 2008 and is discussing with organisations and different departments about her future work programme. This will include addressing the embedding of community development values and principles across the partnership. **March 2009 update** The Leeds Initiative is setting up a new Harmonious Communities strategy and development group with a workshop on 11th February 2009. The community development issues will be discussed as part of the broader work on community engagement and empowerment. At the present time, this is being considered by several different individuals, departments and groups and we want to bring this together and be clear about how we want to take it forward in partnership. The White Paper *Communities in Control* (CLG 2008) supports work to enhance community development skills among a range of frontline professionals and the increased focus on community engagement and empowerment. In terms of investment, the VCF sector partnership group has taken this forward as part of the response to the research commissioned by Leeds Initiative on the sustainability of the VCF sector in Leeds. This group has a resources task group which is working on this. The current economic situation is having a detrimental effect on funding and resources are reduced. Funding for a post based within Leeds Voice was identified by the Resources Group to work with commissioners and VCF sector on future commissioning and delivery. The new Health and Wellbeing Plan identifies engagement and community development as a specific strand and the PCT is making explicit and specific the community development contribution expected of each VCF sector partner it funds during this commissioning period (for SLA's April 09 up to 3 years)	4	

Key

1 – stop monitoring	3 – not achieved (obstacle)	5 – not achieved (progress made not acceptable)
2 – Achieved	4 – not achieved (progress made acceptable)	6 – not for review this session

Community Development **Report published July 2007** **Last update received March 2008**

	Recommendation	Where we are up to	Stage	Complete
4	**That the Health Leeds Partnership champions the Leeds Community Health Development Network (CHDN) and ensures that it provides opportunities for community development projects to share best practice, celebrate achievements and actively encourage joint working initiatives across the city.** **The Network should also develop a themed training programme based on the needs of community development workers and encourage broader education and understanding of community development across the city.**	March 2008 position The Healthy Leeds Partnership values the Community Development Network and, in relation to the new partnership arrangements, is examining where it would need to be placed to have the most influence. The Community Health Development Network has identified the need to develop training as part of its future work programme. The future of the CHDN is integral to the development of accredited training for current CD workers as well as the development of induction plans for new workers. The majority of CD work is delivered by CVFS partners, and the aim is to improve the skills and competence of those workers. This development work needs to be supported through the CHDN, which would ensure local staff became competent using the National Competency Standards for CD. **March 2009 update** The new partnership structures for health and wellbeing came into place last year with a smaller Joint Strategic Commissioning Board as well as the Healthy Leeds Partnership. Workshops in March are looking to develop the locality partnerships. Community health development relates most to the Promoting Health and Wellbeing Commissioning Sub-group and they are leading on developing a partnership strategy and joint commissioning issues. A celebration event is planned for 18th March on the healthy living grants which support the activities of many community and voluntary sector groups. The Community Health Development Network is still meeting and focussing on key training issues.	4	

Key

1 – stop monitoring	3 – not achieved (obstacle)	5 – not achieved (progress made not acceptable)
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Community Development **Report published July 2007** **Last update received March 2008**

	Recommendation	Where we are up to	Stage	Complete
5	**That the Healthy Leeds Partnership carries out an evaluation of the Community Health Development Network during its first year and explores joint funding opportunities to maintain the sustainability of the Network in the long term. The results of this evaluation will be reported back to the Scrutiny Board in April 2008.**	March 2008 position The current and potential contribution of the network is recognised at senior level by the Chief Executive of the PCT and the Director of Adult Social Services. In the previous response we agreed that evaluation of the Community Health Development Network was important but that it would be too early to do this after its first year. We can give the Scrutiny Board an update on its first year's activity and we are exploring mechanisms to do an independent evaluation at a later date. A meeting of key officers and Community Health Development Network representatives was convened in January to address the sustainability of the Network. From this a small task group, involving the PCT, voluntary sector and the Leeds Initiative was set up to develop a proposal to secure resources to continue to develop and maintain the Network. The PCT has secured £25K funding for a part time post to support the CHDN and work on the delivery of the recommendations. In the meantime Leeds VOICE is providing interim support for the network. **March 2009 update** The part-time development post started in May 2008 but there have been problems with continuity. The independent evaluation of the Community Health Development Network is being carried out by Steve Skinner Associates. It started in September/October 2008 and the final report is due in March 09. A meeting of the task group will discuss this and make recommendations on the next steps.	**4**	

Key

1 – stop monitoring	3 – not achieved (obstacle)	5 – not achieved (progress made not acceptable)
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Community Development **Report published July 2007** **Last update received March 2008**

	Recommendation	Where we are up to	Stage	Complete
7	**That the Leeds City Council Member Development Working Group includes community development training within the Member training programme.**	March 2008 position Further information on this recommendation would be provided to the Member Development Steering Group at its April meeting. **March 2009 update** The Member Development Team are working with the Healthy Leeds Partnership to arrange a number of learning events for Members on community development within the wider context of community engagement and empowerment. This is planned to coincide with the launch of a corporate community engagement toolkit and the 'Talking Point' website. The training will probably include modules on Community engagement and use of the portal and Community Development and Health. Both are expected to take place early in the new municipal year.	**2**	

Key

1 – stop monitoring	3 – not achieved (obstacle)	5 – not achieved (progress made not acceptable)
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Localisation **Statement published May 2008** **Last update received September 2008**

	Recommendation	Where we are up to	Stage	Complete
1	**That :** • **a thematic group be developed for health and wellbeing, including adult social care, in each of the three new areas** • **the thematic groups work with the area committees to discuss and agree the nature and regularity of their dialogue in the future**	<u>September 2008 position</u> **Response from Leeds Primary Care Trust (PCT)** The Primary Care Trust (PCT) and Adult Social Care support this recommendation and are working together to identify the most effective way to ensure implementation on a sustainable basis. This work includes gaining a better understanding of how other large urban areas work on a locality basis. A visit to Nottingham is planned for September 2008. The PCT and Adult Social Care recognise the need for dedicated officer time for each of the three new areas. This will ensure effective coordination and link the health and wellbeing programme to the officer coordination groups, area committees, local neighbourhoods and the Healthy Leeds Partnership. Proposals are being developed and will be presented to the Scrutiny Board by the year end. **Response from Adult Social Services** Area Management is represented on the Council's Strategic Leadership Team for Health and Wellbeing - providing a direct link between citywide and area concerns. Development of a locality focus for health and wellbeing is included in the draft Adult Social Care service plan, as are plans to increase capacity to enable improved co-ordination around Health and Wellbeing for area committees and the development of local thematic groups. **<u>March 2009 update</u>** **Response from NHS Leeds** The Public Health team at NHS Leeds is working closely with the Leeds Initiative to develop local partnership working arrangements to deliver the health and wellbeing improvement priorities in the Leeds Strategic Plan and to improve the links between the local and the city wide work. Workshops will take place during March in three areas of the city with a range of local stakeholders from different agencies in order to shape future local partnership arrangements. These will be informed by the emerging Leeds Health and Wellbeing Plan 2009-12. Plans are in place to appoint to three Locality Health and Wellbeing posts in order to support these arrangements. Work is also progressing to co-ordinate the PCTs response to locality partnerships and to develop a PCT governance framework in relation to external partnerships. **Response from Adult Social Services** Area Managers have been consulted about how best the forthcoming Health and Wellbeing Theme Plan can link to areas and inform local planning. Three introductory area workshops are being held in mid March 2009 focusing on each area, including a discussion of how best to set up a locality thematic group / partnership for health and wellbeing. It is proposed that with the introduction of these partnerships they will be supported in part by the joint funded appointment of three Locality Enablers for Health and Wellbeing.	**4**	

Key

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Localisation **Statement published May 2008** **Last update received September 2008**

	Recommendation	Where we are up to	Stage	Complete
2	**That the results of the PCT's review of minor surgery in Leeds be reported to this scrutiny board at the earliest opportunity.**	September 2008 position The PCT has concluded a review of current minor surgery facilities in primary care which shows areas of under utilisation. The PCT has set goals for increasing this uptake. We have completed a service specification for minor surgery to further encourage the use of local facilities. Discussions are now taking place with Practice Based Commissioners about how we can work with providers to increase service options and choice for patients locally. We are also working with Leeds Teaching Hospitals NHS Trust (LTHT) to ensure that any new capacity will deliver faster access to services for patients (18 weeks). **March 2009 update** NHS Leeds is continuing to work with PBC and commissioners about how we can work with providers to increase service options and choice for patients	4	
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.**	September 2008 position Since the localisation report was published the PCT has finalised arrangements for a number of additional clinical services to be either relocated or provide clinical sessions in LIFT buildings. The PCT is keen to ensure the Scrutiny Board is kept up-to-date on these developments. Due to the length of time it takes to implement changes of this nature a further report to the Board is proposed in six months' time. **March 2009 update** Over the last six months a number of new services have been introduced into the PCT's existing LIFT buildings. This has focussed mainly on the under-utilised space in the south of the city which has seen the National Artificial Eye Service relocate to Parkside Community Health Centre from unsuitable accommodation in Hunslet. Parkside is also being used as a team base for the newly established Family Nurse Partnership Project, which is a clinical service providing intensive support to families, and an admin base for the Referral Management Service. At Armley Moor Health Centre a new twilight community nursing service has been set up and the Looked After Children nurses' team expanded. In January, Harrogate and District Foundation Trust began providing dermatology outpatient clinics at Wetherby Health Centre.	4	

Key

1 – stop monitoring	3 – not achieved (obstacle)	5 – not achieved (progress made not acceptable)
2 – Achieved	4 – not achieved (progress made acceptable)	6 – not for review this session

	Recommendation	Where we are up to	Stage	Complete
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.**	September 2008 position The PCT is committed to listening to the views of patients and the public when improving health services. Engagement/consultation on services and opening times for GP practices and health centres has been undertaken in the following ways: • Citywide engagement on GP-led Health Centre • GP patient surveys and local questionnaires • Engagement on Joint Service Centres • Engagement on GP Services in Rothwell, Middleton and Swillington **March 2009 update** NHS Leeds continues to take forward public involvement work as highlighted above.	**2**	
5	**That Leeds PCT keeps this Board informed of progress with the programme of refurbishment over the next municipal year.**	September 2008 position The PCT Board signed-off the capital investment programme for 2008/09 in July. The programme includes investment to enable the PCT to improve buildings by undertaking essential maintenance and statutory work (£1.1 million investment); and refurbishment and carbon-reducing opportunities (£0.8 million investment). The programme for 2008/09 is currently out to tender and will be delivered by March 2009. One of the first schemes to be completed is the refurbishment of Burmantofts Health Centre which will host the GP-led Primary Medical Care service delivering essential healthcare services for the people of Leeds. **March 2009 update** Tenders have been awarded through our partnering agreement with Community Ventures (Leeds) Limited. After a formal process of competitive tendering IMS Limited have been awarded the contract of around £2.0m, for backlog maintenance and refurbishment of our health centres. The current programme expenditure projections identify the work commissioned through Community Ventures (Leeds) Limited will be delivered within time and we will deliver a substantial part of all improvement schemes by 31.3.2009. £0.32m has been allocated to Burmantofts Health Centre to deliver services as part of the GP-led Health Centre scheme. The scheme is progressing well and will be completed by the end of February 2009. Individual programmes have been produced for all sites and will be monitored carefully including finances, health and safety issues and security.	**2**	

Key

1 – stop monitoring	3 – not achieved (obstacle)	5 – not achieved (progress made not acceptable)
2 – Achieved	4 – not achieved (progress made acceptable)	6 – not for review this session

	Recommendation	Where we are up to	Stage	Complete
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.**	<u>September 2008 position</u> Leeds Teaching Hospitals Trust (LTHT) and the PCT are working closely together to develop proposals to ensure the best solution for the population of Leeds. LTHT is presenting a separate paper to the September Board meeting to cover their Peripheral Hospitals Strategy. <u>Extract from Peripheral Hospitals paper</u> Wharfedale Hospital (WH) was opened in October 2004. It is a high quality facility that was designed to provide a range of healthcare services to the population of in and around Otley that are safe and appropriate to their needs. In the three and a half years since it opened, the Trust and its partners in the health economy have struggled to utilise the facilities at WH efficiently and effectively. In April 2007, the LTHT Board approved a Framework for the development of WH, which had been jointly developed by the Trust and the PCT. This framework clarified the vision and strategic direction for WH. Since the agreement of the strategy, the Trust and PCT have been working to deliver a better utilised hospital within the agreed parameters. The review of the 2007/8 business plans resulted in the Lymphodema Service being relocated to WH. During April 2008, all Directorate Managers and Clinical Directors within the Trust were asked to consider the following questions in relation to Wharfedale: • How might they better utilise/expand the volume of any existing services? • Are there any new services, either for the local population or the whole city that could be relocated to Wharfedale? This exercise generated a longlist of projects. Some of these are still in the process of being assessed, however, a number of developments are planned for 2008/9: • Improved utilisation of the 2 theatres. A plan to improve utilisation will be implemented from October with the objective of achieving an average 90% utilisation across all lists (average in 2007/8 was 66%). • Establishment of a 4 chair low risk chemo facility for the local population • Full utilisation of the endoscopy facilities (part of the Endoscopy Services Business Case currently being implemented and numbers already rising) • Improved utilisation of the outpatient capacity via the roll out of direct booking and the continued efforts of directorates to allocate trust booked patients to WH • Improved utilisation of the radiology facilities and possibly creation of a permanent breast screening facility.	**2**	

Key

1 – stop monitoring	3 – not achieved (obstacle)	5 – not achieved (progress made not acceptable)
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		Work has been undertaken in the PCT to identify potential service moves and development opportunities. A key area of work is to investigate the need, desirability and potential for some local primary care and community based services to be relocated to accommodation at Wharfedale. This might include, for example, GP and GPSI led services and community services such as podiatry, substance use services, falls clinics and audiology. The potential for some community intermediate care beds for older people to be based at Wharfedale is also being explored. The PCT is working to develop community based services for people with long term conditions (COPD, chronic vascular disease etc) so that, for those people whose care can be provided appropriately outside an acute hospital setting, services are available in the local community. We are looking at the demand for and opportunities for such services to be provided at Wharfedale. Both the PCT and LTHT acknowledge that finding a mix of services that can utilise the WH facility effectively has been, and remains, challenging. We are jointly aiming to develop a plan for the next 5 years by the end of 2008/9. **March 2009 update** **Response from LTHT** See attached briefing. **Response from NHS Leeds** The urgent care procurement in Leeds and across West Yorkshire has now been concluded. From April 2009 Local Care Direct , a social enterprise company, will provide emergency dental services, minor illness and injury walk-in services at St George's Centre and Wharfedale Hospital, and GP out-of-hours appointments and home visits operating out of the latter centres in addition to Lexicon House. The specific improvements relating to Wharfedale Hospital are: o Introduction of GP appointments out-of-hours & weekends o Expansion to provide nurse-led minor illness services o Improved seamless care pathways as a result of one organisation providing both minor injury & illness walk-in services as well as out-of-hours GP appointments		

Key

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	Recommendation	Where we are up to	Stage	Complete
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.**	<u>September 2008 position</u> **Response from Leeds Primary Care Trust (PCT)** The PCT is arranging plain English training for a range of staff responsible for producing documents for the public and other stakeholders (such as voluntary and community groups). This training will ensure our information is clear and concise. The PCT is also developing a 'style guide' to make sure that it has clear standards and expectations in place about how information should be produced. Leeds PCT has a Patient Reader Group which comments on the design, layout, content and style of the PCT's patient leaflets and some corporate and public information documents. We are encouraging all services to make sure their patient leaflets are approved by this group before distribution. This ensures our information is logical, easy to understand and jargon free. Leeds PCT regularly communicates with the Voluntary, Community and Faith sector (VCFs) groups and supports them in the procurement process by holding 'bidder' events to explain the process and ensure equity. **Response from Adult Social Services** The Chief Officer, Social Care Commissioning has been asked to prepare a separate report for the Adult Social Care Scrutiny Board on commissioning practice within adult social care. In this report attention will be drawn to a commissioning toolkit which has been developed for adult social care which provides advice and guidance to staff, including the use of plain English. This report is due to be consider by the Adult Social Care Scrutiny Board at its meeting on 17 September 2008. **<u>March 2009 update</u>** **Response from NHS Leeds** One successful plain English course has already taken place and NHS Leeds have two more planned to take place in March. The NHS Leeds Patient Reader group is ongoing and public documentation is reviewed by members of this group. The group has been expanded in the past six months to enable it to review more information. **Response from Adult Social Services** Officers have taken two subsequent reports to the Adult Social Care Scrutiny Board in September 2008 and December 2008 detailing their approach to commissioning with smaller organisations recognising the need to provide officer support to such organisations to assist in their capacity to participate in tendering processes. The reports have indicated how such commissioning initiatives have been promoted in non-technical language to the organisations concerned.	**2**	

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	Recommendation	Where we are up to	Stage	Complete
8	**That Leeds PCT provides a report to the Scrutiny Board in July 2008, providing information about the funding received for, and money spent on, Choosing Health priorities in 2007/8.**	September 2008 position The board received a report breaking down how Leeds PCT spent its full 2006/2007 Choosing Health allocation of £1.67m in 2007/08 **March 2009 update** There is no further update to add.	**2**	
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.**	September 2008 position Leeds PCT has tendered the provision of all urgent care, in-hours and out of hours. This is a competitive dialogue process, whereby the PCT does not set out how services will be delivered, but instead looks to the bidders to develop proposals as to how patients' needs would best be met, using information from the engagement process. The final specification for the urgent care service will be available in September and an update will be provided to the Health Proposals Working Group. **March 2009 update** Local Care Direct will be providing both out-of-hours dental services and also the Dental Access Centre service Monday-Friday, from 1st April 2009. This will maximise efficiency of the current capacity and streamline access. Lexicon House lease is due to expire in March 2010, and the project to explore alternative estate will begin in April 2009 in preparation.	**2**	

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	Recommendation	Where we are up to	Stage	Complete
10	**That Leeds PCT gives an assurance to this Board that it intends to provide funding for the intermediate care beds at Middlecross home for older people in 2009/10.**	September 2008 position **Response from Leeds Primary Care Trust (PCT)** The Middlecross Care Home currently provides five beds within a total of 15 dementia Intermediate Care beds. All of the Partnerships for Older Peoples Projects (POPPs) pilots are subject to evaluation of their effectiveness in terms of both quality and finance and this information will influence the future sustainability to mainstream projects. It is also recognised through the development of the Leeds Intermediate Tier Strategy that provision for people with dementia is a priority but should be as part of the PCT's Care Closer to Home programme. These types of service will be developed as part of the commissioning plan to implement the Intermediate Tier Strategy; within that will be a plan to provide Intermediate Care Beds including the dementia beds where appropriate. **Response from Adult Social Services** The intermediate care provision within Middlecross Resource Centre has been funded for a further year (April 08 – March 09) with a combination of POPP Programme slippage, Adult Social Care and PCT funding. The activity and outcomes continue to be monitored against the service milestones by the POPP Performance management group. The service continues to meet its activity targets and is developing new and innovative ways of providing hospital admission avoidance, early supported discharge and rehabilitation for older people with dementia and physical and social needs. Plans for securing the long term sustainability of the service are in place with a Programme evaluation event planned for September 08. Following this event business plans will be developed and submitted for consideration by the commissioning teams within Adult Social Care and the PCT. This service will be considered alongside other POPP projects as part of a "whole system" package of interventions to improve the rehabilitation opportunities for older people with mental health needs. **March 2009 update** **Response from NHS Leeds** The recently published National Dementia Strategy places an emphasis on community based care for people with dementia. The local evaluation and impact assessments of all the POPPs schemes is now complete. The evaluations are positive and NHS Leeds is supportive of the continuation of these schemes including intermediate care beds for people with dementia. NHS Leeds financial plan for 2009/10 is still being refined and will be signed off at the Board in March. **Response from Adult Social Services** Awaiting Board decision on funding, this will be available after the 12th March.	**2**	

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	Recommendation	Where we are up to	Stage	Complete
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.**	<u>September 2008 position</u> Everyone in a CIC bed at Richmond House has a full assessment while they are there. This can include a home visit and certainly includes a full exploration of their needs in order to return home. Most people returning home from the CIC beds do so with the support of the Intermediate Care Team. They are then reassessed at home by a member of the Joint Care Management Team in conjunction with the ICT. If longer term services are required a Care Plan is presented to the West Gatekeeping Panel. There are occasions when people return home and the return home does not succeed. In some cases people have then returned to a CIC bed at Richmond House. However, we are looking carefully at this practice in order to ensure that people whose need is for permanent residential care do not return to a CIC bed and wait there, possibly for several weeks, when a CIC bed is no longer required. As these arrangements are flexible and can accommodate a number of uncertainties, it is felt that the introduction of a 'trial run' will only add a further unnecessary step in what is already a very thorough process. **<u>March 2009 update</u>** There is no further update	**1**	

Key

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<table>
<tr><th></th><th>Recommendation</th><th>Where we are up to</th><th>Stage</th><th>Complete</th></tr>
<tr><td>12</td><td>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.</td><td><u>September 2008 position</u>
Recent reconfiguration of the Practice Based Commissioning (PBC) Consortia in Leeds is outlined below:
<table><tr><th>Consortia</th><th>No. of practices</th><th>Population</th></tr><tr><td>H3+</td><td>31</td><td>276496</td></tr><tr><td>Leodis Healthcare</td><td>30</td><td>205093</td></tr><tr><td>North East Consortium</td><td>13</td><td>116277</td></tr><tr><td>Leeds Commissioning Collaborative</td><td>14</td><td>49828</td></tr><tr><td>The Wetherby & District Group</td><td>5</td><td>33155</td></tr><tr><td>Church Street Group</td><td>6</td><td>14964</td></tr><tr><td></td><td></td><td></td></tr><tr><td>Unaligned Practices</td><td>14</td><td>98265</td></tr></table>The two largest consortia have fulfilled the requirements of “earned autonomy”, demonstrating that they have robust governance and risk management arrangements in place, and have achieved against previous years’ plans.

The PBC Governance Committee has approved ambitious strategic and operational plans for five of the consortia, and it is anticipated that remaining plans will be approved in September 2008. All PBC plans demonstrate a commitment to national and local priorities, to patient and public involvement and joint working with local authority and third sector organisations.

We anticipate that the number of unaligned practices will reduce as discussions are still taking place between some of these practices and the established PBC consortia. At least seven practices are implementing PBC as individual practices this year, and only two practices in the city have declined to participate in PBC at this stage.

Plans are being developed in partnership with the PBC Forum to establish a Commissioning Executive to ensure strategic connections between different strands of PCT commissioning and PBC. It is anticipated that the new arrangements will be in place in shadow form from October 2008.

The PCT has reviewed the management support for PBC. The dedicated PBC team provides direct support to PBC consortia and practices and facilitates support from other PCT departments, such as Finance, Information, Public Health, Patient and Public Involvement (PPI), and Commissioning. The PCT has invested in a dedicated PBC information system which enables activity and financial information to be made available to support commissioning.</td><td>3</td><td></td></tr>
</table>

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		PBC plans are required to describe arrangements for patient and public involvement in the development of commissioning plans and redesign proposals. All PBC consortia have completed a baseline audit of current PPI arrangements, and the PCT is providing support to develop more Patient Participation Groups at practice and consortium level. Some consortia have appointed or are currently appointing lay members to their Boards. The PCT's PPI team supports the development of focus groups to inform the redesign of services. The Patient Advisory Group, with a wide membership from patient groups and community and voluntary organisations in Leeds, reviews all PBC proposals from a patient and public experience perspective and makes recommendations to the PBC Governance Committee. Significant improvements in services have already been achieved through PBC – for example, practice based diagnostic services, admissions avoidance schemes, enhanced care for people in care homes, genital warts service for the student population, improvements to 18 week pathways – and in 2007/08 almost £2 million was freed up for reinvestment in local services. As part of the establishment of partnership arrangements between the PCT and the Local Authority, PBC Consortia have been engaged in how they can make effective links with the Local Authority through partnerships at locality level. Practice based commissioners have been encouraged to establish links with Area Committees and agree areas of joint working on the delivery of Local Area Agreement priorities. **March 2009 update** Changes have taken place with the re-configuration of some PBC Consortia and there are now five PBC Consortia with 14 Practices remaining independent. The most significant change has been the development of Calibre (former NE Consortium) with the former Wetherby Group joining, together with three Practices in the west area of the city. Nationally, there is a drive to reinvigorate practice based commissioning and currently work is being undertaken, in partnership with practice based commissioners, to build upon the local successes in Leeds to date. This includes the development of a local incentive scheme to reflect the local priorities for 2009/2010. Year end reviews will take place in late spring to assess achievement again plans during 2008/2009.		

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SCRUTINY BOARD (HEALTH) LOCALISATION OF SERVICES INQUIRY

WHARFEDALE HOSPITAL - UPDATE MARCH 2009

This briefing paper provides a general update and set out the clinical areas where significant changes have happened since September 2008.

Bilberry Unit

Bilberry Unit opened on Monday 5th January and consists of 13 Community Integrated Care (CIC) beds; they are provided by LTHT on behalf of NHS Leeds. These 13 beds were previously an integral part of Ward 1.

The purpose of the unit is to provide 'sub acute' care closer to home. This is achieved by supporting discharge from acute hospital beds into the 'community'. There are many reasons why patients sometimes cannot go straight home e.g. patients unable to go home due to being alone, or patients who require a period of rehabilitation. Patients being admitted to CIC beds should however be medically fit. This means that CIC beds are therapy-led involving multi-disciplinary working between nurses', physiotherapists and occupational therapists.

Another key role for the unit is to avoid the need for acute hospital admission for patients who may need further assessment, treatment or care which cannot happen at home. They may have suffered 'functional decline' and became too dependant to remain at home. Patients continue to be cared for by a GP but are not unwell enough to need a hospital admission. These patients often benefit from the slower paced environment offered here at Wharfedale.

Patients and relatives frequently tell us that they want to be cared for 'closer to home' and Bilberry Unit's CIC beds allow this to happen, patients and relative frequently welcome this environment rather than have to travel to Leeds.

Cancer Treatment Unit

A new nurse-led cancer treatment service opened at Wharfedale in January 2009. This means cancer patients in Otley and the surrounding area together with north Leeds can now benefit from chemotherapy and other supportive treatment much closer to home.

Two cancer nurses who currently deliver the treatment at the St James's Institute of Oncology travel to Wharfedale Hospital two days a week to provide this additional service, supported by an advanced nursing assistant.

It has been specially tailored to the needs of residents of north Leeds and the surrounding area already undergoing treatment at Leeds Teaching Hospitals. A range of chemotherapy as well as blood transfusions, iron infusions and other supportive treatment can be safely delivered in Wharfedale Hospital, meaning local patients do not have as far to travel.

Patients will have their initial assessment at the regional cancer centre at St James's and then be given the opportunity to have their treatment at Wharfedale Hospital.

The unit is based on the 1st floor of Wharfedale Hospital and can treat six patients at any one time. Typically treatment times last from half an hour up to five hours, so the capacity is expected to be around 8 patients on each of the two days once the service is fully established.

Day Case Surgery
As a result of an evaluation of surgical services 6 overnight stay beds have been re-introduced 3 days per week as of 1st August 2008 with medical support cover for these three days per week.

In order to maximise the opportunities for overnight stay it was agreed to rotate the 3 nights on a 2 weekly basis. As a result of these changes there has been a rise in session theatre utilisation from 66 % in general surgery to 89%. Work continues to investigate how the remaining theatre space can be better utilised

Out patient Services
Out patient activity at the hospital continues to rise with new services being commenced on a regular basis. Examples include urology, ENT, a cardiac arrythmia clinic, and a nurse-led incontinence clinic.

Direct booking service now available for most of the clinics, those that aren't available through direct booking are being addressed and it is hoped they will be on line soon. Discussions are underway with a number of services within the Trust about setting up additional and new clinics at the hospital.

Diabetes care
Emphasis over the past year has been to give patients the choice of retuning to their GP for their care where iot is appropriate. Wharfedale was unusual in Leeds in providing services that could be provided in a primary care within the hospital.

The remaining diabetes service remains stable and new referrals are still being received. In addition a PCT led community diabetes clinic is now being provided out of Wharfedale Diabetes Centre (this is in the hospital) by PCT staff to help ensure effective use of resources.

Day Hospital
The services which were traditionally provided out of the day hospital have now been relocated and are provided by the physiotherapy and occupational therapy departments at the hospital. This has enabled the vacant space to be used as an educational and multi-use area.

Pre assessment / Preadmissions
In April an expanded preassessment / preadmission department will transfer into the vacated Day Hospital suite. Since the increase in activity and with better scheduling of patients for theatre and new MRSA screening requirements the service needs a bigger department.
The vacant preassessment department will now enable outpatient services to expand further.

Ward 1 – Older people
Care for older people remains an important element of hospital care for many people in the area. Currently patients are admitted to the Leeds General Infirmary prior to being transferred

to Wharfedale Hospital. This gives access to diagnostic tests which only occur on the LGI site to be done more quickly before transfer to a more appropriate care environment.

Ward 1 is able to offer limited direct admission service if beds are available and the patient is deemed suitable for the site.

Urgent Care
The NHS Leeds urgent care procurement has now been concluded. From April 2009 Local Care Direct , a social enterprise company, will provide emergency dental services, minor illness and injury walk-in services at Wharfedale Hospital, GP out-of-hours appointments and home visits.

The specific changes relating to Wharfedale Hospital are:

- Introduction of GP appointments out-of-hours & weekends
- Expansion to provide nurse-led minor illness services
- Improved seamless care pathways as a result of one organisation providing both minor injury & illness walk-in services as well as out-of-hours GP appointments

Environment and Infection Control
Wharfedale continues to perform well against infection control standards. There were no MRSA bacteraemias in 2008. C. Diff rates were comparatively low.

In 2008 Wharfedale Hospital was awarded **Excellent** in all areas in the annual Patient Environment Action Team (PEAT) Assessment. This work assesses the environment through a user perspective. The team carrying out the assessment includes patient representatives. It covers:

- general and specific cleanliness (toilets and bathrooms)
- Infection control
- Environment (overall presentation)
- Access
- Safety and security
- Food
- Privacy and dignity

Next Steps
Apart from a small amount of clinic space there is no spare accommodation for new services. Our focus now will be to ensure services provided out of Wharfedale are used to their maximum potential.

A very successful GP open evening was held at Wharfedale Hospital in January to help raise awareness of the services available to local GPs. Approximately 10% of the local GPs attended the evening. Further sessions will be held in the future as a rolling education / information giving session.

LTHT
March 2009

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Leeds CITY COUNCIL

Originator: P N Marrington

Tel: 39 51151

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 24th March 2009

Subject: Scrutiny Board (Health) – Work Programme

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

1.0 INTRODUCTION

1.1 At its meeting in July 2008, the Board agreed its outline work programme. Attached at Appendix 1, for the Board's further consideration is an updated work programme for the Scrutiny Board (Health) for the remainder of the current municipal year.

1.2 The Executive Board Minutes for the meeting held on the 4th March 2009 are presented at Appendix 2 for information.

2.0 RECOMMENDATIONS

2.1 Members are asked to;
(i) Note the Executive Board minutes
(ii) Agree the Board's work programme.

3.0 BACKGROUND DOCUMENTS

None used

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Scrutiny Board (Health)
Work Programme 2008/09

Item	Description	Notes	Type of item
Meeting date – 28 April 2009			
Mental Health Provision	To have a general discussion around mental health provision in Leeds.	This may lead to further specific scrutiny at later meetings.	B
GP-led Health Centre	To receive an update following the Centre's opening.		RP
Improving Young Peoples Sexual Health	To approve final report		RP
Health Proposals Working Group	To consider an update from the working group		B
Annual Report	To agree the Board's contribution to the annual scrutiny report		

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

Scrutiny Board (Health)
Work Programme 2008/09

Working Groups			
Working group	**Membership**	**Progress update**	**Dates**
Health Proposals	Cllr Grahame Cllr Lamb Cllr McKenna Cllr Rhodes-Cayton Eddie Mack	➢ Initial terms of reference agreed on 22 July 2008 ➢ Revised terms of reference agreed on 16 September 2008 ➢ 8 September 2008 - notes attached for SB meeting held on 21 October 20 ➢ 6 October 2008 - issues discussed included: ▪ Project updates on: o Changes to GP services; o Urgent care services ▪ New Proposals around Older Peoples Mental Health service	*8 Sept. 2008* *6 Oct. 2008* *15 Dec. 2008* *3 Feb. 2009* *30 March 2009*
Improving Young Peoples Sexual Health	Cllr Grahame Cllr Monaghan Cllr Kirkland Cllr McKenna Somoud Saqfelhait	➢ Initially proposed to consider the issue of teenage pregnancy, the Board agreed to expand the scope of this inquiry to cover sexual health among young people in general. ➢ Terms of reference agreed 16 September 2008 ➢ Initial meeting held on 9 September 2008 – notes presented to the SB meeting held on 21 October 2008 ➢ Report scheduled for SB meeting in December 2008 ➢ Further working group meeting dates to be confirmed	*9 Sept. 2008* *4 Feb. 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

Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Review of National Blood Service Strategy	To consider the specific implications of the planned changes to the structure of NHS Blood and Transplant, including the closure of the blood testing and processing centre within Leeds.	At its meeting in July 2008, the Board considered proposed changes to the structure of NHS Blood and Transplant and the specific implications of closing the blood testing and processing centre within Leeds and transferring its operation to other centres in the North of England. The Board requested and received additional information regarding the proposals. A further update is expected in January 2009. In January 2009, NHS Blood and Transplant were contacted and requested to clarify the current position regarding the service changes previously presented to the Scrutiny Board (Health) – particularly in terms of the existing Leeds site at Seacroft.

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

Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Clinical Services Reconfiguration – Full Business Case	To consider an update on the full business case for the proposed service reconfiguration.	The Board has been updated on the impact for Children's Hospital Services and considered the engagement work undertaken to date and planned for the future. Consideration of the full business case was originally scheduled for November 2008, but is unlikely to be reported before Spring 2009 and the precise timing is to be confirmed.
Clinical Services Reconfiguration – Implications for Adult Medicine	To consider the implications and proposed changes to service provision on adult medicine.	The Board has been updated on the impact for Children's Hospital Services and considered the engagement work undertaken to date and planned for the future. At its meeting in January 2009, the Board agreed to consider the implications and proposed changes to service provision on adult medicine at a future meeting (to be determined).

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

Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Specialised commissioning arrangements	To consider the current arrangements for specialised commissioning within the region and the role of scrutiny.	The planned Department of Health (DoH) consultation on developing / strengthening Health Scrutiny may have an impact.
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

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EXECUTIVE BOARD

WEDNESDAY, 4TH MARCH, 2009

PRESENT: Councillor A Carter in the Chair

Councillors R Brett, J L Carter, R Finnigan, S Golton, R Harker, P Harrand, J Procter, S Smith and K Wakefield

Councillor J Blake – Non Voting Advisory Member

207 Exclusion of the Public

RESOLVED – That the public be excluded from the meeting during consideration of the following parts of the agenda designated exempt 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 public were present there would be disclosure to them of exempt information so designated as follows:

(a) Appendix 1 to the report referred to in minute 211 under the terms of Access to Information Procedure Rule 10.4(3) and on the grounds that the public interest in maintaining the exemption outweighs the public interest in disclosing the information because publication could prejudice the Council's commercial interests by prejudicing sensitive negotiations currently underway with private sector investors to secure a contribution to the schemes.

(b) Appendix 1 to the report referred to in minute 214 under the terms of Access to Information Procedure Rule 10.4(3) and on the grounds that the public interest in maintaining the exemption outweighs the public interest in disclosure on the grounds that it contains commercially sensitive information about the respective financial and business affairs and commercial positions of the Council and Bidders.

(c) The appendix to the report referred to in minute 225 under the terms of Access to Information Procedure Rule 10.4(3) and on the grounds that it contains information relating to ongoing negotiations that are confidential and/or commercially sensitive. In these circumstances it is considered that the public interest in not disclosing this information outweighs the interests of disclosure.

208 Declaration of Interests

Councillor Brett declared a personal interest in the item relating to Brooksbank – Completion of Residential Care Strategy (minute 223) as a member of Burmantofts Senior Action Management Committee.

Councillor Wakefield declared personal interests in the items relating to The National Challenge and Structural Change to Secondary Provision (minute 217) and the Machinery of Government Changes and 14-19 Commissioning (minute 218) as a governor of Leeds City College and Brigshaw School.

Councillors J Procter, Harrand and Blake declared personal interests in the item relating to the City Varieties Music Hall (minute 222) as members of the Grand Theatre and Opera House Board.

Councillor Blake declared a personal interest in the items relating to the Joint Strategic Needs Assessment (minute 224) and Joint Service Centres (minute 225) as a non-Executive Director of Leeds NHS Primary Care Trust.

Councillor Finnigan declared, in relation to minute 225, that as a member of the Plans Panel (East) he had been involved in the planning approvals for the Chapeltown Centre.

209 Minutes

RESOLVED – That the minutes of the meeting held on 13th February 2009 be approved.

210 Chair's Announcement

The Chair reported on discussions which he had had with ITV in connection with local job losses at the company and the intention of the Council to work with the company and former employees to ameliorate the situation.

DEVELOPMENT AND REGENERATION

211 Refurbishment of Kirkgate and Bond Street, Leeds City Centre

The Director of City Development submitted a report on the proposed scheme design for the refurbishment of the pedestrianised section of Kirkgate that is bounded by Briggate and Vicar Lane and the refurbishment of Bond Street. Following consideration of appendix 1 to this report designated as exempt under Access to Information Procedure Rule 10.4(3) which was considered in private at the conclusion of the meeting it was

RESOLVED –

(a) That approval be given to the scheme design as outlined in the report.

(b) That approval be given to the injection of funding into the Capital Programme together with authority to incur expenditure as identified in the exempt appendix to the report.

212 Legible Leeds Project

The Director of City Development submitted a report on proposals to improve the legibility of Leeds City Centre by investing in the pedestrian wayfinding system.

RESOLVED –

(a) That approval be given in principle to the phased implementation of a new contemporary on-street wayfinding system, the first phase focusing on the central retail area, as indicated in the report;
(b) That the Director of City Development be requested to work up a detailed design and costed programme of works, and to progress funding proposals to a total cost of £1,200,000.

213 The Former Headingley Primary School

Referring to minute 115 of the meeting held on 14th November 2007 the Director of City Development and the Director of Environment and Neighbourhoods submitted a joint report detailing a proposal of Headingley ward members, on behalf of the Headingley Development Trust, for the Council to provide £500,000 to enable the Trust to develop its 'Heart' proposal at the former Headingley Primary School.

The report contained officer commentary on the current proposal from the Trust, the risks associated with the proposal and the steps which the Council could take in mitigation of those risks should members be minded to support the proposal.

RESOLVED –
(a) That, having regard to all that is said in paragraph 8 of the report:-
  (i) the request from Headingley Development Trust for the transfer of the former Headingley Primary School to the Trust be approved; and
  (ii) Council funding, in the amount of £500,000, be made available to support the scheme
(b) That the transfer and the funding be subject to the imposition of the conditions outlined in paragraph 9.1 of the report.

NEIGHBOURHOODS AND HOUSING

214 Little London and Beeston Hill and Holbeck Round 5 PFI Housing Project - Impact of Wider Economic Changes on Project Scope

The Director of Environment and Neighbourhoods submitted a report providing an update on the procurement of the Housing PFI Project covering Little London and Beeston Hill and Holbeck, including issues arising from bids received at the 'Detailed Solutions' stage of the procurement exercise and proposed changes to the scope of the project.

The proposed changes to the scope of the project were summarised as follows:

- removal of the Development Agreement including the removal of disposal of land for construction of private homes for sale
- retention of Meynell Heights for refurbishment
- removal of three development sites in Beeston Hill and Holbeck (Waverley Garth, Malvern Rise/Grove, Cambrian Street) and two sites in Little London (Leicester Place and Cambridge Road)
- removal of parts of the Holbeck Towers and Carlton Gate sites

- reduction in PFI new build development in Beeston Hill and Holbeck from 350 to 275 units.

Following consideration of appendix 1 to the report designated as exempt under Access to Information Procedure Rule 10.4(3) which was considered in private at the conclusion of the meeting it was

RESOLVED -

(a) That approval be given to the changes to the PFI project scope as set out in the submitted report and in Appendices 2 and 3 thereto and that they be referred to the Homes and Communities Agency for approval.

(b) That the opportunity to consider land removed from the PFI project scope at this stage for alternative residential development be noted.

(c) That the revised timetable for the Invitation to Submit Refinement of Solutions and Final Tender stages of procurement be noted.

(d) That the Director of Environment and Neighbourhoods be requested to ensure that the annual review of the Lettings Policy considers options for the policy to be tailored to localised needs within the City.

215 The EASEL and West Leeds Gateway Worklessness Project

The Director of Environment and Neighbourhoods submitted a report outlining the approach taken to addressing worklessness following the Round Table discussions which had taken place with the Minister for Local Government, elected members, officers and partners.

RESOLVED – That the project, as outlined in the report, be endorsed and that a further report be brought to the Board on the outcome of the evaluation.

216 Under Occupation Scheme

The Director of Environment and Neighbourhoods submitted a report providing an update on the under occupation scheme launched in July 2008 and outlining proposals on how to encourage further customers who are currently under occupying to downsize.

RESOLVED –

(a) That, having noted that the scheme had released 27 homes up to January 2009, approval be given to the continuation of the scheme in 2009/10.

(b) That the Director of Environment and Neighbourhoods works with the Leeds ALMOs and the Belle Isle Tenants Management Organisation to increase the level of support offered to customers on the scheme.

CHILDREN'S SERVICES

217 The National Challenge and Structural Change to Secondary Provision in Leeds - Progress Report

The Chief Executive of Education Leeds submitted a report outlining recommended options for delivering the next phase in structuring secondary provision in Leeds, and in particular, the response to the National Challenge.

The report outlined options in relation to the individual elements of the Central Leeds Learning Federation, Primrose High School, City of Leeds High School, Parklands Girls' High School, Boston Spa School and Wetherby High School in Outer North East Leeds and presented two composite options dependent on the availability of BSF funding as follows:

OPTION A: If BSF Funding Is Available To Leeds

The Central Leeds Learning Federation
To propose that the Federation be dissolved and that the possibilities and opportunities of Trust developments be explored as other structural options are developed.

Primrose High School
To consult on a proposal that Primrose High School should be closed and be replaced by an Academy which should open in September 2010.

City of Leeds
To consult on a proposal that City of Leeds School should be closed and be replaced by an Academy which should open on the City of Leeds site in September 2010. To propose that the Academy be moved to new build provision in East Leeds as soon as possible and using the current site for girls only provision.

Parklands Girls High School
To consult on a proposal that Parklands Girls' High School should be closed and replaced by an Academy which should open in September 2010. It is intended that the Academy sponsor and the associated partners would help the school focus on developing academic and vocational excellence. The Academy should be moved to the City of Leeds site as it becomes available. The current site would be further developed through BSF and used for new mixed secondary provision to meet the demand for secondary places in the area.

Outer NE Leeds
To consult on a proposal to establish a federation between Boston Spa School and Wetherby High School which would move into newly-built provision in Outer North East Leeds to cater for young people living in Boston Spa and Wetherby. Such a federation could also become a sponsor for a new build provision in East Leeds with full extended services provision and incorporating community and special educational needs provision.

OPTION B: If No BSF Funding Is Available To Leeds

The Central Leeds Learning Federation
To propose that the Federation be dissolved and the possibilities and opportunities of Trust developments be explored as other structural options are developed.

Primrose High School

To consult on a proposal that Primrose High School should be closed and be replaced by an Academy which should open in September 2010.

City of Leeds
To consult on a proposal that City of Leeds School should be closed and be replaced by an Academy which should open in September 2010 and transfer to the Parklands site. To then propose to use the City of Leeds site for girls only provision.

Parklands Girls' High School
To consult on a proposal that Parklands Girls' High School should be closed and replaced by an Academy which should open in September 2010. It is intended that the Academy sponsor and the associated partners would help the school focus on developing academic and vocational excellence. The Academy should be moved to the City of Leeds site as it becomes available. The site would be used for a new Academy providing mixed secondary provision.

RESOLVED –

(a) That, subject to additional BSF funding being available, option A above be adopted and that further reports be brought to the Board for final approval as each proposal moves to implementation.

(b) That, in the absence of additional BSF funding, option B above be adopted and that further reports be brought to the Board for final approval as each proposal moves to implementation.

(Under the provisions of Council Procedure Rule 16.5 Councillor Wakefield required it to be recorded that he abstained from voting on this decision).

218 Machinery of Government Changes and 14-19 Commissioning Arrangements: Leeds/Sub-Regional Proposals

The Chief Executive of Education Leeds submitted a report on the proposed structures and governance arrangements that will form the basis for the next stage of local and sub-regional development work on the commissioning of 14-19 provision in Leeds.

RESOLVED –

(a) That approval be given to the stage 2 Machinery of Government submission to the Department for Children, Schools and Families attached as annex 1 to the submitted report.

(b) That the approach to establishing local authority and sub-regional level governance arrangements, as outlined in the report, be approved.

219 Proposal to Close South Leeds High School on 31st August 2009

Further to minute 142 of the meeting held on 3rd December 2008 the Chief Executive of Education Leeds submitted a report informing of the response to the statutory notice for the proposal to close South Leeds High School on 31st August 2009 and recommending the closure of the school on the same date.

RESOLVED –

(a) That, noting that there were no responses to the statutory notice and having regard to the following four key reasons, approval be given to the unconditional closure of South Leeds High School on 31st August 2009:-

- The need to accelerate improvement, recognising that there has been improvement, but that there is a need to see this impact faster on the achievements of young people.
- An academy would bring extra capacity (both professional expertise and other resources) to sustain improvement into the medium term.
- In the School Partnership Trust (SPT) we have a local partner committed to sustaining and building upon South Leeds High School's contribution to the wider education community of Leeds.
- SPT's knowledge and expertise involving local colleges, our universities, local health and social care services, the police and local businesses to improve opportunities and outcomes for young people is needed in South Leeds.

(b) That the PFI development costs that will be incurred by the City Council arising from the closure of South Leeds High School and establishment of an Academy be noted.

220 Proposal to Close Intake High School Arts College on 31st August 2009

Further to minute 143 of the meeting held on 3rd December 2008 the Chief Executive of Education Leeds submitted a report informing of the response to the statutory notice for the proposal to close Intake High School Arts College on 31st August 2009 and recommending the closure of the school on the same date.

RESOLVED – That, noting that there were no responses to the statutory notice and having regard to the following four key reasons, approval be given to the unconditional closure of Intake High School Arts College on 31st August 2009:-

- The need to accelerate improvement. Whilst there has been improvement, there is a need to see this impact faster on the achievements of young people.
- An academy would bring extra capacity (both professional expertise and other resources) to sustain improvement into the medium term.
- Edutrust is an organisation that is geared up to maximise what Intake can learn from the family of schools in Leeds and that can supplement this with support from their network of academies.
- Edutrust's commitment to developing local communities means that there is an exciting opportunity, with a new state of the art school, to see learning becoming inspiring and accessible to everyone in Bramley, Stanningley, Armley and Kirkstall.

221 Feedback on Executive Board Requests for Scrutiny

The Head of Scrutiny and Member Development submitted a report providing feedback on the two requests made at the January meeting of the Board

(Minute 175(b)) for work to be undertaken by the Scrutiny Board (Children's Services).

RESOLVED – That the response of the Scrutiny Board be noted.

LEISURE

222 City Varieties Music Hall

The Director of City Development submitted a report outlining the progress made on the refurbishment of the City Varieties Music Hall, advising of the Heritage Lottery Fund award and presenting proposals for further work to be undertaken.

RESOLVED –

(a) That the HLF Stage 2 application award of £2,739,000 be noted.

(b) That the Council enter into a grant agreement with the HLF on the terms and conditions detailed in the report subject to any further variations agreed by the Assistant Chief Executive (Corporate Governance).

(c) That the decision of the Leeds Grand Theatre and Opera House Ltd Board of Management to increase their fundraising contribution to £1,261,000 to the project budget be noted.

(d) That authority be given to incur expenditure of £8,210,000 on the refurbishment project including authority to enter into a building works contract.

(e) That approval be given to an injection of £125,000 to the Capital Programme through an increase in the existing prudential borrowing arrangements for the purchase of the Swan Public house.

(f) That a letter of intent be issued to carry out preliminary works, if required, to avoid delay to the project programme.

(g) That the revised total project cost of £9,325,000 be noted.

ADULT HEALTH AND SOCIAL CARE

223 Brooksbank - Completion of Residential Care Strategy

The Director of Adult Social Services submitted a report providing an update on the progress made with respect to the Older People's long-term strategy and seeking specific approvals in respect of Brooksbank following external assessments of the building as life expired.

RESOLVED –

(a) That the completion of the strategy approved in 2001 be noted.

(b) That the Board agrees that Brooksbank as a building is life expired as a safe modern residential care home and declares it surplus to the requirements of Adult Social Care.

(c) That the Director of Adult Social Care request the Asset Management Board to investigate alternative uses for the site, including its potential for an extra care scheme.

224 Joint Strategic Needs Assessment

The Director of Adult Social Services and Director of Children's Services submitted a joint report presenting the Joint Strategic Needs Assessment report, the data pack and other qualitative information used to arrive at the current findings.

RESOLVED –

(a) That the findings of the first phase of the Leeds Joint Strategic Needs Assessment be endorsed and that approval be given for publication of the report Implementing the Leeds JSNA;

(b) That the Director of Adult Social Services and the Director of Children's Services produce further reports on at least an annual basis, to report the results of future JSNA work;

(c) That all Directors, and in particular the Directors of Adult Social Services and Children's Services be requested to ensure that all future commissioning plans and service plans reflect the health and well being priorities identified through the Leeds JSNA process.

(d) That the interest already shown by the three relevant Scrutiny Boards, be noted and that they be asked to keep an oversight of JSNA work within their work programmes.

(e) That the final report of Implementing the Leeds Joint Strategic Needs Assessment Framework, as attached to the report, be circulated to all members of Council for information and reference.

CENTRAL AND CORPORATE

225 Joint Services Centres at Chapeltown, Harehills and Kirkstall

The Deputy Chief Executive submitted a report on progress on the procurement of the Chapeltown and Harehills elements of the Joint Service Centres Project and on a package of proposals from Community Ventures Limited to develop a joint service centre at Kirkstall.

Following consideration of the appendix to the report designated as exempt under Access to Information Procedure Rule 10.4(3) which was considered in private at the conclusion of the meeting it was

RESOLVED -

(a) That the Stage 2 Offer for the Chapeltown and Harehills centres as prepared by Community Ventures Limited be acknowledged and that the Deputy Chief Executive be authorised to formally accept the offer on behalf of the Council subject to completion of a satisfactory value for money assessment, to be undertaken by the District Valuer.

(b) That the Deputy Chief Executive be authorised to submit the Offer for the Chapeltown and Harehills centres to the Leeds Lift Strategic Partnering Board for Stage 2 Approval under the LIFT process subject to completion of a satisfactory value for money assessment, to be undertaken by the District Valuer.

(c) That approval be given to the financial implications for the Council of entering into the Joint Service Centre Project for the Chapeltown and Harehills centres ("Project") and that the maximum affordability deficit

to be funded by the Council for these two Centres as set out in Appendix 1 to the report be approved.

(d) That the Deputy Chief Executive be authorised to submit the Final Business Case for the Project to the Department of Communities and Local Government subject to the District Valuer having completed a satisfactory value for money assessment, and that the Project remains within the maximum affordability ceiling set out in recommendation c, above.

(e) That approval be given to the arrangements to Financial Close and implementation of the Project to include (but not by way of limitation) the award of/entry into Lease Plus Agreements with Community Ventures Limited (CVL), and, in connection therewith, that the Deputy Chief Executive (or in his absence the Director of Resources) be authorised to

(i) make any necessary amendments to the Final Business Case.

(ii) give final approval to the completion of the Project, including (but not by way of limitation) the terms of the Lease Plus Agreements together with any other documentation ancillary or additional to the Lease Plus Agreements necessary for the completion of the Project ("Project Documents"), subject to

(C) CLG approval of the Final Business Case.

(D) the Deputy Chief Executive (or in his absence the Director of Resources) being satisfied that the Project remains within the affordability constraints set out in recommendation (c) above;

(iii) approve the signing of any necessary certificates under the Local Government (Contracts) Act 1997 in relation to the Project;

(iv) approve the execution of the Project Documents, by affixing the Council's common seal and/or signature (in accordance with Articles 14.4 and 14.5 of Part 2 of the City Council's Constitution) and to approve (or authorise any officer of the Council to take) any necessary further action following approval of completion of the Project to complete the Project including any final amendments to the Project Documents.

(f) That the Stage 1 Offer for the Kirkstall Joint Service Centre as prepared by Community Ventures Limited be acknowledged and that the Deputy Chief Executive be authorised to formally accept that offer on behalf of the Council subject to completion of a satisfactory value for money assessment, to be undertaken by the District Valuer and that the offer is affordable to the City Council.

(g) That the Deputy Chief Executive be authorised subject to a successful Value for Money Assessment and the Project being affordable to the City Council, to submit the Stage 1 Offer for the Kirkstall Joint Service Centre to the Leeds Lift Strategic Partnering Board for Stage 1 for Approval under the LIFT process.

226 Amendments to the Leeds Strategic Plan 2008-2011

The Assistant Chief Executive (Policy, Planning and Improvement) submitted a report on a number of proposed amendments to the Leeds Strategic Plan 2008-11, the Local Area Agreement for Leeds.

RESOLVED –

(a) That approval be given to Appendix 1 to the report as the Council's proposed revisions and additions to the 'Government Agreed' targets prior to submission to Government in time for 9 March 2009.

(b) That the Assistant Chief Executive (Planning, Policy and Improvement) be authorised to make minor amendments, if required, prior to submission to Government. Should any revisions be required, the Assistant Chief Executive will inform Members of Executive Board prior to submission.

(c) That future reports on the realism of targets in light of the impact of the economic recession be brought to the Board.

DATE OF PUBLICATION: 6TH MARCH 2009
LAST DATE FOR CALL IN: 13TH MARCH 2009 (5.00 PM)

(Scrutiny Support will notify Directors of any items called in by 12.00 noon on 16th March 2009).

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