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Leeds CITY COUNCIL

SCRUTINY BOARD (HEALTH)

Meeting to be held in Civic Hall, Leeds on
Tuesday, 28th July, 2009 at 10.00 am

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

MEMBERSHIP

Councillors

S Bentley - Weetwood;
J Chapman - Weetwood;
D Congreve - Beeston and Holbeck;
M Dobson (Chair) - Garforth and Swillington;
J Illingworth - Kirkstall;
M Iqbal - City and Hunslet;
G Kirkland - Otley and Yeadon;
A Lamb - Wetherby;
G Latty - Guiseley and Rawdon;
L Rhodes-Clayton - Hyde Park and Woodhouse;
L Yeadon - Kirkstall;

Co-opted Members

E Mack - Leeds Voice
Vacancy - Leeds LINk

Agenda compiled by:
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A G E N D A

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

Item No	Ward/Equal Opportunities	Item Not Open		Page No
3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATIONS OF INTEREST** To declare any personal/prejudicial interests for the purpose of Section 81 (3) of the Local Government Act 2000 and paragraphs 8 to 12 of the Members' Code of Conduct.	
5			**APOLOGIES FOR ABSENCE** To receive any apologies for absence.	
6			**MINUTES OF THE PREVIOUS MEETING** To receive and approve the minutes of the previous meeting held on 30th June 2009.	1 - 10
7			**RENAL SERVICES - PROVISION AT LEEDS GENERAL INFIRMARY** To consider the attached report of the Head of Scrutiny and Member Development attaching information to allow the Board to consider current proposals from LTHT associated with the provision of renal services across the Trust, particularly in terms of provision at LGI.	11 - 50
8			**RENAL SERVICES: PATIENT TRANSPORT SERVICE** To consider the attached report of the Head of Scrutiny and Member Development presenting the Scrutiny Board with a report from the Yorkshire Ambulance Service on the current performance of its Patient Transport Service for renal patients.	51 - 52

Item No	Ward/Equal Opportunities	Item Not Open		Page No
9			**JOINT PERFORMANCE REPORT: QUARTER 4 - 2008/09** To consider the attached report of the Head of Scrutiny and Member Development presenting the joint performance report from NHS Leeds and Leeds City Council which provides an overview of progress against key improvement priorities and performance indicators relevant to the Board at Quarter 4, 2008/09.	53 - 90
10			**RECOMMENDATION TRACKING** To consider the attached report of the Head of Scrutiny and Member Development to assist the Board in monitoring progress on recommendations from previous inquiries.	91 - 108
11			**WORK PROGRAMME** To consider the attached report of the Head of Scrutiny and Member Development presenting an outline work programme for the Board to consider, amend and agree as appropriate.	109 - 124
12			**DATE AND TIME OF NEXT MEETING** Tuesday 22nd September 2009 at 10.00am (Pre-meeting at 9.30am).	

SCRUTINY BOARD (HEALTH)

TUESDAY, 30TH JUNE, 2009

PRESENT: Councillor M Dobson in the Chair

Councillors J Illingworth, G Kirkland, A Lamb, G Latty, L Rhodes-Clayton and L Yeadon

1 Chair's Opening Remarks

The Chair welcomed everyone to the first meeting of the Scrutiny Board (Health) for this municipal year.

2 Declarations of Interest

Councillor G Kirkland declared a personal interest in his capacity as a Member of Wharfedale Hospital Board (Minute 8 refers).

3 Apologies for Absence

Apologies for absence were submitted on behalf of Councillor J Chapman, Councillor M Iqbal, and Councillor C Townsley.

4 Minutes of the Previous Meeting held on 28th April 2009

RESOLVED – That the minutes of the meeting held on 28th April 2009 be confirmed as a correct record.

5 Input into the Work Programme 2009/2010 - Sources of Work and Establishing the Board's Priorities (Part 1)

The Head of Scrutiny and Member Development submitted a report on an input into the Board's work programme for 2009/10 and to identify sources of work and establish the Board's priorities.

Appended to the report were copies of the following documents for the information/comment of the meeting:-

- Scrutiny Board (Health) - Terms of Reference (Appendix 1 refers).
- Leeds Strategic Plan 2008 to 2011- Executive Summary (Appendix 2a refers)
- Extract from Leeds' Director of Public Health Annual Report (2007-2008)(Appendix 2b refers)
- List of Scrutiny Board (Health) inquiries undertaken between October 2003 to April 2009 (Appendix 2c refers).

The Chair explained that both Councillor Harrand, Executive Board Member for Adult Health and Social Care and John England, Deputy Director Partnerships and Operational Effectiveness would make their presentations to this item early on the agenda in order that they could attend another meeting.

The Executive Board Member for Adult Health and Social Care outlined some of the current and future pressures on the Adult Social Services Department, including spending levels/ budgetary issues, higher levels of expectation and longer life expectancy. He also raised the issue of the separation of Health and Social Care services and the need for continued collaborative working between the Council and its NHS Partners, suggesting this might be any issue/area that the Board may want to examine during the coming year.

The Deputy Director Partnerships and Operational Effectiveness (Adult Social Services) outlined the Department's working relationship with outside organisations, such as NHS Leeds and summarised key activities and priorities for the Board to consider including in its work programme, including:

- Premature mortality issues
- Outcomes from the Joint Strategic Needs Assessment (JSNA)
  - People living longer
  - People (children and young people) needing a good start in life, covering issues such as:
- Obesity
- Sexual Health
- Emotional needs and support
- Significant issues (when compared regionally and nationally), such as:
  - Obesity
  - Levels of harmful alcohol consumption
  - Drugs
  - Smoking – including local differentials (i.e. health inequality issues)
- Matters highlighted in the (KPMG) Health Inequalities report, such as:
  - Targeting areas of greatest need
  - Ensuring health issues have a higher profile within the Council

Members commented and sought further clarification on some of the issues highlighted for possible inclusion in the Board's future work programme.

Following detailed discussions, the Chair thanked the Executive Board Member and the Deputy Director Partnerships and Operational Effectiveness for their contribution and attendance.

The Chair informed the Board that further input into establishing the Board's priorities from external partners would also be discussed later on the agenda.

RESOLVED - That the content of the report and appendices be noted.

6 Co-opted Members

The Head of Scrutiny and Member Development submitted a report which outlined the provisions to allow the appointment of co-opted members to Scrutiny Boards on the following basis:

- Up to five non-voting co-opted members could be appointed to the Board for a term of office which did not go beyond the next annual meeting of Council; and,
- Up to two non-voting members for a term of office which related to a particular scrutiny inquiry.

The report also made reference to the recently launched Local Involvement Network.

It was reported to the Board that both Leeds Voice and Touchstone (organisations previously represented on the Scrutiny Board) had indicated a desire to continue to be represented on the Scrutiny Board.

The Board discussed the contents of the report in detail and identified the potential benefits of appointing co-opted members from Leeds Local Involvement Networks (LINk) and to appoint co-opted members on an ad hoc basis to assist the Board with its specific inquiries during the municipal year.

RESOLVED –

(a) That the contents of the report be noted.

(b) That Leeds Voice (Health Forum) be allocated a non-voting co-opted seat on the Scrutiny Board (Health) and that Mr E Mack, as a representative of Leeds Voice, be appointed for the remainder of the 2009/10 municipal year.

(c) That pending the establishment of a formal LINk Steering Group, nominations be sought from Leeds LINk for a representative to act as a non-voting co-opted member on the Board for this municipal year.

(d) To assist the Board with any specific inquiries during the municipal year, that:

  (i) The appointment of non-voting co-opted members (on an ad hoc basis) be kept under review; and,

  (ii) Consideration be given to the invitation and use of expert witnesses.

7 Legislation and Constitutional Changes

The Head of Scrutiny and Member Development submitted a report requesting the Board to note the changes to the Council's Constitution in relation to Scrutiny. Specific matters outlined in the report related to:

- Councillor Call for Action (CCfA) Provisions
- Arrangements for the Scrutiny of Crime and Disorder Functions and Local Crime and Disorder Matters
- Local Involvement Networks (LINkS)
- Responding to inquiry report and recommendations
- Scrutiny of Partners

RESOLVED – That the contents of the report and appendices be noted.

8 Input into the Work Programme 2009/2010 - Sources of Work and Establishing the Board's Priorities (Part 2)

Further to Minute 4 above, the Chair welcomed the following representatives to the meeting:-

- Jill Copeland (Executive Director of Partnerships and Development) – NHS Leeds
- Chris Butler (Chief Executive) – Leeds Partnerships Foundation Trust (LPFT).
- Sylvia Craven – Leeds Teaching Hospitals NHS Trust

Each of the above gave a brief presentation and outlined key issues and priorities relevant to the organisations they represented, as follows:

Leeds Partnerships NHS Foundation Trust

- Completing the redesign of Older People's Mental Health Services
- Improving the Trust's position with regard to delayed transfer of care (between service providers both health and social care)
- Building on the Trust's work on patient safety, further improving the quality of, and reducing the variation in, services (related to excellence in service provision and delivering the aims of "Healthy Ambitions")
- Understanding the implications and planning for a downturn in NHS finances.
- Challenging stigma and discrimination often associated and with mental health problems and learning disabilities, and promoting social inclusion.

NHS Leeds

- Saving lives and reducing health inequalities
- Improving health, wellbeing and healthcare
- Responding to population needs
- Sustaining performance against access and safety standards
- Shaping the provider landscape
- Becoming a world class commissioner

Leeds Teaching Hospitals NHS Trust

- Key performance targets
  - Improving the excellence of clinical outcomes
  - Improving the management of business
  - Becoming the hospital of choice (for patients and GPs)
- Service provision in a changing financial environment – focusing on improving productivity, efficiency and the quality of services
- Outcomes of Leeds Strategic Review (focusing on Leeds Health Economy) being undertaken by the Strategic Health Authority
- Providing care closer to home, including different models of care (including services not based at hospitals)
- Clinical Services Reconfiguration Programme
- Foundation Trust status process – including the need to act like a business when considering changes to services and delivery models
- Internal and external cultural changes associated with changes in service models and delivery

Members received and commented on the presentations and raised a number of queries, including the following issues, for which written responses would be sought:

NHS Leeds

- To provide a copy of the Young People's Sexual Health / Teenage pregnancy report, presented to NHS Leeds Board – February 2009 (received)
- To provide the Board with health data/ information on a geographical basis, highlighting particular health issues across the city, particularly in deprived areas.

LPFT

- The Trust's power (and associated processes) for detaining patients

LTHT

- To provide confirmation of any proposed changes to the membership of Wharfedale Hospital Consultative Committee, in addition to any proposed changes to the operation/ role of Wharfedale Hospital.

The Chair thanked Jill Copeland, Chris Butler and Sylvia Craven for their presentations and advised that the Scrutiny Board would like further updates (i.e. on a quarterly basis) on the identified key issues and priorities. The Chair also suggested that future updates might usefully include areas where the local authority could improve in order to be a more effective partner.

RESOLVED - That any outstanding issues referred to above be dealt with by those officers now identified within the minutes.

9 Leeds Local Involvement Network (LINk) - Annual Report

The Head of Scrutiny and Member Development submitted a report to provide Scrutiny Board (Health) with the first Annual Report of Leeds Local Involvement Network (LINk). The Annual Report was tabled for the information/comment of the meeting.

It was reported to the Board that the purpose of the item was to:

- Continue to raise awareness of the role and work of Leeds' LINk (both publicly and among members of the Scrutiny Board (Health);
- Provide members with more detail of what Leeds' LINk has done during its first year, alongside any future plans; and,
- Provide an opportunity for a general discussion between the Scrutiny Board (Health) and representative members of Leeds' LINk , including any work programme issues.

The Chair welcomed the following representatives who were in attendance to introduce the report and to respond to Members questions and comments:

- Emily Wragg (LINk Co-ordinator) Shaw Trust (Leeds host organisation)
- Joy Fisher, Co-Chair, Leeds LINk Interim Steering Group
- Arthur Giles, Co-Chair, Leeds LINk Interim Steering Group

Joy Fisher addressed the meeting and welcomed the Board's willingness to work with Leeds LINK in the future and pointed out some of the following issues that had already been identified by their group:

Key issues raised by the public:

- Better Services for Older People
- Better Support for People with mental health problems
- Improved out hours services
- Free access to GP (No 0845 numbers)
- Better transport for patients
- Better listening and communication. Examples were:
  - GP'S giving patients more time
  - Regular updates for patients on waiting lists
  - Carers being kept informed and involved
- Better training and support for staff working in care homes
- More respite care so that Carers can have a break
- Improved access for people from BME Communities

Issues identified by LINk Members:

- Eccleshill
- Dentistry
- Quality controls in NHS facilities and inspection

- Early discharge and re- admissions- a joined up health and social care service
- Personalisation Agenda
- Intermediate care
- Maternity provision
- Out of hours
- Strokes

The Chair thanked the representatives of Leeds LINk for attending the meeting and requested that the following information be provided to the Board as soon as practicable:

- Details of the overall membership of Leeds LINk (i.e. total number of members)
- Details of the organisations currently represented through membership of Leeds LINk
- The outcome of the forthcoming elections and membership of the Steering group proper.

RESOLVED - That the contents of the report and appendices be noted.

10 KPMG Audit Report

The Head of Scrutiny and Member Development submitted a report on a recent KPMG external audit review of Scrutiny. The report provided details of management's response to the review recommendations.

Peter Marrington, Head of Scrutiny and Member Development presented the report and responded to Members' queries and comments.

In brief, specific reference was made to the following issues:-

- The need for clearer roles for scrutiny with a view to focusing more on policy development.
- The need to produce smaller agenda in order to keep Members at the meeting.
- The need to employ experts in a particular field.
- That Members concerns should also be put in writing to KPMG on the quality of the information in their Review report.
- The need for Scrutiny Boards to look at how they framework their work programmes.

RESOLVED –
(a) That the contents of the report and appendices be noted.
(b) That the Review's recommendations and accompanying management responses be noted and that the above comments be referred to the Scrutiny Advisory Group for consideration.

11 Determining the Work Programme 2009/2010

The Head of Scrutiny and Member Development submitted a report to aid the Scrutiny Board to determine its priorities and work programme for 2009/2010.

Appended to the report were copies of the following documents for the information/comment of the meeting:-

- Draft Protocol between Scrutiny Board (Health) and NHS Bodies in Leeds (Appendix 1 refers)
- Scrutiny Board (Health) – Health Proposals Working Group terms of reference (Appendix 2 refers)
- Minutes of the Executive Board meeting held on 13th May 2009 and 17th June 2009
- Scrutiny Board Procedure Rules Guidance Note 7 – Inquiry Selection Criteria (Appendix 3 refers)
- Scrutiny Board (Health) - Draft Work Programme 2009/2010

The Board raised and discussed the following issues for possible inclusion in the Board's work programme:

- Renal Unit Provision at Leeds General Infirmary (LGI).
- Alcohol and its related harm, including the role of the Authority in promoting sensible and responsible alcohol consumption, and highlighting the associated health implications, especially for those citizens living in the most deprived areas of the city.
- Childhood Obesity and levels of physical activity.
- Health considerations with the Council's decision-making processes.
- Smoking Cessation - to reduce the number of people who smoke.
- Young People's sexual health and teenage pregnancies.
- Focusing on 'the health of young people'
- The role of the Health Proposals Working Group, including arrangements for meetings to take place immediately prior to the Scrutiny Board (Health) meetings on a quarterly basis
- Quarterly updates from NHS partners on the key issues and priorities identified earlier in the meting (minute 8 refers)

In relation to keeping the Board up to date with proposed services changes, associated consultation and implementation (work previously undertaken through the Health Proposals Working Group), the Chair proposed that such matters be incorporated into the arrangements for quarterly updates, with any urgent matters relayed through the Chair in the first instance.

The Chair requested that the Principal Scrutiny Adviser inform the NHS bodies of these new arrangement.

RESOLVED –
(a) That the contents of the report and appendices be noted.

(b) That the Protocol between Scrutiny Board (Health) and NHS Bodies in Leeds, as presented (Appendix 1 refers) be agreed.

(c) That the Principal Scrutiny Adviser, in conjunction with the Chair and taking account of the issues raised at the meeting, formulate a more detailed work programme to be presented and considered at the next Scrutiny Board meeting..

12 Date and Time of Next Meeting

Tuesday, 28th July 2009 at 10.00 a.m. (Pre-meeting at 9.30 a.m.)

(The meeting concluded at 1.00 p.m.)

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Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 28 July 2009

Subject: Renal Services: Provision at Leeds General Infirmary

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

1.0 Executive Summary

1.1 The Scrutiny Board was first advised of the need to close the Welcome Wing at Leeds General Infirmary (LGI) in February 2006. The decision to close the Welcome Wing included the decision to reconfigure and re-house the services elsewhere in Leeds Teaching Hospitals NHS Trust (LTHT). This included the reconfiguration of renal services, which saw St. James' Hospital become the main centre for inpatient renal services.

1.2 Since that time, the Scrutiny Board has considered the provision of renal services (particular dialysis services) and associated patient transport on several occasions.

2.0 Purpose of this Report

2.1 The purpose of the report is to allow the Scrutiny Board (Health) to consider current proposals from LTHT associated with the provision of renal services (dialysis) across the Trust, particularly in terms of provision at LGI.

3.0 Main Issues - Progress Towards Improvement Priorities

3.1 To assist the Scrutiny Board consider the issue in detail, the following information is attached to this report:

- Appendix 1 – a timeline of decisions, actions and considerations associated with the provision of renal services by LTHT since February 2006.
- Appendix 2 – a briefing note from LTHT on the current provision of renal services and considerations.

- Appendix 3 – a joint report from NHS Leeds and Specialist Commissioning Group (SCG) (Yorkshire and Humber) on their role as commissioners of renal services and current considerations.
- Appendix 4 – a submission on behalf of the LGI Kidney Patients Association (KPA)
- Appendix 5 – a submission on behalf of the St. James' Kidney Patients Association (KPA)
- Appendix 6 – a submission on behalf of the National Kidney Federation

3.2 With the exception of the National Kidney Federation, representatives from the organisations outlined in paragraph 3.1 will attend the meeting to address any questions identified by the Scrutiny Board.

3.3 A separate report associated with Patient Transport Services is presented elsewhere on the agenda.

4.0 Recommendation

4.1 That members of Scrutiny Board consider the information presented in this report (and attached appendices) and the details of the discussion at the meeting, and determine:

4.1.1 Any specific action the Board may wish to take;

4.1.2 Any recommendations the Board may wish to make;

4.1.3 Determine any matters that require further scrutiny.

5.0 Background Papers

None

PROVISION OF RENAL SERVICES BY LTHT – TIMELINE SUMMARY

MONTH	ACTIVITY:			NOTES
	NHS LEEDS[1]	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)[2]	
FEB. 2006		2 Feb. 2006 **Wellcome Wing at LGI** The Board was briefed on the main themes of the business case concerning the future of Wellcome Wing. The following points were made: • The Wing housed several different services, including the Renal Service. • Its structure dated from the early 1960s and the electrical infrastructure was in need of major remedial work • There were serious concerns about the presence of asbestos in the building. • Refurbishment costs of between £9m and £17m were anticipated. • A timescale of around two years was likely for the necessary work. **RESOLVED** The Board endorsed the recommendation that **Option 6** should be progressed, noting that further business cases would be received in due course for each element of the reprovision of services within Wellcome Wing	13 Feb. 2006 The Board was advised that LTHT had approved in principle the vacation and closure of the Welcome Wing at the LGI, with all services based there, including renal services, being reconfigured and rehoused elsewhere in the Trust. Members were advised that the Trust believed that the best option for the disposition of renal services was to centralise inpatient beds and acute dialysis on the St James's site and to provide satellite dialysis units on the LGI and Seacroft Hospital sites The Board requested that further information on the proposed transfer be submitted to the March meeting of the Scrutiny Board	**Option 6 included:** • Ward 32 (inpatients) would be reprovided into Lincoln Wing at St James adjacent to the current renal wards. (**Capital cost £1.745m** for the new ward.) • 18 dialysis stations would be created at Seacroft hospital with all supporting facilities. (**Capital cost £1.697m** for the Seacroft dialysis station.) • ***A 10 dialysis station unit would be created at LGI***. **(Capital cost £0.5m** for the 10 station dialysis unit at LGI.) • Outpatient facilities at LGI would remain as would vascular access and on site renal support to LGI patients.

[1] Formally known as Leeds Primary Care Trust (PCT)
[2] Formally known as Scrutiny Board (Health and Wellbeing) and Scrutiny Board (Health and Adult Social Care)

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OPTIONS PRESENTED TO LTHT BOARD – FEBRUARY 2006

A long list of 6 options for action were initially presented to the LTHT Board (2 February 2006), as follows:

- Option 1: Do nothing
  (Discounted as the Trust has a responsibility to protect the safety of patients and staff and meet health and safety requirements: the criteria are therefore not met.)
- Option 2: Upgrade the Wing on a rolling programme, floor by floor, and fully refurbish it at a capital cost of approximately £17m.
  (Discounted given the strategic direction of Making Leeds Better and a single acute hospital on the St James site as well as the significantly greater capital costs required: the criteria are therefore not met.)
- Option 3: Upgrade the Wing, having decanted all occupants on a temporary basis and then fully refurbish the Wing at a capital cost of approximately £17m.
  (See option 2)
- Option 4: Upgrade the Wing on a rolling programme, floor by floor to a minimum standard to meet immediate health and safety requirements at a capital cost of approximately £9m. There will be 2 different approaches/sub options to this decant option.
- Option 5: Upgrade the Wing, having decanted all occupants on a temporary basis elsewhere to a minimum standard to meet immediate health and safety requirements at a capital cost of approximately £9m.
  (Discounted as this was considered more disruptive than the other equivalent (Option 4).)
- Option 6: Reconfigure the services in the Wing and rehouse them elsewhere in the Trust at a capital cost of approximately £9m and then close the Wing.

Options four & six were the short listed options as they best met the criteria overall. A more detailed summary of these options is attached.

Other issues

The main contentious issue reported was around which option best fitted the needs of Renal patients across Leeds, whilst at the same time being consistent with the Trust's overall strategic direction.

It was reported that the majority of current LGI users wanted the service to be retained at LGI. In summary, the reasons for this were:

- a strong belief in the very high quality of the service currently provided and an anxiety that this might not be the case if the service moves
- anxiety about a change of site meaning a change of staff as users appreciate continuity of care
- current users are used to and familiar with the service and facilities at LGI
- anxiety about access to the dialysis service as LGI is the closest site for the North West and the West of the city and for Bradford patients.
- concern in case there are not appropriate support services at Seacroft and worry in case the twilight service is stopped.

RENAL SERVICES – POTENTIAL SOLUTIONS RELATING TO OPTION 4((A) and (B)) AND OPTION 6

Reported to the LTHT Board – 2 February 2006

	Refurbishment Option 4(a) Decants for some areas with other areas temporarily not being re-provided.	**Refurbishment Option 4 (b) Decants for all areas with some areas remaining in their decanted position.**	**Reconfiguration (Option 6)**
Renal – Ward 32 and Ward 50 This is the most complex and contentious of all the areas within the Wing. The current Leeds Service comprises the following: LGI – 23 inpatient beds – 24 dialysis stations with 4 extra available through providing a night shift. – an outpatient department. – supporting clinical and non-clinical services. SJUH – 19 inpatient beds – 25 dialysis stations – 4 bed HDU – 10 bed transplantation unit – an outpatient department – clinical and non-clinical support areas There are also a number of satellite units under the aegis of the Leeds service – including a 10 station satellite unit on the Seacroft site and a satellite unit in Beeston.	A number of options have been reviewed: that of upgrading ward 91 and using it as a decant facility for the renal ward is believed to be the most effective option. Ward 32 would be refurbished as part of a rolling programme. Dialysis would have to be decanted to Seacroft on a temporary basis prior to ward 50 being refurbished. **Capital cost £0.5m** for the dialysis decant. The ward decant costs are contained in the costs for reproviding ward 33.	Under the refurbishment option, neither ward 50 nor ward 32 would remain in a decanted position after the refurbishment but would go back into the Wellcome Wing. **Capital cost £0.5m** for the dialysis decant. The ward decant costs are contained in the costs for reproviding ward 33.	Ward 32 would be reprovided into Lincoln Wing at St James adjacent to the current renal wards. The outpatient department at St James would move up to ward 68 & 69 to allow the creation of both a ward and an ambulatory area within the wing specifically for renal patients. 18 dialysis stations would be created at Seacroft hospital with all supporting facilities. A 10 dialysis station unit would be created at LGI. Outpatient facilities at LGI would remain as would vascular access and on site renal support to LGI patients. **Capital cost £1.745m** for the new ward. **Capital cost £1.697m** for the Seacroft dialysis station. **Capital cost £0.5m** for the 10 station dialysis unit at LGI.

PROVISION OF RENAL SERVICES BY LTHT – TIMELINE SUMMARY

MONTH	ACTIVITY:			NOTES
	NHS LEEDS[3]	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)[4]	
MAR. 2006			13 Mar. 2006 **Proposals on the Reconfiguration of Renal Services in Leeds** The Board received an outlined of the proposals to reconfigure Renal Services in Leeds. It was reported to the Board that the proposals to close the Wellcome Wing at the LGI would include an expanded satellite service, which would be delivered from Seacroft Hospital, ***in addition to a new 10 bed unit at the LGI for patients with chronic renal failure***. **RESOLVED** (i) That the Chair writes to the Chief Executive of Leeds Teaching Hospitals NHS Trust to convey the views of the Board and recommend that further consultation is carried out with patients on the reconfiguration proposals in an open and transparent manner. (ii) That the Trust is asked to provide a written response to the Board's recommendation prior to the Board's meeting in April 2006.	The Board heard from a range of stakeholders, including: • Leeds Teaching Hospitals NHS Trust • The LGI Kidney Patients Association's • UNISON reps. from LTHT • RCN reps. Members raised concerns that patients had not been reassured at any time throughout the process, and acknowledged that although consultation had occurred in 2000, on the whole the consultation process had been unsatisfactory.

[3] Formally known as Leeds Primary Care Trust (PCT)
[4] Formally known as Scrutiny Board (Health and Wellbeing) and Scrutiny Board (Health and Adult Social Care)

PROVISION OF RENAL SERVICES BY LTHT – TIMELINE SUMMARY

MONTH	ACTIVITY:			NOTES
	NHS LEEDS[3]	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)[4]	
APR. 2006		6 Apr. 2006 **Matter arising: Wellcome Wing** The Board was informed that the Council's Scrutiny Board had recommended a period of public consultation with regard to the Trust's proposals to relocate Wellcome Wing. It was explained that the PCTs would lead this process. The Board accepted the Scrutiny Board's recommendation.	10 Apr. 2006 **Matters arising** It was reported that a formal response had been received from LTHT in relation to the Board's recommendation for further consultation and it was confirmed this had been approved at the Trust Board meeting held on 6th April 2006. ***Members were assured that the Board would be informed of any developments as they occurred***.	
JUN. 2006		1 Jun. 2006 **Wellcome Wing Contingency Plan** The Board received an update on the Wellcome Wing Contingency Plan. The Board was briefed on the need for urgency and the action being taken to communicate with external stakeholders and to identify temporary accommodation for the services that would need to move. It was agreed that any urgent action that became necessary would be pursued by way of Chairman's Action as opposed to extra-ordinary Board meetings.	19 Jun. 2006 **Presentation from Local Primary Care Trusts and Acute Trusts** Under a general item, it was reported that consultation on the reconfiguration of renal services had commenced and would be completed in August 2006. The Board agreed to continue to keep a watching brief on this matter.	

PROVISION OF RENAL SERVICES BY LTHT – TIMELINE SUMMARY

MONTH	ACTIVITY:			NOTES
	NHS LEEDS[3]	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)[4]	
JUL. 2006		6 Jul. 2006 **Wellcome Wing Exit Programme** The Board noted the progress towards vacating Wellcome Wing by the end of October 2006. The Board was reminded that the arrangements were temporary and could need to change as a result of the consultation process currently in progress.		
AUG. 2006		3 Aug. 2006 **Interim Re-provision of Renal Services from Wellcome Wing** The Board was presented with an interim solution for the reprovision of renal services, which highlighted the need for urgency as part of the process of vacating Wellcome Wing. The Board was advised that the consultation process concerning the future of renal services continued and was unaffected by the proposal. The business case received the Board's approval.		

PROVISION OF RENAL SERVICES BY LTHT – TIMELINE SUMMARY

MONTH	ACTIVITY:			NOTES
	NHS LEEDS[3]	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)[4]	
SEP. 2006			18 Sep. 2006 **Consultation Update: Reconfiguration of Renal Services in Leeds** The Board received a verbal update on the consultation process from LTHT and was advised that the analysis from the consultation was due to be submitted to the LTHT Board in October 2006. Members urged the Trust to maximise transportation links for patients and requested further details about the re-provision of renal services and the evaluation of the consultation process as soon as was practicable. **RESOLVED –** (i) That the information detailed within the report be noted; (ii) That the Airedale consultation document be circulated to Members for their information; (iii) That an update on the information relating to the re-provision of renal services in Leeds in addition to the evaluation of the results from the consultation process be circulated to the Board as soon as is practicable; (iv) That a letter on behalf of the Board be forwarded to the Chief Executive of Leeds Teaching Hospitals NHS Trust which outlines the Board's comments about need to maximise transportation links for patients.	At the Scrutiny Board meeting, the LGI Kidney Patients Association, raised concerns over the way in which the whole consultation process had been conducted.

PROVISION OF RENAL SERVICES BY LTHT – TIMELINE SUMMARY

MONTH	ACTIVITY:			NOTES
	NHS LEEDS[3]	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)[4]	
OCT. 2006		5 Oct. 2006 **Update on Wellcome Wing Exit Programme** The Board was reminded of the exit programme and contingency plans associated with the closure of Wellcome Wing. ***It was confirmed that the Trust would be able to re-provide all of the services previously housed there.*** **Renal Services Consultation** The Board received the summarised outcome of the formal consultation, however a formal recommendation was awaited from the newly-formed Leeds PCT, which had now assumed responsibility for the process The Board accepted the outcome of the consultation process and, subject to the PCT's recommendation, confirmed its support for the proposals being taken forward as set out in the consultation document. The Board also agreed that the Trust should pursue the concerns raised during the consultation process.	23 Oct. 2006 **Reconfiguration of Renal Services in Leeds** The Board received the Consultation Analysis document presented to the LTHT Board on 5 October 2006. **RESOLVED –** (i) That the report be noted. (ii) That further consideration be given to the Reconfiguration of Renal Services in Leeds following consideration of the consultation analysis by the Leeds Primary Care Trust.	**PROPOSALS** (as presented in the consultation document) • Create a new haemodialysis unit at Seacroft Hospital • Centralise the renal inpatient bed base at St James's • Centralise the peritoneal service at St James's • ***Create a 10 station dialysis unit at LGI as the local facility for dialysis patients in the West and Northwest of the city and for inpatients at the LGI suffering acute renal failure***. The written consultation process received 297 responses. The analysis of responses showed: • 53% (156) supported the proposal • 21% (61) opposed the proposal • 26% (80) were neutral

PROVISION OF RENAL SERVICES BY LTHT – TIMELINE SUMMARY

MONTH	ACTIVITY:			NOTES
	NHS LEEDS[3]	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)[4]	
NOV. 2006	16 Nov. 2006 **Renal Services Consultation** The Board received the summarised outcome of the formal consultation and resolved to: (i) Note the findings of the consultation analysis; (ii) Support the Trust in working with partner organisations to address the specific concerns raised in the consultation; (iii) Strongly recommend that LTHT pursue a solution for dialysis patients from the west of the city in the short term and have discussions on a satellite unit at WGH; (iv) Consider pursuing alternative provision should an acceptable resolution not be reached to recommendation (iii) above.		20 Nov. 2006 **Matters arising** It was reported that a further report on the Reconfiguration of Renal Services in Leeds at the December Board meeting.	There was broad agreement between LTHT and Leeds PCT on the substantive issues arising from consultation and about the way forward. A number of key issues were identified and both organisations met to agree the next steps in key areas. These are set out in the attached document.

KEY ISSUES AGREED BY LEEDS PCT AND LTHT

November 2006

In-patient Services

Centralisation of in-patient services at St James's will proceed. The PCT report into consultation did not identify any major difficulties with this part of the proposal. The LTHT clinical management team for renal services, the Kidney Patients Associations (LGI and St James's) and the regional planning forum for renal services will address any outstanding matters or new issues as they arise.

Haemodialysis services for patients in West/North West Leeds

LTHT will now work towards a permanent dialysis facility at Seacroft, to replace the temporary facility which was commissioned at short notice and has a fixed lifespan.

LTHT will also respond to concerns about access to services for people in the West and North West of the city and will therefore prioritise work to identify a location then set up a project to deliver a 10-station haemodialysis unit at LGI. Three potential locations at LGI are under consideration, alongside the LTHT Acute Service Review and continuing estate rationalisation. LGI Brotherton Wing offers several potential sites and if agreement on the detail can be reached with the PCT and stakeholders a **10-station unit could be established within 18 months unless there are any delays in plans to vacate space or if there are unforeseen difficulties in making it fit for purpose.**

Transport

LTHT will shortly be considering bids for a dedicated transport service for renal patients intended to resolve many of the difficulties that have arisen historically both at Seacroft and elsewhere in the network of units and satellites, although these difficulties are not related to the interim or long term changes. A patient representative will be on the tender evaluation panel. The Trust is continuing discussions with the local authority, West Yorkshire Passenger Transport Executive (WYPTE), Metro and commercial providers about transport links and the infrastructure for St James's Hospital, as part of the *Making Leeds Better* programme.

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MONTH	ACTIVITY:			NOTES
	NHS LEEDS[5]	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)[6]	
DEC. 2006			18 Dec. 2006 **Reconfiguration of Renal Services in Leeds** The Board considered a joint report from Leeds PCT and Leeds Teaching Hospitals NHS Trust (LTHT) following the renal services consultation. Issues discussed included: • Timescales associated with the provision of a 10-bed unit at the LGI for patients with chronic renal failure. • Using Wharfedale Hospital to provide a satellite unit to serve those in the North West of the City. • Transport issues. **RESOLVED –** a) That the report be noted. b) That a further report be brought to the Board which specifically addressed the transport issues raised by renal patients.	At the Scrutiny Board meeting, the LGI Kidney Patients Association expressed concern regarding the consultation process and felt that it was flawed. Amongst concerns raised was that the consultation literature was not translated for ethnic groups which will have resulted in a lack of responses. It was also felt that the consultation process should have been carried out by an independent body rather than the PCT as the commissioning body. Further issues of concern included transport provision, access to Seacroft Hospital and the affect on the quality of life for patients.

[5] Formally known as Leeds Primary Care Trust (PCT)
[6] Formally known as Scrutiny Board (Health and Wellbeing) and Scrutiny Board (Health and Adult Social Care)

MONTH	ACTIVITY:			NOTES
	NHS LEEDS[5]	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)[6]	
JAN. 2007			22 Jan. 2007 **Reconfiguration of Renal Services in Leeds - Patient Transport Issues** The Board considered current transport provision, alongside additional information on the tendering process for transport. **RESOLVED** a) That the report be noted. b) That the Board receives a further report in March 2007 on the wider issues relating to the reconfiguration of renal services in Leeds.	It was reported that the tendering exercise was currently being evaluated and the results could be made available to the Board in due course. Following the last meeting of the Board where it was suggested that a member of the Kidney Patients Association participate in the tendering process, it was reported that this had happened successfully
APR. 2007			23 Apr. 2007 **Provision of Renal Services in Leeds** The Board was informed that that only one viable bid had been received for the transport tender, however it was anticipated that the new arrangements would include a number of measures to strengthen transport provision, including stricter penalties and the provision of a dedicated transport contact desk within the Yorkshire Ambulance Service. **RESOLVED** That the report be noted	The Board was advised that proposals for the establishment of a permanent facility at Seacroft Hospital and ***a 10 station satellite unit at Leeds General Infirmary (LGI)*** were to be considered by the LTHT Management Board. Planned dates for completion of the new facilities were Autumn 2008 for Seacroft and ***June/July 2008 for LGI.***

MONTH	ACTIVITY:			NOTES
	NHS LEEDS[5]	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)[6]	
NOV. 2007		29 Nov. 2007 **Business Case for creating a permanent renal haemodialysis unit at Seacroft Hospital** **Business Case for creating a renal haemodialysis unit at Leeds General Infirmary** The LTHT Board considered the two business cases in consequence of the closure of Wellcome Wing. The Board was reminded that both units had been agreed as part of the Wellcome Wing emergency closure process and ***honoured commitments made to the KPA at an earlier Board meeting.*** The Board was advised that the precise location of the Unit had been discussed with the KPA and other users and Ward 46 was their preferred location. **Both business cases received the Board's support.**		14 Nov. 2007 Letter from the Chair of the Scrutiny Board to LTHT ***seeking clarification on timescales and location of the 10 station unit at LGI*** and concerns raised by the KPA. 29 Nov. 2007 It was reported to the LTHT Board that, in relation to the LGI scheme: • The scheme fits the overall direction of the Trust in its demonstration of responsiveness to patient demand for an accessible dialysis service on the LGI site; • £3M had been allocated in the capital programme across 07/08 and 08/09 for renal dialysis schemes. • The initial estimate for the LGI Unit was £1.7m. • There was no additional revenue expenditure; • The provision would deliver dialysis to inpatients at the LGI with acute renal failure and chronic renal patients receiving inpatient care in another specialty at the LGI.

MONTH	ACTIVITY:			NOTES
	NHS LEEDS[5]	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)[6]	
MAR. 2008			17 Mar. 2008 **Matters arising** The Board considered an update on the long-term plans for Renal Services in Leeds. This included plans to provide ***a 10 station satellite unit at Leeds General Infirmary (LGI).*** It was reported that: • The new unit was planned to be sited in Ward 46 • Works would go out for tender on 25 April 2008 • It was expected that LTHT Board would agree the approved contractor on 26 June 2008, with a start on site date of 14 July 2008. • The works were anticipated to be completed on 12 December 2008, with commissioning taking place between December 2008 and January 2009. **RESOLVED** a) That the report be noted. b) That WYMAS be contacted and requested to supply the Board with information regarding the transport of patients accessing Renal Services.	The KPA advised the Scrutiny Board that they still had some concerns, including: • Facilities at Seacroft Hospital breaking down. • Demand for services at St James and the ability to meet this demand. • Transport – although the KPA had been actively involved in the tendering process, only one suitable bid had been received. Problems had been encountered with the transport of patients and examples of patients not being collected for treatment and the adverse knock on effects were given. • ***The timescale to implement new provision at Leeds General Infirmary***

MONTH	ACTIVITY:			NOTES
	NHS LEEDS[5]	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)[6]	
JUN. 2008			**Work Programme** As part of the new Board's discussions around its work programme, Members were advised that the Scrutiny Board received regular reports regarding the long term plans for renal services in Leeds. Following a monitoring session held on 17 March 2008, it was highlighted that the Leeds Kidney Patients Associations (LGI and SJUH) had concerns regarding the transport provided by Yorkshire Ambulance Service (YAS) under contract to LTHT. **RESOLVED** a) To include renal services (particularly around transport) as part of the Board's work programme.	LTHT, YAS and KPA invited to attend the Board in September 2008 to update Members, particularly in terms of any on-going renal transport issues.
JUL. 2008		**Award of Contract - Renal Dialysis Unit at the Leeds General Infirmary** Considered as part of the non-public part of the agenda. (No public minutes available)		

MONTH	ACTIVITY:			NOTES
	NHS LEEDS[5]	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)[6]	
SEP. 2008			16 Sep. 2008 **Renal Services** The Board heard from NHS Leeds, LTHT, YAS and the KPA. The main issues centred around the operation of the renal services transport contract between LTHT and YAS. The KPA provided examples of problems experienced transporting patients to and from appointments, including late and missed collections of patients and patients having to travel on long unnecessary journeys whilst other patients were collected. The Board was reminded that during discussion around the reconfiguration of Renal services, the KPA had highlighted a number of areas of concern, particularly in terms of transport arrangements. **RESOLVED** That the report and information presented be noted. That a further report be presented to the Board, to include greater detail on current performance and trends in performance, particularly in the areas discussed at the meeting.	Following closure of Wellcome Wing, the report presented to the Board confirmed the following service changes: • **February 2008**: Inpatient ward moved to ward 62 in Lincoln Wing at St James's in. • **May 2008**: Work started on 24-station unit at Seacroft Hospital. Completion: Jan. 2009. • Work due to start shortly at LGI to create a 10-station chronic unit, with 2 acute beds. Completion: Spring 2009. LTHT and NHS Leeds stated their intention to continue to work in partnership with both the YAS and the Kidney Patients Association (KPA) in an attempt to resolve areas of concern.

MONTH	ACTIVITY:			NOTES
	NHS LEEDS[5]	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)[6]	
OCT. 2008		23 Oct. 2008 **Briefing note on renal dialysis services at LTHT issued to the Chair of the Scrutiny Board** • Confirmed the new renal dialysis satellite unit would open on Ward 44 in December 2009. • Described the delay as a result of the Children's Hospital Services Reconfiguration. • Confirmed the unit will meet the commitment made by the Trust to re-provide renal dialysis facilities at LGI • Outlined that a new 6-station (previously stated as a 10-station) unit, costing over £1m would provide services for patients who prefer to dialyse in the City Centre.	21 Oct. 2008 **Renal Services – Transport Update** The Board considered a report from YAS, which detailed statistical information in relation to transport provision. This also included benchmarking information against the Cheshire and Merseyside Action Learning Set. The Board was also informed of 3 main areas highlighted at the recent meeting between the YAS, LTHT and KPA which focussed on planning concerns, communication issues and how to reduce complaints. Reasons for missed appointments were also highlighted. **RESOLVED** That the report be noted and the Board be kept updated on the position regarding Renal Services transport.	At the Scrutiny Board meeting the KPA informed Members of outstanding concerns which included: • Responses to complaints; • Times involved in transporting patients; and, • The future provision of services at Leeds General Infirmary
JAN. 2009				Report from KPA regarding ongoing renal patient transport, with particular concern regarding the Christmas period. Concern expressed regarding the delay to and the long-term plans for the LGI renal unit.

MONTH	ACTIVITY:			NOTES
	NHS LEEDS[5]	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)[6]	

FEB. 2009	6 Feb. 2009
	
	Renal Services update report presented to the Trust Board. The report stated:
	• No formal targets for delivery of renal services – but standards and markers for good practice.
	• Sufficient capacity within the city to provide dialysis to all patients who require it.
	• ***The longer term agreed plan was to:***
	  ○ ***Provide 18 stations at Seacroft***
	  ○ ***Relocate 10 stations at LGI (due to open in Dec. 2009)***
	• Main, continuing issue for patients revolves around transport availability and response to individual needs.
			6 Feb. 2009
			
			Letters to LTHT and YAS on behalf of the Scrutiny Board regarding the concerns of the Scrutiny Board regarding the ongoing problems associated with renal patient transport – particularly in relation to a '*number of quite severe difficulties'* over the Christmas period, highlighted by the KPA.
			
			26 Feb. 2009
			
			Response from LTHT (to letter dated 6 February 2009) and advised the following:
			• Every effort being made to improve the renal patient experience in respect of transport and a Renal Patient Transport Steering Group had recently been established
			• Over the Christmas period, Renal Units closed on different days of the week and inconsistent information was given YAS.
			• For future Christmas periods, there will be a standard approach from all the Renal Units over communications with YAS
			• Other work being undertaken around:
			  ○ Patient journey experience
			  ○ Patient transport – eligibility criteria
			  ○ Patient awareness, including patient responsibilities around transport
			  ○ Communication to improve aborted inward journeys
				6 Feb. 2009
				
				Letter sent to KPA advising of the approach to seek information from LTHT and YAS.

MONTH	ACTIVITY:			NOTES
	NHS LEEDS[5]	LEEDS TEACHING HOSP. TRUST	SCRUTINY BOARD (HEALTH)[6]	
MAR. 2009			10 Mar. 2009 Response from YAS (to letter dated 6 February 2009) providing details of the service review undertaken (covering the Christmas period). YAS recognised that some patients experienced a disrupted service with their transport over the Christmas holiday period. Some of the outcomes of the review included: • No Patient failed to be transported as a result of YAS failings. • 54 patients (w/c 22/12/08) and 29 patients (w/c 29/12/08 experienced delays as a result of transport: • 27 patients had to reduce dialysis (as confirmed by LTHT) There were 100 'abortive' journeys over the period	
JUL. 2009		30 Jul. 2009 Report to Trust Board. Content TBC.	28 Jul. 2009 Consideration of current proposals regarding delivery of renal services at LGI Update on provision of renal patient transport	

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APPENDIX 2

LEEDS TEACHING HOSPITALS NHS TRUST

PROVISION OF RENAL DIALYSIS ACROSS THE TRUST

BRIEFING ON THE FACTS

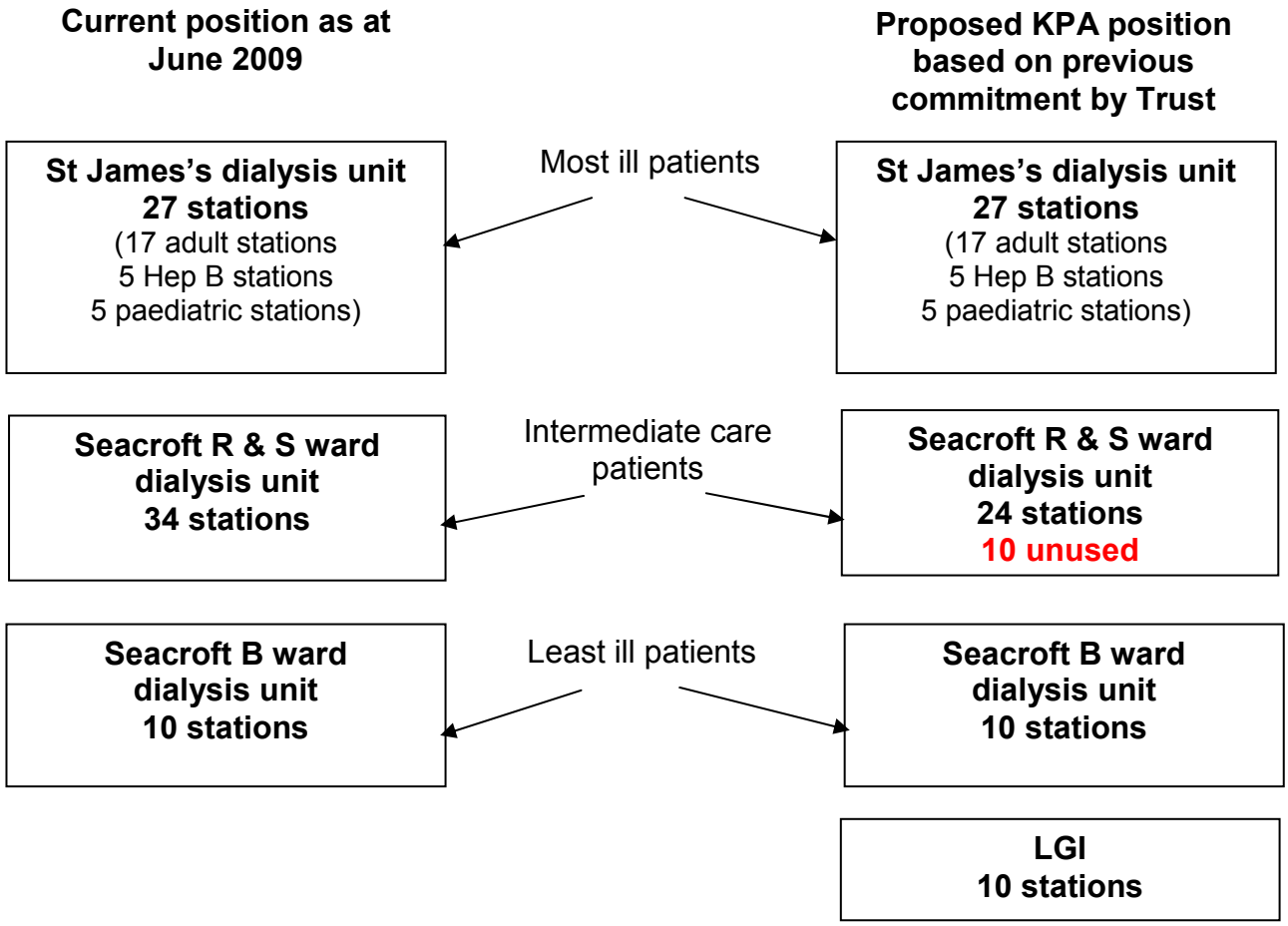
1. BACKGROUND

During public consultation on the closure of the Wellcome Wing in 2006 because of its very poor infrastructure, the Trust committed to building a dialysis unit on the LGI site although at the time the particular location could not be identified. Subsequently a location was identified and the Trust agreed to move ahead. The location was changed to ward 44 in 2008 and the Trust again gave a commitment to delivery. However, following a detailed review of the demands on the Trust's capital programme, and the current clinical priorities and patient safety issues that have emerged, the Trust is reviewing this decision and difficult choices will have to be made in the light of both the promise that has been made to create the dialysis unit whilst knowing that there is enough clinical capacity for dialysis in the Trust without building any more.

2. DIALYSIS

There are 44 dialysis stations on the Seacroft site and 27 on the St James's site. Additionally many of the wards and intensive care units have dialysis points within the wards on both the LGI and SJUH sites so that those patients who are acutely ill and are either, having dialysis because of their ongoing kidney failure, or because they have kidney failure as a consequence of another condition, can have the necessary treatment.

The St James's dialysis unit generally deals with the sickest patients. The Seacroft R & S ward dialysis unit is the intermediate unit and the Seacroft B ward satellite dialysis unit is the unit least ill patients attend. There are also a number of other satellite units in other parts of West Yorkshire.



It is clear from the above distribution that when all the stations are fully staffed, there is already enough capacity in the Trust for all the dialysis patients who need it (with some left over). Most of the stations are currently run for two sessions a day. More capacity can be created by instituting 'twilight' shifts which are already common in other parts of the country. These tend to benefit patients who are still working full time despite having renal failure. Introducing twilight shifts on existing machines would provide extra capacity without the need to fund a new capital development.

The Trust therefore has enough clinical capacity already to meet the clinical need: if we were to create 10 stations at LGI we would have 10 stations at Seacroft that would be empty.

3. CAPITAL

The position with capital is that the Trust is allowed - and can only afford - a certain amount of capital spend each year. There are always many more things that are either required or desired from this amount of money each year and decisions have to be made on an annual basis about the prioritisation of this spend. When faced with difficult choices the need to provide safe and effective clinical care to all patients has to be the deciding factor.

The capital spend is not only for buildings but is also for medical and scientific equipment and for information technology.

We need to spend the capital for buildings both on maintaining the infrastructure of the Trust buildings and for developing accommodation for new services or improving the accommodation from a patient's point of view.

Similarly, we have to replace old items of medical equipment and purchase new ones to meet the opportunities of developing technologies.

The Trust commits a proportion of the overall capital available for replacement of infrastructure or equipment each year, in order to ensure that we are providing a safe environment and that relevant Health and Safety issues are being addressed.

This year, 09/10, we have £58.5m to spend on capital. Of this, at the start of the year, the following was already committed either because schemes had already started, or because the Trust has agreed to spend a certain amount on infrastructure in order to maintain the upkeep of buildings, or because external organisations had provided the money for specific projects.

£13m on buildings infrastructure
£6.m on medical and scientific equipment
£2.5m on information technology
£33m on clinically related schemes

This left approximately £3.5m to be used for the highest clinical priorities. In making decisions about allocation of capital, the Trust Board will always put clinical need and patient safety at the heart of decision making. Value for money and cost effectiveness also have to be considered.

29 June 2009

COMMISSIONERS REPORT
PROVISION OF RENAL DIALYSIS AT LEEDS GENERAL INFIRMARY

The commissioning of NHS Renal Services across Yorkshire & the Humber is the responsibility of the Yorkshire & the Humber Specialised Commissioning Group.

1. Specialised Services

Introduction

Specialised services are those services which are not provided in every hospital (generally, they are provided in less than 50 hospitals nationally), because of:

- The small number of patients suffering from the condition and requiring treatment.
- The need for expert staff.
- The provision of expensive equipment.
- Frequently, but not always, the provision of these services will also be very expensive.

A specialised service is defined as a service with a planning population of more than one million people.

Specialised Services National Definitions Set

These describe specialised services in more detail. There are 35 individual definitions, including such services as bone marrow transplantation, rehabilitation services for brain injury and complex disability, specialised burn care services, specialised heart surgery, spinal cord injury and **renal services**.

The Carter Review (2006)

The purpose of this review, which was requested by the Department of Health, was to propose improvements in planning and providing specialised services in England.
Within this review, Professor Sir David Carter, (former Chief Medical Officer for Scotland), acknowledged that patients requiring specialised services often have a long-standing relationship with the specialist centre providing their care, and have a high level of knowledge about their condition.

Professor Carter also recognised the significant financial risk of an individual Primary Care Trust having to fund expensive, unpredictable activity. This risk can be reduced by Primary Care Trusts grouping together to collectively commission specialised services and share the financial risk. Large-scale capital investment is often necessary, and the availability of other key specialities, (for example intensive care, 24-hour operating theatres and sophisticated x-ray services), is also critically important.

Specialised Commissioning Groups (SCGs)

An agreed recommendation of the Carter Review was that future responsibility for commissioning specialised services would rest with Specialised Commissioning Groups, which would share the same boundaries as the relevant Strategic Health Authority; locally this is, of course, Yorkshire & the Humber. The Yorkshire & the Humber Specialised Commissioning Group (SCG) is a permanent Joint Committee of, and acts on behalf of, all the Primary Care Trusts in the Yorkshire & the Humber Strategic Health Authority area, of which there are 14.

The underlying aims of the new commissioning arrangements for specialised services are to: ensure fair access to clinically effective, high quality, cost effective specialised services across the region; to ensure that scarce skills are used effectively; and to prevent wasteful and potentially unsafe duplication of these services.

Specialised Commissioning Groups are required to pay particular attention to areas where significant increases in demand are likely to lead to pressures on services, e.g., renal replacement therapy (dialysis and transplantation).

Specialised Renal Services (Adult) – Definition No. 11

The purpose of a definition is to identify the activity that should be regarded as specialised, and therefore, within the remit of the Specialised commissioning Group. Each definition is drawn up by a process involving clinical staff, managers, commissioners and patient groups, and then endorsed by relevant national organisations. Definition No. 11 has been endorsed by the British Renal Society, the Kidney Alliance and the Renal Association.

Definition Introduction

The National Service Framework for Renal Disease was published in January 2004 (Part I) and February 2005 (Part II), and covers all aspects of renal care, including early renal disease, chronic kidney disease (previously known as chronic renal failure), dialysis, transplantation, acute kidney injury (previously called acute renal failure) and appropriate palliative care for patients in whom dialysis is not, or is no longer, appropriate.

Renal services for patients with moderate to severe chronic kidney disease are largely delivered by renal specialists working in the specialist renal centre itself and on an out-reach basis to surrounding local hospitals. With the growing occurrence of renal disease in the elderly population, there is an increasing need to provide care for pre-dialysis patients and low clearance renal patients receiving palliative care as close to home as possible; this can be done by increasing local hospital renal care provision and improving community and primary care services.

Specialist renal centres also treat patients with acute kidney injury.

Kidney transplantation services are provided in 20 of the 50 or so renal centres across the country; in Yorkshire and the Humber, they are provided in Leeds and Sheffield.
Specialist renal centre services include:

- ✓ Renal out-patient clinics on site and as an outreach service to local hospitals.
- ✓ Haemodialysis services on site.
- ✓ Satellite haemodialysis services.
- ✓ Support to patients on peritoneal dialysis and home dialysis.
- ✓ Renal anaemia management and specialist renal dietetic support.
- ✓ Conservative management programmes for established renal failure.
- ✓ Out-patient and in-patient services for acute kidney injury.
- ✓ Transplantation services.

Renal services require support from a variety of other services. Specialist surgery is necessary for haemodialysis vascular access and peritoneal dialysis catheter insertion and removal. Specialist radiology support is required for monitoring and intervention for haemodialysis vascular access, renal biopsy support and renal imaging and intervention.

Specialised Renal Activity

The renal patient pathway follows the early detection and treatment of chronic kidney disease, pre-dialysis, dialysis, transplantation, acute kidney injury and appropriate palliative care for patients in whom dialysis is not, or is no longer, appropriate. The early stages and treatment of chronic kidney disease are generally carried out in primary care in consultation, where appropriate, with a specialist renal centre. If the patient's kidney function worsens they are usually transferred to the care of a specialised renal centre for further care and, perhaps, dialysis and/or transplantation.

For patients who do not enter a dialysis programme, but instead receive conservative management (also known as palliative care), they will receive their care supervised by a specialised centre; increasingly, they will receive as much of their care as possible close to home, from their local hospital, community and primary care services.

2. Clinical Networks

Introduction

In his review, Professor Carter reported a clear need for Specialised Commissioning Groups to forge strong links with clinical networks, to ensure that commissioning and investment plans support the delivery of integrated care. GP practice and Primary Care Trust commissioning plans should be integrated with those relating to specialised services, to ensure continuity of patient care and appropriate use of resources.

The Yorkshire & the Humber Renal Network

As in many other areas of the country, new renal network arrangements have been established for Yorkshire & the Humber. These arrangements comprise a single Renal Strategy Group for the whole of the Yorkshire & the Humber region, supported by three Local Implementation Groups, which reflect and support local commissioning, provider and patient population groups and relationships. Every hospital providing renal services in the region has senior clinical and managerial representation on the Renal Strategy Group. All commissioning organisations (including the SCG) across the region are represented at senior level. There is also a patient representative.

3. Renal Haemodialysis Provision at Leeds Teaching Hospitals Trust

Background

Both the Yorkshire & the Humber SCG and NHS Leeds, (on whose behalf the SCG commissions renal services from the Leeds Trust), are aware that pre-existing renal facilities (both in-patient and dialysis) at Leeds General Infirmary (LGI) were assessed almost three years ago as unsafe under a number of mandated regulations. As a result, in-patient services were transferred to St. James's Hospital (SJH) – now the main renal centre for Leeds – and dialysis provision was temporarily transferred to Seacroft – where there are now permanent facilities.

A consultation with patients and an option appraisal were undertaken in February 2006 to agree the revised proposal. Commissioners are also aware that, as part of the consultation process that took place at that time, it had been agreed that, although in-patient facilities would remain permanently on the SJH site, some, but not all, dialysis provision would be returned to LGI – 10 stations, accommodating up to 40 patients.

Current Position

Renal dialysis is currently provided at four locations within the Leeds boundary, and the current, shared view of both the SCG, NHS Leeds and the Hospitals Trust, is that this will deliver sufficient immediate, medium and long term capacity, particularly given the joint strategy to repatriate those clinically suitable patients currently receiving their care in Leeds, to planned facilities closer to home, for example, in Huddersfield and Wakefield.

A recent patient audit has indicated that as few as 11 patients, out of a total of over 85, currently receiving dialysis at Seacroft, would prefer to re-locate to Leeds General Infirmary.

The SCG and NHS Leeds further understand that the capital cost of the planned move to the Trust would be in the region of £1.4m, which would, in this case, represent very poor value for money. Such an investment would also leave suitable existing facilities at Seacroft un-utilised.

Patient Transport

The issue of patient transport has also been raised. However, although it has been acknowledged that there are still a small number of delays, there has been a significant improvement in services and performance, which has, in fact, been commended by the National Clinical Director for Renal Services. A separate report, prepared by the ambulance service, will be presented to members in conjunction with this report.

4. Summary

It is the shared and agreed view of the Yorkshire & the Humber Specialised Commissioning Group, and NHS Leeds, that a decision by the Leeds Teaching Hospitals Trust not to invest in the re-provision renal dialysis facilities at the Leeds General Infirmary would be the right decision at this time. Such a decision would also

be supported by the majority of members of the Yorkshire & the Humber Renal Strategy Group. This support is based on the position outlined above, which does not demonstrate a robust case for change in respect of overall cost benefit at this time.

The SCG and NHS Leeds remain committed to continuously reviewing capacity, demand and future plans for investment in all types of renal replacement therapy, (not just haemodialysis) which may lead to future changes following further consultation.

There does remain, however, an issue for patients living in North West Leeds. A recent needs analysis revealed a small number of patients in this part of the city and there have been no reported issues to date regarding access to dialysis. There are insufficient numbers to consider opening additional units, however if access does become an issue NHS Leeds working with SCG will need to explore access to units in neighbouring areas.

Jackie Parr
Senior Commissioning Manager

Yorkshire & the Humber SCG

Paula Dearing
Head of Development & Commissioning
Long Term Conditions & Urgent Care
NHS Leeds

16th July 2009

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Submission to Leeds City Council Scrutiny Board by LGI Kidney Patients Association (KPA)

1. On 2 June 2009 following a number of questions raised by the KPA to the Trust regarding the lack of progress towards establishing the much promised and awaited LGI dialysis unit Lilian Black was informed by senior staff of the Leeds NHS Trust that the unit would not now go ahead.

2. To date, despite a variety of requests for information regarding the basis for such a decision we have received what we consider to be a totally inadequate response from the Trust – they have betrayed their promises to the chronically sick renal patients of Leeds and beyond. We have spent hours planning the unit with the Trust to the point of working with architects on detailed plans – the cost of the plans must be enormous. We have been engaged with the Trust over two years on this process.

3. After closing Wellcome Wing at the LGI, the cost of creating the temporary unit at Seacroft to be followed by closing this down and building another unit next door, to now be faced by having to replace the water treatment plant at St James Hospital and needing to find another place to dialyse patients whilst this work goes on beggars belief. The argument about having to make capital funding choices pales into significance against this mismanagement and waste of public money.

4. Everything we said when Wellcome Wing was to be closed has come true. Chronically sick patients living out of area and in parts of Leeds not near to Seacroft and within easy reach of a dialysis unit continue to be condemned to what is in effect an 7/8 hour day three times a week to receive their life saving treatment.

5. If the Trust approved the unit previously then what has changed now to say that there is no clinical need?

6. What is the meaning of the phrase 'clinical need' used by the senior management of the Trust? The only factor mentioned is the number of stations and even their location is secondary. Our contention is that location is fundamental both to patients within the boundary of the city of Leeds and beyond. Travel time to and from dialysis is fundamental to their quality of life.

7. Renal clinical guidelines for haemodialysis state that,

> *"Except in remote geographical areas the travel time to a haemodialysis facility should be less than 30 minutes or a haemodialysis facility should be located with 25 miles of the patients' home. In inner city areas travel times over short distances may exceed 30minutes at peak traffic flow periods during the day. Haemodialysis patients who require transport should be collected from home within 30 minutes of the allotted time and be collected to return home within 30 minutes of finishing dialysis."* (Renal Association Clinical Practice Guidelines for Haemodialysis 2007)

8. The paper produced by the Trust makes absolutely no reference to patients who are travelling to Seacroft from Halifax, Pontefract, Huddersfield and from the North/North West of the City. It makes no reference to patients waiting to go onto dialysis, it makes no reference to the projected growth projections for the increased need for dialysis, nor the fact that there will be a large population growth in Pakistani and Bangladeshi communities who have a five times higher propensity for renal failure than other members of the population. There is no reference to the separation from other major clinical centres such as the LGI which compounds the challenge these patients face with the ordeal sometimes of travel into Leeds centre for a morning clinic followed by the journey to Seacroft and then home.

9. So what is the Trust's definition of clinical need? Over what period is 'clinical need' assumed to be met? These capital spending decisions are clearly annual yet any responsible measure of 'clinical need' would have to be set within at least a medium time period of say three to five years. Where is their evidence that the current disposition and number of stations meets the needs of this part of the city region over such a period? We have evidence that there is a clinical short-fall already which can only get worse. We have not been presented with any evidence that this has been the subject of strategic planning or consultation.

10. What value can the Scrutiny Board or any of us place on the word of the Trust? The commitment made to open a ten station facility at the LGI was a critically important part of us all being reassured that the decision to close the Wellcome Wing was going to be mitigated by the restoration of a dialysis facility for out-patients in the LGI. Moreover we were encouraged to become actively involved in the decision process and help determine the precise location etc. It is difficult to see how we can trust the Trust again.

11. It is true that transport arrangements have been un-satisfactory but on this occasion that is a secondary issue. It is not acceptable for the Trust to deflect the argument in that direction. This is the sole responsibility of the management of the Trust and its Board.

12. The conclusion of the LGI KPA is that the need for the unit at the LGI has not changed and if anything, our experience since the closure of the Wellcome Wing proves even more than ever that we need a central location at the LGI. There are serious problems in Leeds for renal patients. Having 10 'spare' machines at Seacroft is not helpful in meeting the medium to long term needs of these patients.

Lilian Black
LGI Kidney Patients Association

St. James's Kidney Patients Association

Registered Charity Number 700981

An Association run by Patients for

Please reply to: **The Secretary**, St James KPA, FREEPOST NAT18200, Huddersfield, HD7 4LP
Tel:01484 640401 e-mail: paul@pgt67.eclipse.co.uk

Steven Courtney
Principal Scrutiny Adviser
1st Floor, West
Civic Hall
Leeds
LS1 1UR

20/07/2009

Dear Steven

The committee of the above association would like it to be known that we are in full support of our fellow KPA at the LGI where the promised building of a new Haemodialysis unit is concerned.

We appreciate that difficult decisions have to be made and that there is only so much funding available for capital investment. However to have gone as far as they have with the promise of the LGI dialysis unit, have the plans developed and raise everyones hopes and expectations only to have them quashed is incomprehensible to say the least.

The lives of renal patients from all over West Yorkshire depend on this unit being built. Following recent communication from the Trust, Lilian Black of the LGI KPA informed us that the Trust stipulates there is enough capacity. If that is the case then why are some patients dialysing twice weekly when they require dialysis three times a week? Why are patients from Halifax, Wakefield and Huddersfield travelling to Seacroft enduring countless hours sitting in traffic, often have their treatment cut short and then enduring the same journey home? It is comparable to an 8 hour day 3 times a week just to stay alive – where is the quality of life in that?

To say that there is enough capacity within the Trust when there are over 30 known patients, of a cohort of over 400, (IPST mins, Jan 09) who in the near future will more than likely require Renal Replacement Therapy is ludicrous. Where will these patients dialyse if the satellites are full?

St. James's Kidney Patients Association

Registered Charity Number 700981

An Association run by Patients for

Cont…

The Trust argues that the need to spend the funds allocated to this unit on a new water treatment plant at the St James's site. Whilst we agree that this is an urgent case, the Trust has known about it for sometime. However they chose not to use the temporary infrastructure already in place when T&U was vacated some 6 months ago. We are sure utilising this facility would have saved money if they had acted quickly enough.

Both of these projects are desperately required for the renal patients of West Yorkshire and to give the go ahead of one at the expense of the other is wholly unacceptable.

Yours sincerely

Paul Taylor
On behalf of St James's KPA

Cc Maggie Boyle, Chief Executive, LTHT
Cllr Mark Dobson, Chair Leeds Health Scrutiny Board

APPENDIX 6

Renal Services : A submission on behalf of the National Kidney Federation

I apologise for not being able to be present at the Scrutiny Board meeting on 28 July 2009. I hope this written submission will be helpful to members in their deliberations on this agenda item.

I am sure representatives of the Leeds General Infirmary and St. James's kidney patients' associations will make their own case for the respective capital works programmes.

They have much more detailed knowledge than I do, and it is, of course, their members who are directly affected by the decisions taken.

What I shall endeavour to do in this report is to provide an external and neutral renal patient view of each proposal.

Can I begin by stating that I recognise fully the very real financial pressures facing the health service, especially at the present time, the many competing demands on available monies, and the need to ensure the most effective use of scarce resources.

I appreciate also that changing financial circumstances may necessitate a review of decisions previously agreed, but any such review should, in my view, take into account primarily whether the clinical circumstances that led to the original decision have changed any way.

I do not intend to repeat here the background history to these matters, but will set out, as I see it, the respective need for both two schemes.

Leeds General Infirmary Scheme.

It seems to me that there are at least three reasons why this scheme should go ahead.

(a) It would make more efficient use of the nursing staff already working at the LGI site who are providing specialist renal support to patients who have been admitted for other conditions.

(b) A number of patients who are dialysing at the Seacroft unit and who live closer to the LGI site would have a shorter journey, and less time spent in travelling to and from their thrice weekly sessions, with the transport and environmental costs benefits that would be achieved

(c) Enabling the patients identified at (b) above to dialyse at the LGI would also be in line with best practice of ensuring that patients who are clinically suitable undergo their dialysis as close to home as possible.

The one caveat I would add about b). and c). above is that I have no way of knowing whether the number of patients to whom those points apply is greater than the number for whom Seacroft is the nearer unit.

St. James's Hospital Scheme.

Quite by coincidence, I can see three reasons also for supporting this scheme.

(a) A continuous supply of specially treated water is essential to the haemodialysis process.

(b) Any temporary disruption to the supply itself, and/or to the required standards of purity owing to water treatment plant breakdown, can lead to delays in patients accessing their treatment, with a knock on effect for patients dialysing later on the same day, which can, in turn, cause transport difficulties for patients, and, in extremis, a shortening of their prescribed treatment session.

If such problems occur continually, the overall cost of putting in place essential repairs would need to be weighed against the cost of a full replacement service.

(c) Longer term failure of the water treatment plant would lead to patients having to be transferred to other units to undergo their treatment, with all the potential difficulties that would create in terms of additional travel costs and journey times.

The possibility of patients having their dialysis delayed, or having to dialyse at different times of day or days of the week at a different unit to the norm could well arise, which in turn would impact on other aspects of their lives. Such effects would not necessarily be ones of 'minor' social inconvenience.

For example, a patient who is a resident in a care home could miss a meal that is provided at a set time, or an elderly person living alone might not arrive home until after dark, rather than in daylight hours.

The disruptive effect on staff also should not be forgotten.

Haemodialysis Capacity

I mention this issue only because I know it is referred to elsewhere in the papers that members have received for this agenda item.

The national body that sets standards for renal care in the UK, the Renal Association, states unequivocally that failure to provide thrice weekly dialysis for patients with a clinical need for it, on financial grounds alone, is totally unacceptable.

There may, of course, be reasons other than lack of capacity that prevent such frequency of treatment being available at any given time; for example, relating to staff recruitment, retention and absence levels.

Forecasting future treatment demand can never be an exact science. However, the modelling tool used in the region in recent years has proved to be remarkably accurate.

It is anticipated nationally that numbers of patients requiring all forms of renal replacement therapy will continue to grow for the foreseeable future, with the greatest demand coming in the hospital based haemodialysis sector, (forecast to rise by up to 8% per annum).

Not all patients are suitable for alternative forms of treatment, (home haemodialysis, peritoneal dialysis and transplantation). Even if the numbers of patients on such therapies were to increase significantly, there would be a proportionate increase over time in the number of them needing hospital based haemodialysis because of their transplants failing, home patients becoming too old or frail to dialyse themselves, or being in need of 'respite care' 'should their home carers become unwell.

On current evidence from elsewhere, there is a timescale of anything up to 2 years between the need for additional facilities being identified and the actual opening of the new unit.

In certain circumstances, there could be a need to bring what is currently deemed as 'spare' capacity into use quickly.

Examples might include the need to transfer patients from an existing unit in the event of a serious incident, (e.g. water treatment plant failure or major fire), or, should a 'flu pandemic arise, there being a need to accept patients for treatment in Leeds from the wider region owing to staff absences at units where patients would dialyse usually, (although I accept this could apply equally in respect of the effect on units in Leeds).

Finally, and importantly, there is much evidence now to suggest that patient outcomes, both clinically and in terms of overall quality of life, are enhanced by more frequent and longer hours sessions of dialysis. Inevitably, this improvement in patient care will have implications for the number of hospital based dialysis facilities required.

Conclusion

On the basis of the above, it is my view that there is a need for both the new LGI unit and the replacement water treatment plant at the St. James's site to be priorities for capital investment by the Trust board.

Dennis Crane, MBE, North Region Advocacy Officer, National Kidney Federation.

20 July 2009

Author's Note.

Dennis Crane has been an identified renal patient for more than 40 years. He has first hand experience of all forms of renal replacement therapy; home and hospital based haemodialysis, peritoneal dialysis, and failed and successful transplantation.

A founder member of the North West Region Kidney Patients' Association in 1983, he worked on a voluntary basis with and on behalf of patients both regionally and nationally on a range of renal and transplant related issues for more than 20 years.

He was awarded the MBE for his services to people with renal disease in 2002, and was appointed to his present part time salaried post in April 2004. Prior to that, he worked for almost 36 years in the Education Department of Manchester City Council, retiring from his post as Head of School Governor Support and Training in September 2002.

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Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 28 July 2009

Subject: Renal Services: Patient Transport Service

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

1.0 Executive Summary

1.1 The Scrutiny Board was first advised of the need to close the Welcome Wing at Leeds General Infirmary (LGI) in February 2006. The decision to close the Welcome Wing included the decision to reconfigure and re-house the services elsewhere in Leeds Teaching Hospitals NHS Trust (LTHT). This included the reconfiguration of renal services, which saw St. James' Hospital become the main centre for inpatient renal services.

1.2 Since that time, the Scrutiny Board has considered the provision of renal services (particular dialysis services) and associated patient transport on several occasions.

2.0 Purpose of this Report

2.1 The purpose of the report is to present the Scrutiny Board (Health) with a report from Yorkshire Ambulance Service (YAS) on the current performance of its Patient Transport Service for renal patients.

3.0 Main Issues - Progress Towards Improvement Priorities

3.1 A report from Yorkshire Ambulance Service (YAS) on the current performance of its Patient Transport Service for renal patients is attached (Appendix 1 – to follow). A representative from YAS will attend the meeting to address any questions identified by the Scrutiny Board.

3.2 A separate report associated with the provision of renal services (dialysis), particularly in terms of provision at Leeds General Infirmary, is presented elsewhere on the agenda.

4.0 Recommendation

4.1 That members of Scrutiny Board consider the information presented in report from YAS and the details of the discussion at the meeting and determine:

4.1.1 Any specific action the Board may wish to take;

4.1.2 Any recommendations the Board may wish to make;

4.1.3 Determine any matters that require further scrutiny.

5.0 Background Papers

None

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 28 July 2009

Subject: Joint Performance Report: Quarter 4 – 2008/09

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

1.0 Executive Summary

1.1 During the previous municipal year (2008/09), the Scrutiny Board (Health) received regular performance reports relating to issues within the Board's remit, from both NHS Leeds and Leeds City Council. In January 2009 it was agreed to adopt a more collaborative approach and provide a single, joint performance report on a quarterly basis.

1.2 This report provides an overview of progress against key improvement priorities and performance indicators relevant to the Board at Quarter 4, 2008/09.

2.0 Purpose of this Report

2.1 This report provides a strategic overview of performance and progress against the improvement priorities, specifically in relation to Health and Wellbeing, detailed in the Leeds Strategic Plan 2008-11.

2.2 The Action Tracker Summary Sheet (Appendix 1) provides an overall assessment of progress against each of the improvement priorities relevant to the Board; a rating of Red, Amber or Green is applied to indicate the status of each improvement priority. The detailed Action Trackers are available if required.

2.3 The scope of most improvement priorities is wider than that of any individual performance indicator. As such, the current performance reporting and accountability arrangements tracks progress against the improvement priorities and specific performance indicators. This approach provides the necessary context to capture and monitor progress, providing both a qualitative and quantitative picture of performance.

3.0 Main Issues - Progress Towards Improvement Priorities

3.1 The Health and Well Being theme (within the Leeds Strategic Plan) includes 6 improvement priorities specifically relevant to the remit of Scrutiny Board (Health) – with the 'improved psychological, mental health and learning disability services' priority sub-divided and presented as services to adults and children, thus creating 7 improvement priority areas. Of these, 4 are rated *green*, 2 *amber* and 0 *red* (as detailed in Appendix 1). Those priority areas rated amber are:

- Reduce teenage conception and improve sexual health (HW-2a). Specific performance indicators relating to this priority and presented in Appendix 2 are:
  - NI 112 – under 18 conception rate
  - NI 113 – prevalence of Chlamydia in under 25 year olds
- Improve psychological, mental health and learning disability services for those who need it (children) (HW-3a). Specific performance indicators relating to this priority and presented in Appendix 2 are:
  - NI 50 – emotional health of children
  - NI 51 – effectiveness of child and adolescent mental health services

3.2 The joint NHS Leeds/ Leeds City Council performance report for quarter 4 (2008/09) is attached at Appendix 2 and draws attention to the following areas.

- Health Care Associated Infections (HCAIs)
- Childhood immunisation
- Waiting times: Outpatients (13 weeks) and Inpatients (26 weeks)
- Teenage pregnancy rates
- Accident and emergency (A&E) 4 hour standard
- Delayed discharge rates

3.3 Relevant officers from NHS Leeds and Leeds City Council have been invited to present the key issues highlighted in this report and address any specific questions identified by the Scrutiny Board.

4.0 Recommendation

4.1 That members of Scrutiny Board:

4.1.1 Note the content of the report and its appendices;

4.1.2 Comment on any particular performance issues of concern; and,

4.1.3 Determine any matters that require further scrutiny.

5.0 Background Papers

Leeds Strategic Plan

Leeds Strategic Plan		
Health and Well Being		
Code	**Improvement Priority**	**Accountable Director**
HW-1a	Reduce Premature mortality in the most deprived areas	Sandie Keene
HW-1b	Reduce the number of people who smoke	Sandie Keene
HW-1c	Reduce rate of increase in obesity and raise physical activity for all.	Sandie Keene
HW-2a	Reduce teenage conception and improve sexual health	Sandie Keene
HW-3a	Improved psychological, mental health and learning disability services for those who need it. Adults Childrens	Sandie Keene
Thriving Places		
Code	**Improvement Priority**	**Accountable**
TP-2c	Improving lives by reducing the harm caused by substance misuse	Neil Evans

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Health Scrutiny Board
Joint Performance Report: Quarter 4 2008/09

July 2009

Health Scrutiny Board Joint Performance Report – July 2009

Overview

This is the second 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 continues. It has been possible on this occasion to further join together the reports previously used. The move toward a single style and format is now almost complete.

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.

The approach is generally to report by exception, except for top level and key indicators, which will be reported on each occasion.

Executive Summary – Performance Information

The NHS Leeds information that is provided here is the latest published data, at the time this joint report was drawn up (8 July 2009). Further verbal updates will be provided at the meeting of the Scrutiny Board, where required and available.

The LCC information is based on data from the Quarter 4 performance report (as at 31 March 2009).

Where it is appropriate the performance of Leeds Teaching Hospitals Trust (LTHT) has also been shown, where that is different from the reported performance for NHS Leeds. This difference occurs when LTHT treat patients from outside the city, often because they are delivering regional and national services.

There are several performance indicators that are worth drawing attention to. Some of these indicators are already well known to the Board as they have been reported as poor performing areas. 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 have now fallen to within the maximum number of cases. This is a significant improvement. The process for managing the reporting of cases has been improved and other changes have been made. This has been supported in Leeds Teaching Hospitals Trust by the efforts of the Intensive Support Team from the Department of Health, NHS Leeds and the Strategic Health Authority.

  C.diff rates are also similarly within the maximum trajectory, another major improvement on past months. The task with both C.Diff and MRSA is now to achieve long term sustainability and ensure that previous practices do not re-emerge and affect patient care.

- **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 some improvements now working their way through, as a result of an intensive programme of work, which continues. A GP level data sharing agreement, described in the detailed section on this topic will help ensure that delivery continues to improve. One notable success has been the increased level of immunisations for looked after children, which has risen around 18% over the past few months.

- **13 and 26 Weeks**
  There are still some residual issues for that remain. The position though is now much improved and the aim is now to eliminate such waits altogether.

- **Teenage pregnancy rates**
  Despite a performance recently that shows some improvement, delivery against the nationally-set trajectory has not been achieved. A positive development here is the forthcoming availability of local level data, which should help give a more timely perspective to the work to reduce teenage conceptions.

- **A&E 4 hr Standard**
  This target was achieved across the whole year 2008/09. This was despite performance being adversely affected during the winter pressures period and not recovering during spring. The issue has been identified as due to a combination of factors, which are identified in the detailed section covering this topic. However performance has now recovered somewhat and the 98% minimum standard was achieved during June. One of the key issues affecting performance, the medical vacancies problem, will be addressed in August. The task is now to ensure that performance is delivered during the run up to winter.

- **Delayed discharge rates**
  There is still no clarity on the national threshold for achievement. The chart in the section on this indicator shows performance during 2008/09 against that for 2007/08 to help provide context. There is some risk that 08/09 performance will be indicated at as amber or underachieved.

Report prepared by:

Graham Brown NHS Leeds
Marilyn Summers Leeds City Council

8 July 2009

18 weeks referral to treatment; admitted and non-admitted

Target:

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, broken down by specialty

NHS Leeds has been working closely with providers to ensure that as a health economy we meet the 18 weeks targets at specialty level. We have utilised the contract process to drive performance, to ensure that LTHT as our main provider and that we meet the targets as a whole health economy.

Neurosurgery: NHS Leeds has commissioned activity in line with that proposed by LTHT. There remains a significant backlog issue in this specialty. Clearing the backlog will have an impact on 18 weeks performance and Neurosurgery will remain one of the problem specialties for the next 6 months.

Plastic Surgery: NHS Leeds has commissioned activity in line with that proposed by LTHT. However, demand for plastic surgery, particularly for hands, is high and further work is needed to fully understand the service expansion requirements to meet the targets.

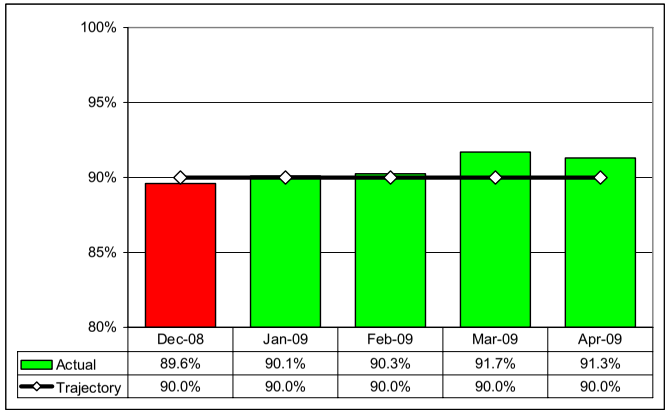
ENT: LTHT during 08/09 focused on clearing a significant proportion of the backlog in ENT, affecting performance. NHSL has agreed to provide resource over the agreed base line to fund increased activity for admitted patients.

Orthopaedics: NHSL have agreed to provide additional resource over the base line particularly focused on delivery of the 18 week targets at sub specialty level for foot/ankle and hands. The investment will be closely monitored in year to ensure that it provides a more sustainable platform for the delivery of 18 week targets. NHS Leeds will also continue to ensure that choice is provided for Orthopaedic procedures, which in turn reduces the pressure on LTHT.

Health economy lead: Matt Walsh
LTHT operational lead: Alison Dailly
NHS Leeds operational lead: Nigel Gray

Periodic Review Standard

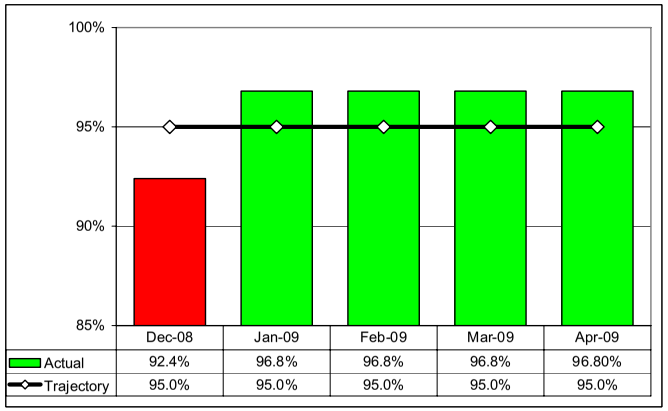
NHSL: Percentage of patients seen within 18 weeks - admitted



	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09
Actual	89.6%	90.1%	90.3%	91.7%	91.3%
Trajectory	90.0%	90.0%	90.0%	90.0%	90.0%

Periodic Review Standard

NHSL: Percentage of patients seen within 18 weeks - non admitted



	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09
Actual	92.4%	96.8%	96.8%	96.8%	96.80%
Trajectory	95.0%	95.0%	95.0%	95.0%	95.0%

18 week performance matrix, NHS Leeds 2009

	Admitted performance (adjusted)	Non-admitted performance	No of reportable specialties (excluding orthopaedics) failing to meet admitted standard	No of reportable specialties (excluding orthopaedics) failing to achieve nonadmitted standard	Total number of reportable specialties (excluding orthopaedics) failing to meet target performance	Orthopaedics - no of standards failing to meet (without breach shares)	Orthopaedics - no of standards failing to meet (with breach shares)
Jan-09	90.1	96.84					
Feb-09	90.25	96.79					
Mar-09	91.65	96.81					
Apr-09	91.28	96.8	5	7	12	2	NA
May-09	NA	NA	NA	NA	NA	NA	NA

13 weeks for outpatients

Target:

That the maximum wait for a first outpatient appointment be no more than 13 weeks from GP referral

There has been significant reduction in levels of 13 week breaches seen in April and May compared to March 2009 as illustrated.

Improved performance is largely due to LTHT, as a result of more effective use of both internal capacity and the use of external capacity via sub-contractor organisations.

Recent breaches (those in the latter part of 08/09) have been primarily due to LTHT capacity issues in both neurosurgery and plastic surgery. Although numbers are much reduced there remains some risk around plastic surgery outpatient breaches of the 13 week standard. All these breaches relate to Nuffield Hospital. LTHT have been using the Nuffield Hospital and other independent sector hospital providers to reduce breach risks.

Leeds Teaching Hospital itself recorded no breaches in May.

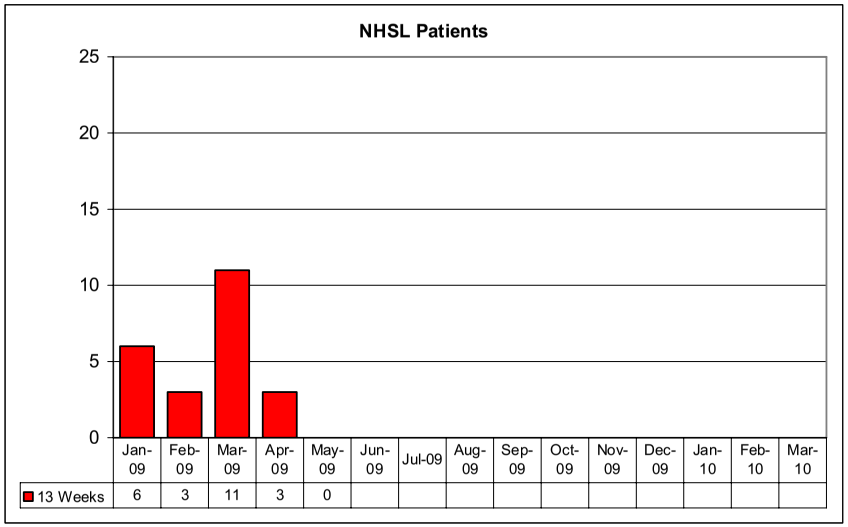
LTHT's appointment of two additional neurosurgeons means additional capacity is expected to come on stream in Aug. Additional capacity for neurosurgery is currently being used with both Nuffield Hospitals in Leeds and Pioneer Healthcare in Sheffield.

As with Neurosurgery, additional independent capacity is being used for plastic surgery. A benchmarking review is being undertaken by LTHT currently to understand what is needed to alleviate further breach risks.

Health economy lead: Matt Walsh
LTHT operational lead: Alison Dailly
NHS Leeds operational lead: Kevin Gallacher

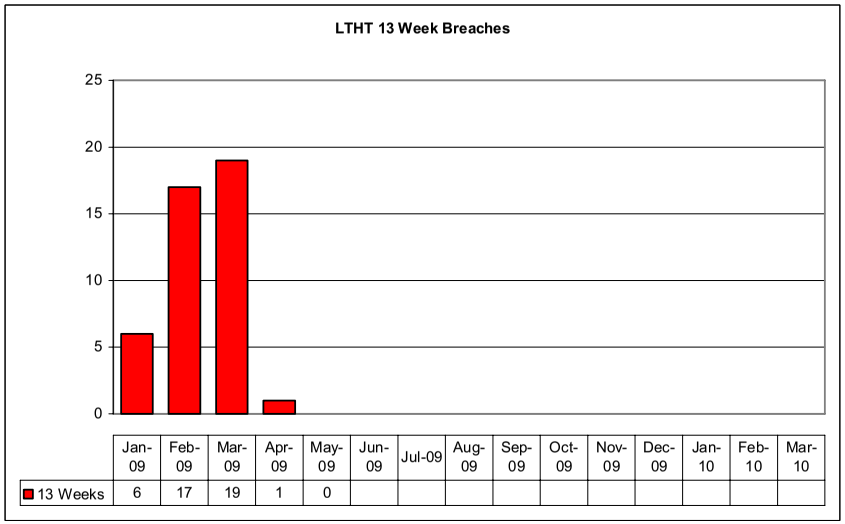
Periodic Review Standard

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



Periodic Review Standard

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



26 weeks for inpatients

Target:

That the maximum wait for an inpatient be no more than 26 weeks after a decision to admit

There has been significant reduction in levels of 26 Weeks breaches seen in April and May compared to March 2009 as illustrated.

Improved performance is largely due to LTHT, as a result of more effective use of both internal capacity and the use of external capacity via sub-contractor organisations.

Breaches in past months have been primarily due to LTHT capacity gaps in both neurosurgery and plastic surgery.

Leeds Teaching Hospital itself recorded no NHSL breaches in May, although there were two breaches for other PCTs. The 26 week breach in Apr occurred in neurosurgery at LTHT. As a result of this a Performance Notice has been issued to LTHT.

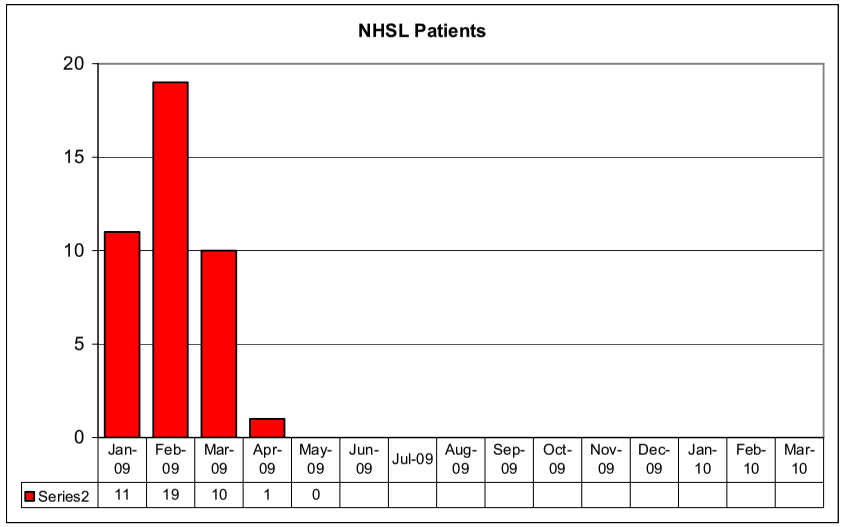
LTHT's appointment of two additional neurosurgeons means additional capacity is expected to come on stream in Aug. Additional capacity for neurosurgery is currently being used with both Nuffield Hospitals in Leeds and Pioneer Healthcare in Sheffield.

Additional independent capacity is being used where it is needed. A benchmarking review is being undertaken by LTHT currently to understand what is needed to alleviate further breach risks.

Health economy lead: Matt Walsh
LTHT operational lead: Alison Dailly
NHS Leeds operational lead: Kevin Gallacher

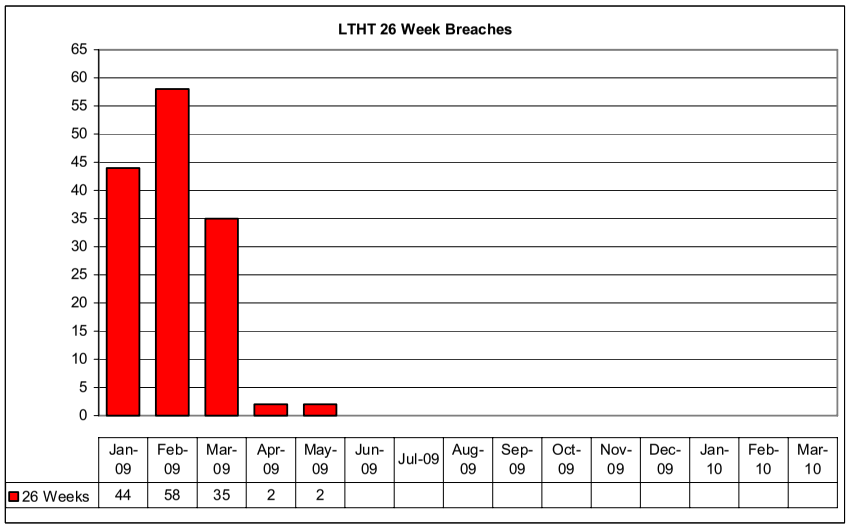
Periodic Review Standard

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



Periodic Review Standard

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



62 day cancer wait standard

Target:

Target not yet confirmed. Presently assuming that achievement will be 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 86% of patients of patients seen within that time.

Performance has improved overall since March, with May performance at 87.7% and expected June performance of 86%. This brings LTHT near to national expected performance levels. LTHT produce a weekly action list of high risk patients with expected resolution action for each patient at risk. This has proved to be an effective method to focus directorate urgent action.

Screening to treatment performance and consultant upgrades are indicating a performance of 100%. LTHT are encouraging consultants to apply the upgrade standard, where appropriate. It is therefore anticipated that numbers currently being recorded within this target will increase.

A weekly action list is now produced for target patients, supplementing the existing 62 day action list.

Lung surgery capacity was affected in May due to lists being cancelled because of theatre capacity and anaesthetic cover issues. This has had a knock on effect into June. LTHT Directorate lead action has been taken to implement improvement actions to prevent reoccurrence. This includes additional surgical capacity, as well as accessing Spire for surgical capacity on a temporary basis.

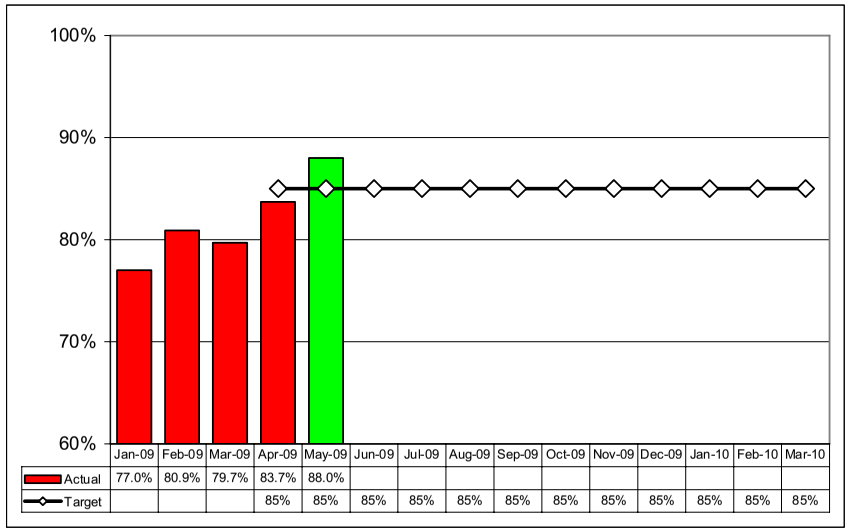
There are significant inter trust referral issues between Mid Yorkshire and LTHT for some patients which need to be resolved. NHS Leeds and Wakefield PCT will be facilitating an improvement workshop in early August, supported by the Yorkshire Cancer Network and the SHA.

The latest data shown for both organisations is yet to be validated

Health economy lead: Matt Walsh
LTHT operational lead: Jacqueline Myers
NHS Leeds operational lead: Nigel Gray

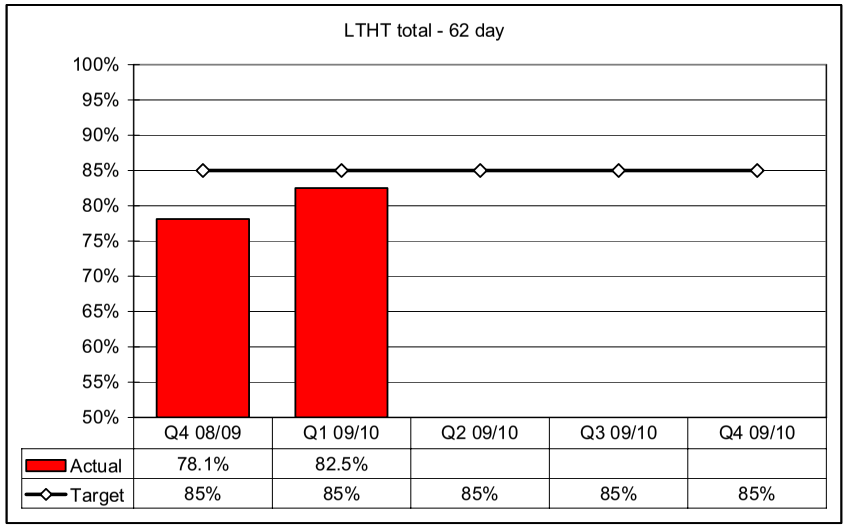
World Class Commissioning Outcomes

Percentage of patients receiving first cancer treatment within 62 days of referral



Periodic Review Standard

Quarterley percentage - LTHT 62 day



31 day cancer wait standard: Subsequent chemotherapy and surgery

Target:

Target not yet confirmed. Presently assuming that achievement will be that there be a maximum wait time of 31 days second and subsequent chemotherapy or surgery, with a target of 97% of patients of patients seen within that time.

31 day performance is now an area of major concern for both first and subsequent treatments. The forecast June position for subsequent treatments is below the fail position at 92.5% and borderline performance for 1st treatments at an estimated performance of 94.5%, which was the confirmed position for May, and indicates a declining position since March when performance reached 97.4%.

A weekly action list is now produced for 31 day target patients as well as the existing 62 day action list.

Areas of particular risk are lung; urology; skin and sarcoma.

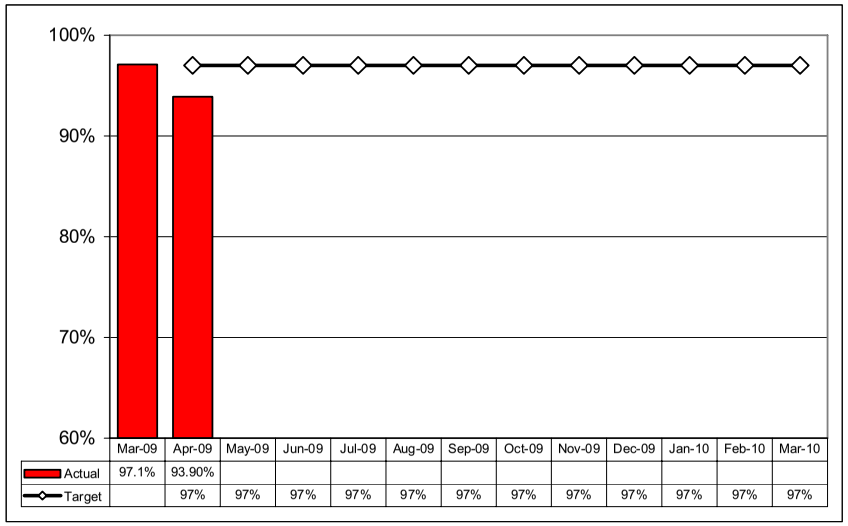
The urology remodelled pathway, implemented from mid May, has not shown the improvements expected by this time. LTHT have assessed the reasons for this and are taking immediate action to ensure appropriate management of patients on the timed pathway.

The latest data shown for both organisations is yet to be validated

Health economy lead: Matt Walsh
LTHT operational lead: Jacqueline Myers
NHS Leeds operational lead: Nigel Gray

Periodic Review Standard

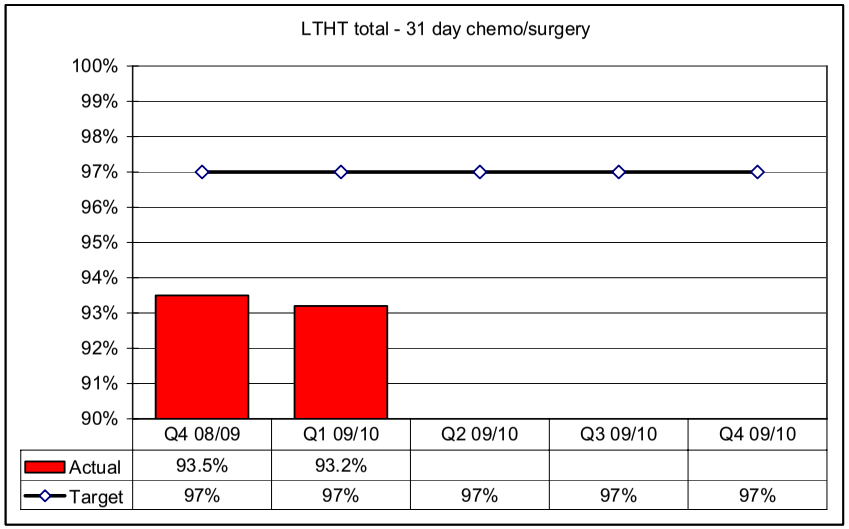
31 Day Subsequent Chemotherapy/Surgery: NHSL



	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
Actual	97.1%	93.90%											
Target		97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%

Periodic Review Standard

Quarterly percentage - LTHT 31 day chemo/surgery



	Q4 08/09	Q1 09/10	Q2 09/10	Q3 09/10	Q4 09/10
Actual	93.5%	93.2%			
Target	97%	97%	97%	97%	97%

Incidence of MRSA bacteraemia

Target:

To not have more than 72 cases for 2010/11, in line with the agreed maximum.

For May there were 3 MRSA cases reported across the Leeds health economy. All of these had their root cause of infection identified as being within LTHT. This is the second month running that LTHT was below the trajectory level.

For June, there were 6 MRSA bacterium cases reported in LTHT, though this is subject to validation, both in terms of numbers and origin. Due to this process of validation, the numbers may change slightly.

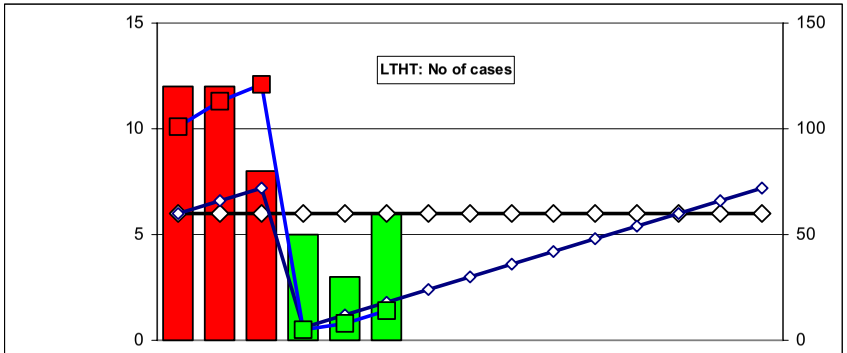
The MRSA screening programme in both LTHT and NHSL has been started and assurance is in place that this process is robust. Decolonisation treatment of patients will reduce the number of patients with MRSA on their skin on admission and this reduces the risk to both the patient and also to others who are nursed on the same ward. This should have a further positive impact on the figures.

From the end of May the key risk area of elderly medicine will be screened acutely on admission to hospital. NHSL provider services are now screening all acute admissions in intermediate care.

Health economy lead: Ian Cameron
LTHT operational lead: Brian Godfrey
NHS Leeds operational lead: Simon Balmer

Vital Signs Standard - Provider

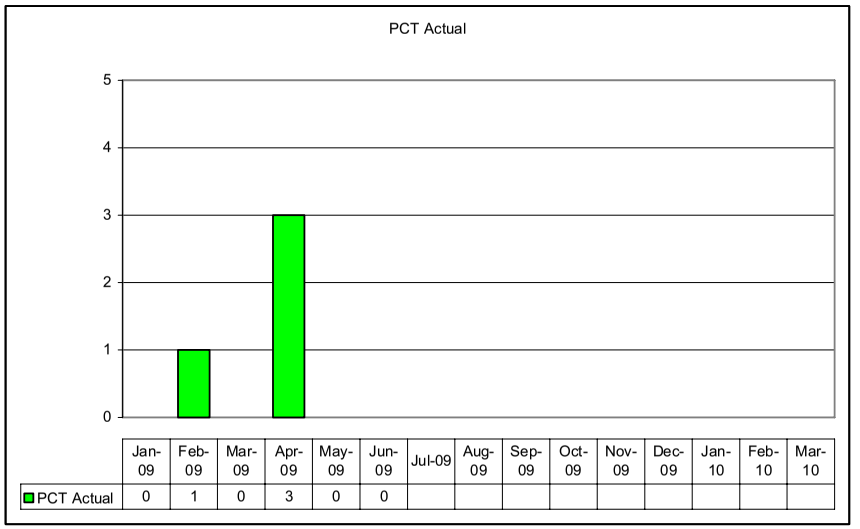
Cumulative number of MRSA positive blood culture episodes (Provider target)



	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
LTHT Actual	12	12	8	5	3	6									
Target	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
YTD Traj.	60	66	72	6	12	18	24	30	36	42	48	54	60	66	72
YTD Actual	101	113	121	5	8	14									

Periodic Review Standard

Number of cases of MRSA accountable to NHSL



	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
PCT Actual	0	1	0	3	0	0									

Incidence of C. difficile

Target:

That the number of cases be no higher than the agreed maximum of 584 for LTHT and 796 for the health economy by the end of March 2010.

At present there is a high degree of focused work in LTHT to ensure that figures continue to drop and that they remain below the maximum target number.

The dedicated time provided by the DH Improvement team comes to an end in July. Much effort is being put in, supported by NHS Leeds to ensure that there is a robust sustainability action plan in place to ensure that performance does not deteriorate.

For May there were 44 cases reported by LTHT; this is below their trajectory of 52 and much reduced from the 97 reported for the same time period last year. For NHS Leeds the overall figure was 53 (as we are measured as a commissioner of all providers) and this is well below the trajectory of 70.

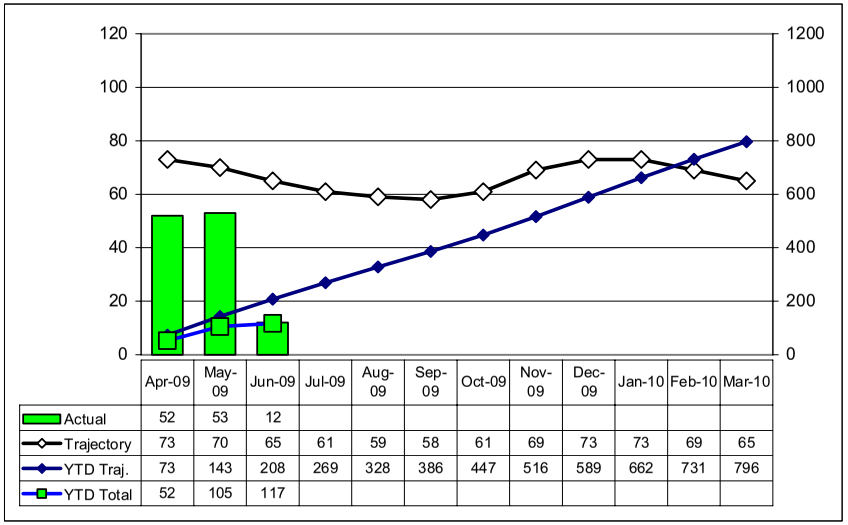
Recent LTHT figures are April - 39 (32 - post exclusion accountable to LTHT); May - 44 (31 accountable); June - 27 (19 accountable)
This is against a trajectory of 48 for LTHT and 65 for NHS Leeds. If the figures remain at this level, then this will be the fourth month where figures have been below trajectory.

Leeds Teaching Hospitals CDiff. trajectory is a variable monthly trajectory and this has been achieved since November 2008. Currently awaiting for feedback from CQC about registration conditions being removed.

Health economy lead: Ian Cameron
LTHT operational lead: Brian Godfrey
NHS Leeds operational lead: Simon Balmer

World Class Commissioning Outcomes

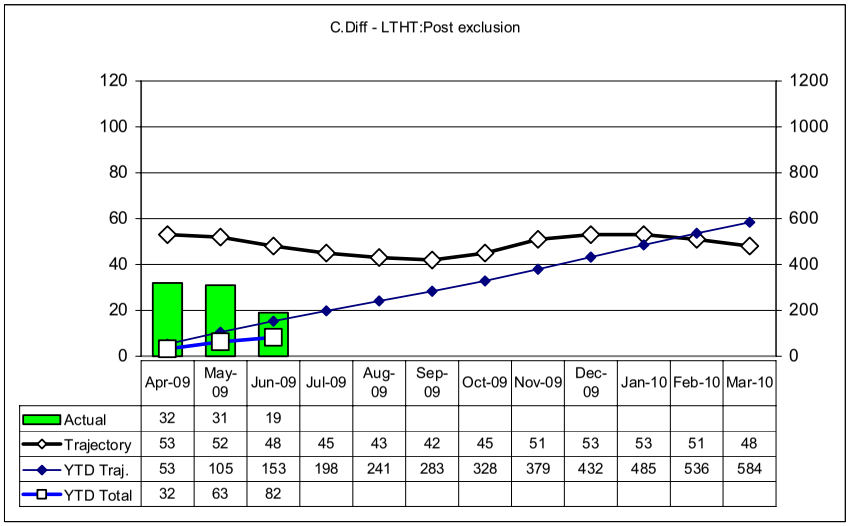
Clostridium difficile infection rates (Commissioner target)



	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
Actual	52	53	12									
Trajectory	73	70	65	61	59	58	61	69	73	73	69	65
YTD Traj.	73	143	208	269	328	386	447	516	589	662	731	796
YTD Total	52	105	117									

Periodic Review Standard

Clostridium difficile infection rates (Provider target)



	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
Actual	32	31	19									
Trajectory	53	52	48	45	43	42	45	51	53	53	51	48
YTD Traj.	53	105	153	198	241	283	328	379	432	485	536	584
YTD Total	32	63	82									

NI 112: 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 in the longer term.

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.

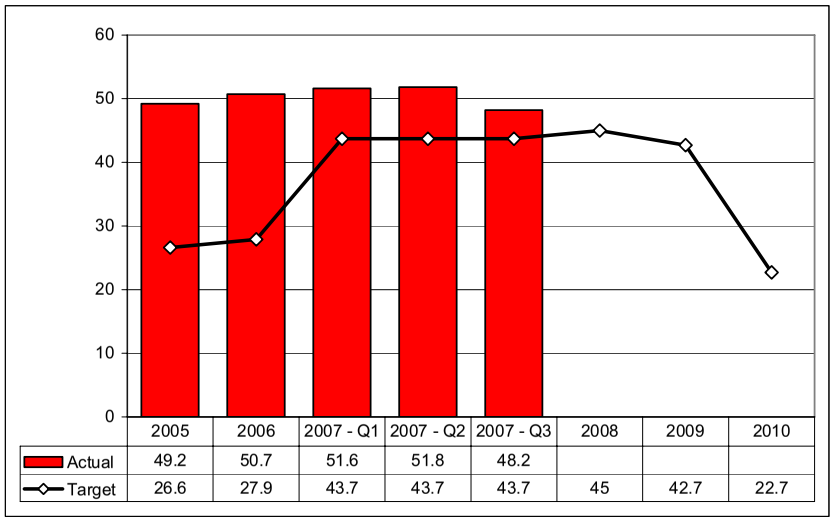
It is hoped that as this data collection becomes more robust, and even though it is limited to information from LTHT, it could be used as an early indication of teenage conceptions and trends and could be used in conjunction with the national-level data.

Overall Traffic Light Rating	
Data Quality	No Concerns

NHS Leeds 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

Four hour A&E standard

Target:

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

LTHT Performance since the first week of June has shown significant improvement with 98% being achieved consistently. In June the average was 98.4%. The year to date performance at that date is 97.14%.

Performance notices were issued for Apr and May. In response, LTHT have identified three key performance factors:

- Increased levels of attendances: there was a 5.4% rise in attendances in Apr and May 09 compared with the same months in 08.
- The pattern of attendances has changed, with the units much busier later in the evening, especially at LGI.
- There are a number of medical vacancies. Despite efforts, these have not been filled and limited success in covering these via locum agencies. The vacancies should be filled during Aug/Sept.

LTHT have also submitted additional actions that are ongoing to ensure that they can return to the levels of performance required and sustain this performance:

- Medical staff to work additional hours until vacant posts are filled.
- Continue to seek locum agency cover.
- Pay existing consultant staff additional rates to cover vacant shifts
- Base the Clinical Site Managers within A&E during out of hours.
- Redirect, where clinically appropriate, to other healthcare settings.
- Undertake assessment of current position of non-elective admission rates from A&E to determine if further actions required

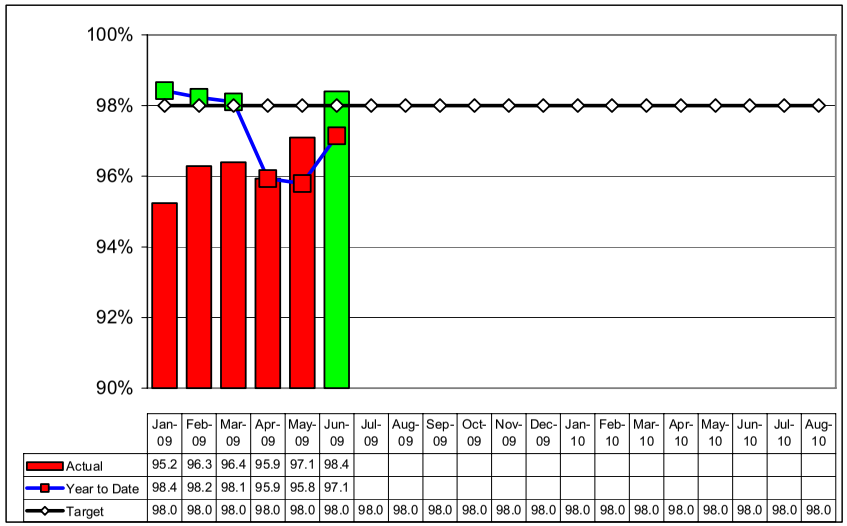
NHS Leeds will be supporting LTHT in improving performance by:

- Promoting walk-in services as alternatives to A&E and providing information to LTHT to assist in the re-direction of patients
- Review changes to the out of hours primary care call handling service

Health economy lead: Matt Walsh
LTHT operational lead: Philip Norman
NHS Leeds operational lead: Nigel Gray

Periodic Review Standard

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



	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10
Actual	95.2	96.3	96.4	95.9	97.1	98.4														
Year to Date	98.4	98.2	98.1	95.9	95.8	97.1														
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	98.0	98.0	98.0	98.0	98.0

NI 131: Delayed transfers of care

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 chart measures the rate per 100,000 of the general population, as opposed to the rate per occupied acute bed day. The Care Quality Commission have not defined the threshold for achievement at the time of writing.

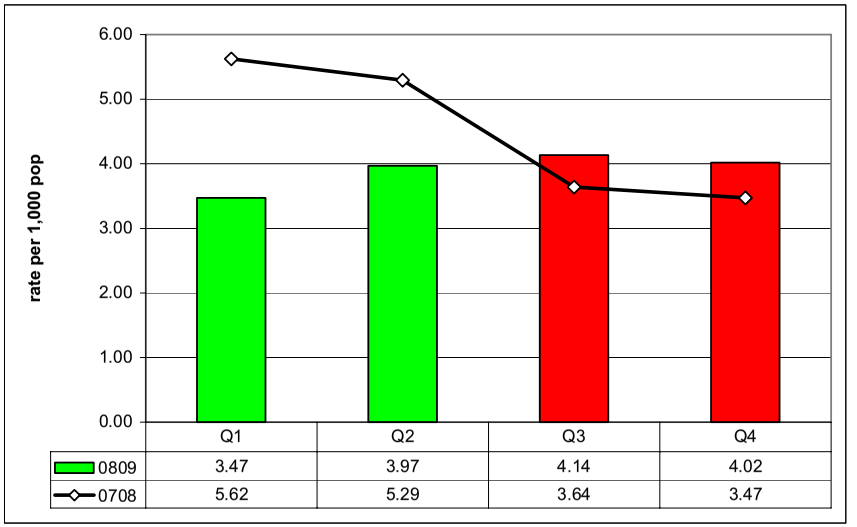
The number of delayed transfers of care in 2008/09 indicates an improvement overall on 2007/08, and performance against the trajectory in Q1-2 was well within the levels seen in 07/08. However, the numbers of delayed transfers of care slightly increased in Q3 at the point when the trajectory reduced to 2.75 rate per 100,000.

The Unplanned Care Board has the discharge planning process as one of its key workstreams, and work started in Jan 2009 on streamlining processes and address how capacity is commissioned. The Unplanned Care Operational Group now receives 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.

Overall Traffic Light Rating	
Data Quality	No Checklist

Periodic Review Standard

Delayed transfers of care per 100,000 population



NHS Leeds Executive Director: Matt Walsh
Management Lead: Nigel Gray
Operational Lead: Paula Dearing

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

This indicator covers a range of immunisations, MMR included, which itself is a stand-alone indicator in the World Class Commissioning programme.

Risks to achievement include -

- Child Health records not up to date
- Data collection issues for practices not on System One
- Non System One practices being unable to view children's immunisation records
- Health visitors not being informed of DNAs so they can follow-up
- Recruitment to service facilitator now progressing
- National uptake falling, particularly for MMR.

Planning is now underway for the stakeholder event on 7 July. This is the first step to implementing some of the recommendations from the As-Is Process Mapping Exercise. This work will aid the delivery of the targets on immunisation, specifically the MMR programme.

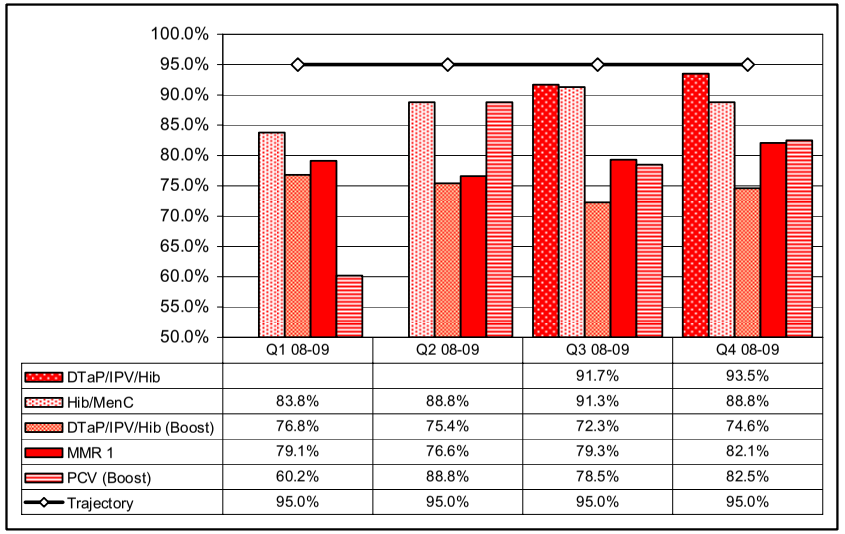
All but one practice has now signed up to a data sharing agreement which means that the PCT can download data directly from GP practices. This will enable more accurate data to be held on Child Health records and form COVER data. This work is to start this month.

Data shown in the chart opposite is not quite complete, though this will be corrected for future versions. On this occasion, Q1 & Q2 data for the first DTaP/IPV/Hib immunisation is not available. Also, HPV immunisation rates are not available though again will be in future.

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

Periodic Review/Vital Signs Standards

Percentage of children given immunisation at the recommended ages



	Q1 08-09	Q2 08-09	Q3 08-09	Q4 08-09
DTaP/IPV/Hib			91.7%	93.5%
Hib/MenC	83.8%	88.8%	91.3%	88.8%
DTaP/IPV/Hib (Boost)	76.8%	75.4%	72.3%	74.6%
MMR 1	79.1%	76.6%	79.3%	82.1%
PCV (Boost)	60.2%	88.8%	78.5%	82.5%
Trajectory	95.0%	95.0%	95.0%	95.0%

NI 40: Number of drug users in effective treatment

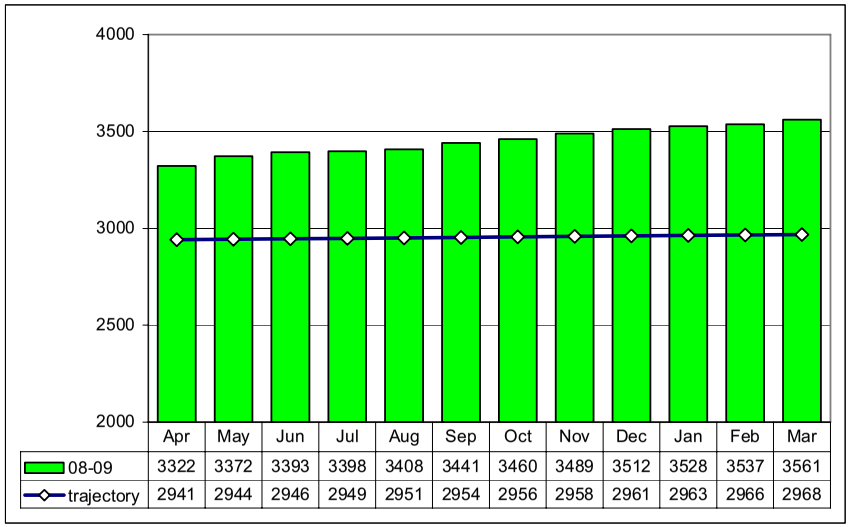
Target:

To increase the number of drug users in treatment, achieving the monthly target trajectory.

This indicator trajectory has been achieved during 2008/09. Further detailed commentary on this and performance moving into 2009/10 will be provided for future reports.

National Indicator

Number of drug users recorded as being in effective treatment (NI 40)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
08-09	3322	3372	3393	3398	3408	3441	3460	3489	3512	3528	3537	3561
trajectory	2941	2944	2946	2949	2951	2954	2956	2958	2961	2963	2966	2968

Overall Traffic Light Rating	
Data Quality	No Concerns

NHS Leeds Executive Director: Jill Copeland
Management Lead: Carol Cochrane
Operational Lead: Luke Turnbull

NI 123: Smoking Prevalence

Target:

Reduce the prevalence of smoking across the city and to narrow the gap between the most deprived areas and the rest of Leeds.

The latest practice data collection exercise figures (for 2008/09) indicate the current smoking prevalence of patients aged 16+ across Leeds is 23.04%. This is broken down to 29.63% in the deprived areas and 20.16% for the rest of Leeds.

It is anticipated that the data for Q1 2009/10 will be available for Aug 09. Although Leeds has experienced a significant reduction in smoking prevalence over the last 5 years, the national trend is suggesting the decline is starting to plateau and there is a risk of an increase in prevalence. It is therefore essential that the tobacco control agenda remains a high priority.

The NHS Leeds/Leeds City Council partnership is currently reviewing the arrangements for the development and delivery of the overarching tobacco control programme and is linking with regional activity including addressing the accessibility of cheap and illicit tobacco, which is a particular problem in the most deprived areas of the city. The service is continuing the delivery of an intensive programme of work using the principles of social marketing within the Richmond Hill area of the city, where uptake of the service has been historically poor.

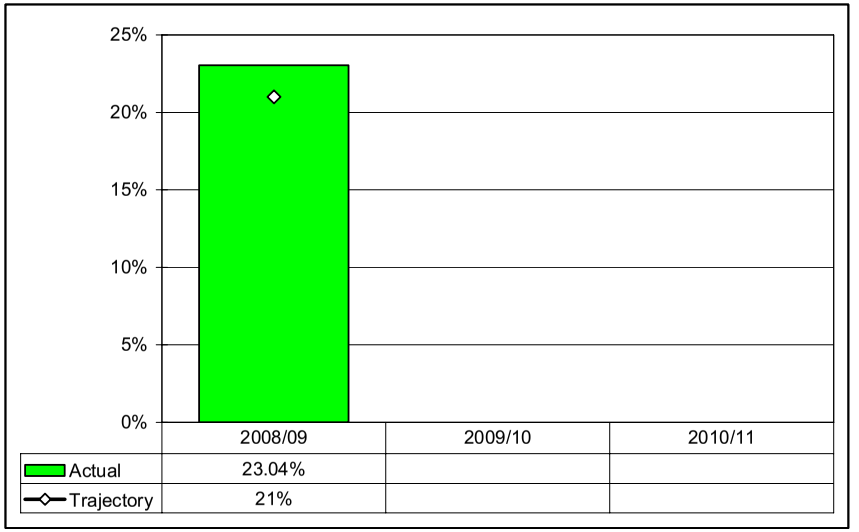
In addition the following assurances are:
The smoking service is well established and achieving 4 week quit target
The service is continuing to maintain high success rates
The service has been commissioned to continue to focus in developing outreach work in deprived areas where access is low

Overall Traffic Light Rating	
Data Quality	No Concerns

NHS Leeds Executive Director: Ian Cameron
Management Lead: Brenda Fullard
Operational Lead: Heather Thomson

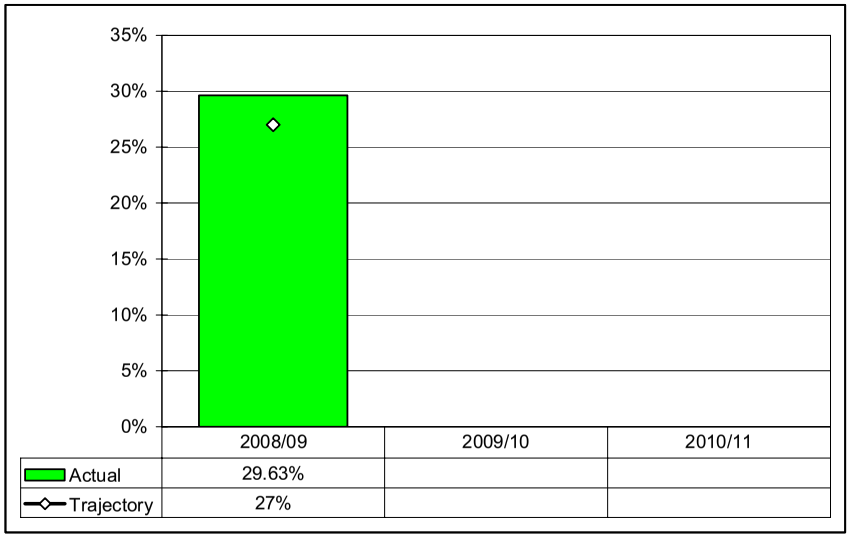
National Indicator

NI 123a: Smoking prevalence - City wide



National Indicator

NI 123b: Smoking prevalence - Depriived areas



NI 125: Independence for older people

Target:

To deliver improved care so as to achieve independence for older people through rehabilitation and/or intermediate care

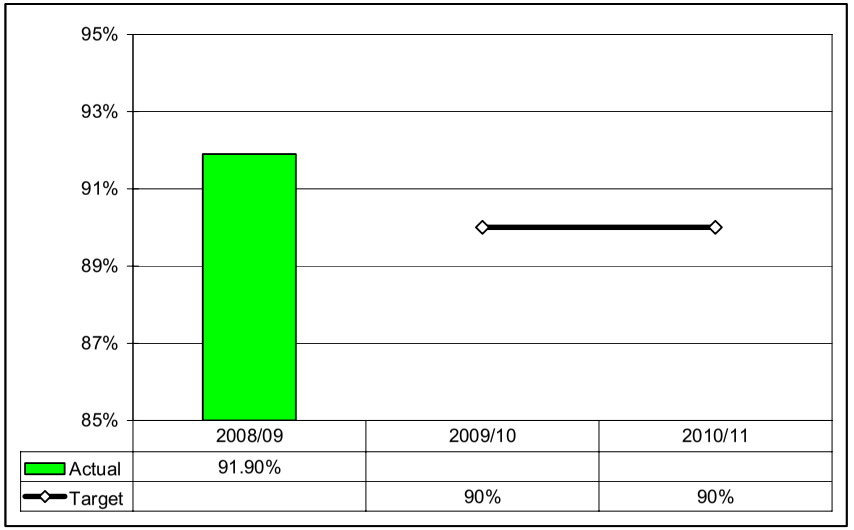
This indicator measures the benefit to individuals from intermediate care and rehabilitation following a hospital episode. It captures the joint work of Social Care and Health staff commissioned by joint teams. The measure is designed to follow the individual and not differentiate between social care and NHS funding boundaries.

This is a provisional figure for a new indicator. It relies on new data for which results have only been reported from February 2009 onwards and no comparator information is available.

As this indicator has limited baseline data derived from a fairly small sample and initial results for the early part of 2009/10 would suggest that the base line level of performance is unlikely to be maintained the targets have been set slightly below the baseline. Furthermore, based on the results which were available from other authorities for 2008/09 a result of 90% would be well within the top quartile.

National Indicator

NI 125: Achieving indepence for older people through rehab/intermediate care



Overall Traffic Light Rating	N/A
Data Quality	Some Concerns

Lead Service: Access and Inclusion, LCC

NI 8: Adult Participation in sport and active recreation

Target:

To increase the participation of adults in sport and active recreation to 24.6% by 2011/12

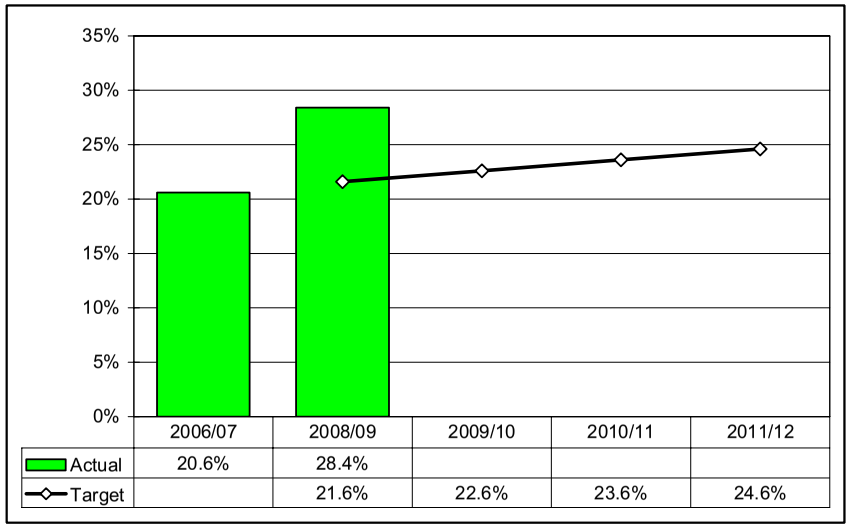
This indicator measures the participation of adults in 30 minutes of moderate intensity sport and active recreation on 3 or more days each week. The figure was gathered by Ipsos MORI who have been commissioned by Sport England to undertake an annual sport and active recreation participation survey. The original survey was undertaken from October 2005 - October 2006 and this collected 1,000 surveys from most local authorities across England. Following this 'Active People 2' was commissioned and this reduced the standardised sample size to 500.

Leeds has moved to 16th (English local authorities) in 2008 from a position of 208th in 2006, the 4th biggest increase in England. Leeds is now in the top 5% performing local authorities in the country.

The Department for Culture, Media and Sport through its Public Service Agreement targets a 1% year on year increase in participation from the baseline figure.

National Indicator

NI 8 Adult participation in sport and active recreation



	2006/07	2008/09	2009/10	2010/11	2011/12
Actual	20.6%	28.4%			
Target		21.6%	22.6%	23.6%	24.6%

Overall Traffic Light Rating	
Data Quality	No Concerns

Lead Service: Sport and Active Recreation, LCC

NI 119: Self reported measure of people's overall health and well-being

Target:

To improve the relative score as taken from the Place Survey

This result is from the 2008 Place Survey and measures the percentage of people who say their health is good or very good.

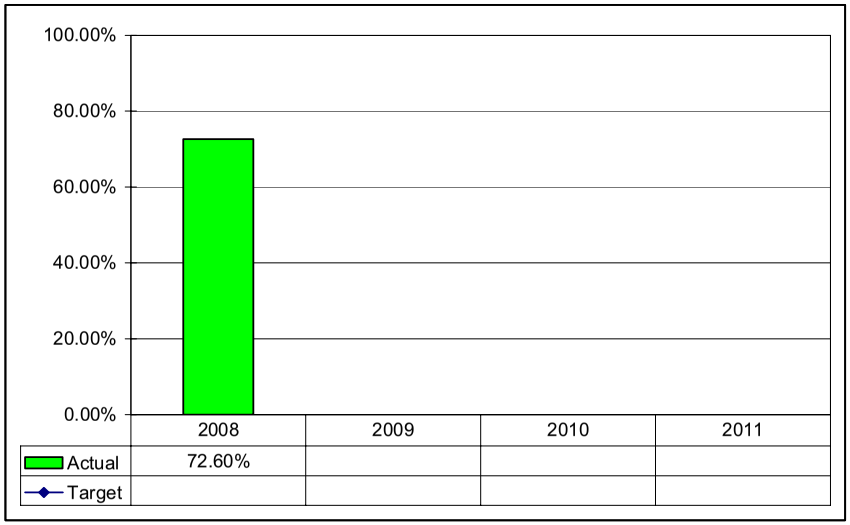
The result of 72.6% is below both the core cities and Yorkshire and Humber averages and places Leeds in the bottom quartile nationally.

This is the first year this indicator has been reported and targets have yet to be set for forthcoming years.

Overall Traffic Light Rating	N/A
Data Quality	No Concerns

National Indicator

NI 119: Self reported menasue of people's health and well-being



Lead Service: NHS Leeds
Executive Director: Ian Cameron
Management Lead: Brenda Fullard
Operational Lead: Heather Thomson

NI 122: Mortality from all cancers at ages under 75

Target:

To reduce the rate of deaths from cancer to 110 deaths per 100,000 by 2011

The trajectory for this indicator is currently being achieved.

The work on delivery forms part of the Cancer Locality Group work programme and the Cancer Strategy Reform action plan.

Achievement moving forward and in the short term depends of improving access to care, reducing stage at presentation as well as changing health behaviour and providing smoking cessation services.

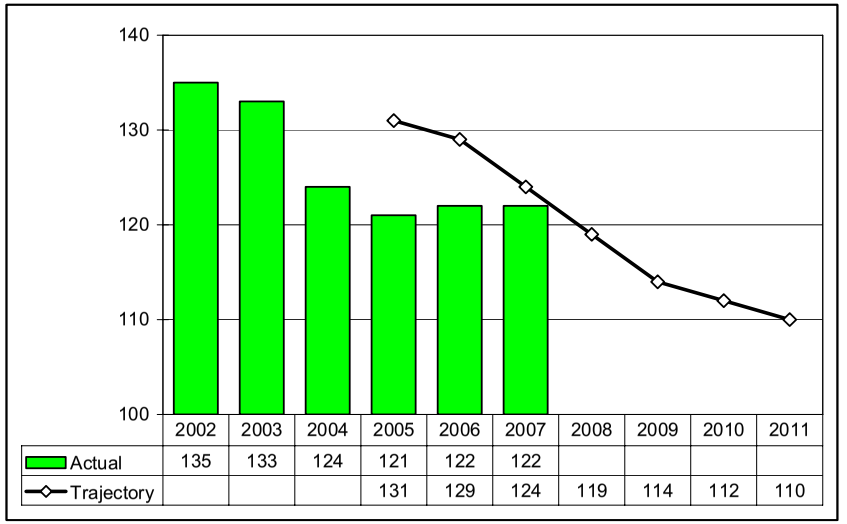
A range of actions by and regular performance review by the Cancer Locality Group and West Yorkshire cancer network and external peer assessment help to provide assurance.

Future work includes improvement of care pathways, enhanced screening programmes (breast cervical and bowel) and continued improvement in delivery of healthy living services, in particular smoking cessation, weight management and alcohol services

Overall Traffic Light Rating	
Data Quality	No Concerns

National Indicator

NI 122: Cancer mortality



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Actual	135	133	124	121	122	122				
Trajectory				131	129	124	119	114	112	110

Lead Service: NHS Leeds
Executive Director: Ian Cameron
Management Lead: Jon Fear
Operational Lead: Jon Fear

NI 53: Prevalence and coverage of breastfeeding

Target:

To increase the prevalence and coverage of breastfeeding at 6-8 weeks from birth.

Promoting and sustaining breastfeeding is an essential part of an integrated programme of child health promotion and parenting support. Over the past few years performance has focused on breastfeeding initiation but from now the indicator is assessing levels of continuation at 6 - 8 weeks and of coverage, that is improving the recording of breastfeeding status.

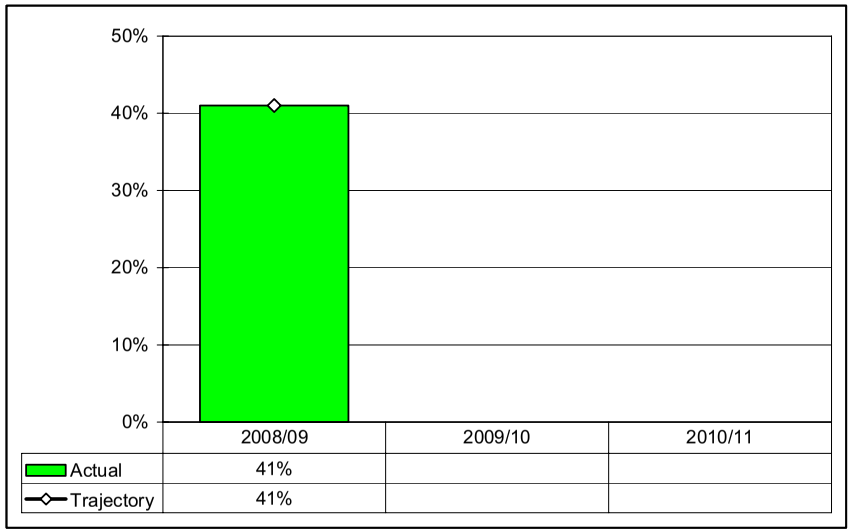
2008/09 has been the first year that this indicator is being reported and though there are issues with regard to recording of the information, progress towards the year end target has been good, as can been seen from the charts.

Overall Traffic Light Rating	
Data Quality	No Concerns

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

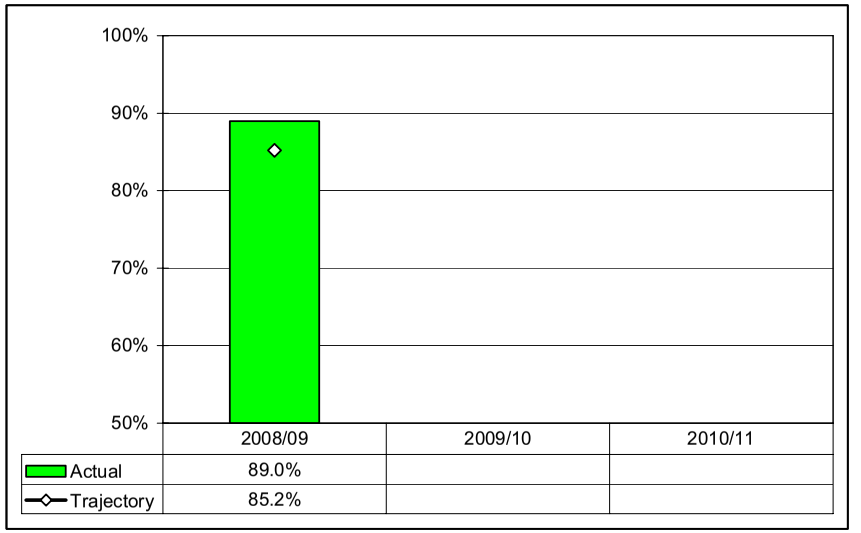
National Indicator

NI 53a: Prevalence of breastfeeding at 6-8 weeks from birth



National Indicator

NI 53b: Coverage of breastfeeding at 6-8 weeks from birth



NI 55: Obesity in Yr R primary school children

Target:

To increase coverage of Yr R children to 91.9% and to reduce prevalence of obesity to 9.17% by 2011.

Childhood Obesity is closely linked with early onset of preventable disease, including diabetes. The ambition is to reverse the rising tide of obesity and people being overweight in the population, by enabling everyone to achieve and maintain a healthy weight. The aim is to reduce the proportion of overweight and obese children to 2000 levels

It measures the percentage of children in reception who are obese as shown by the National Child Measurement Programme (NCMP). PCTs are required to coordinate with schools to weigh and measure all eligible children in year 6 and reception.

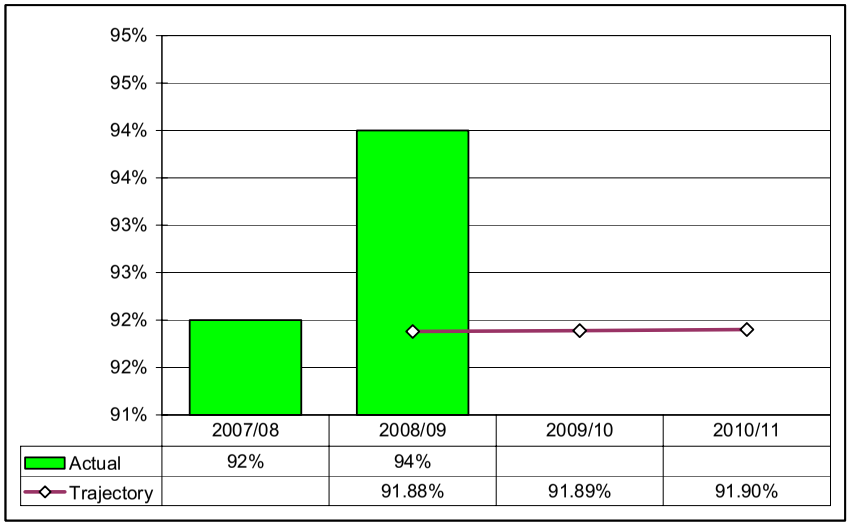
The result provided is for the academic year 2007/08. Both coverage and prevalence rates are exceeding target. Compared to 2006/07 academic year there has been an increase in the number of children measured and a slight drop in prevalence but with only two years of results it is not yet possible to discern trends.

Overall Traffic Light Rating	
Data Quality	No Concerns

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

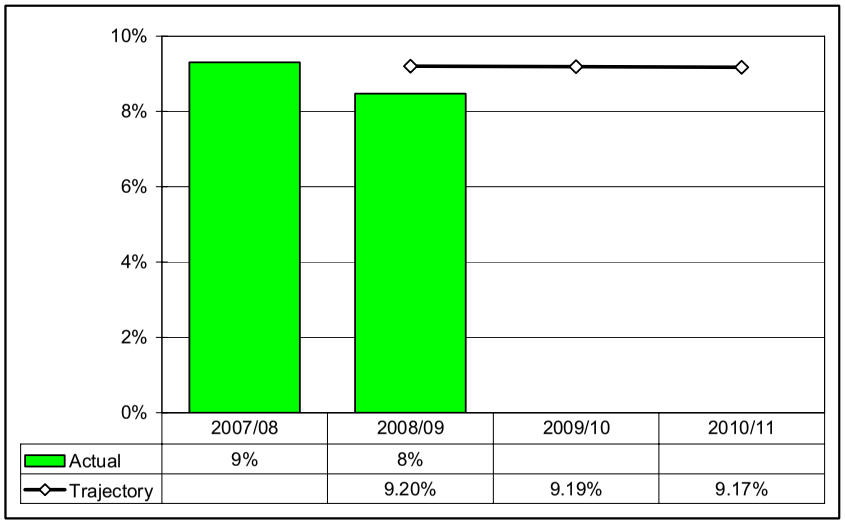
National Indicator

NI 55: Obesity in Yr R - coverage



National Indicator

NI 55: Obesity in Yr R - prevalance



NI 55: Obesity in Yr 6 primary school children

Target:

To increase coverage of Yr 6 children to 98.34% and to reduce prevalence of obesity to 17.67% by 2011.

Childhood Obesity is closely linked with early onset of preventable disease, including diabetes. The ambition is to reverse the rising tide of obesity and people being overweight in the population, by enabling everyone to achieve and maintain a healthy weight. The aim is to reduce the proportion of overweight and obese children to 2000 levels

It measures the percentage of children in year 6 who are obese as shown by the National Child Measurement Programme (NCMP). PCT's are required to coordinate with schools to weigh and measure all eligible children in year 6 and reception.

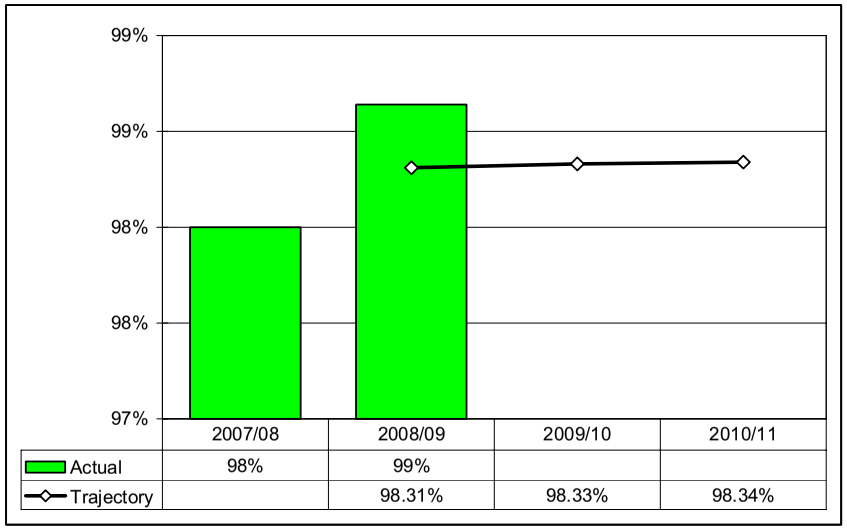
The result provided is for academic year 2007/08. Obesity coverage has increased compared to 206/07 academic year and has exceeded target. However, prevalence has increased and has failed to meet target, although with only two year's data it is not possible to discern if this is a trend.

Overall Traffic Light Rating	
Data Quality	No Concerns

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

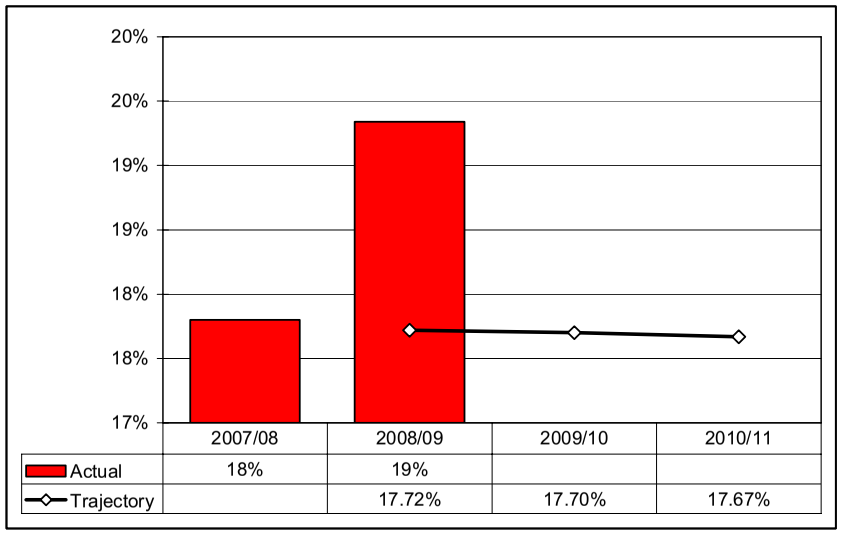
National Indicator

NI 56: Obesity in Yr 6 - coverage



National Indicator

NI 56: Obesity in Yr 6 - prevalance



NI 70: Reduce emergency hospital admissions caused by injury to children

Target:

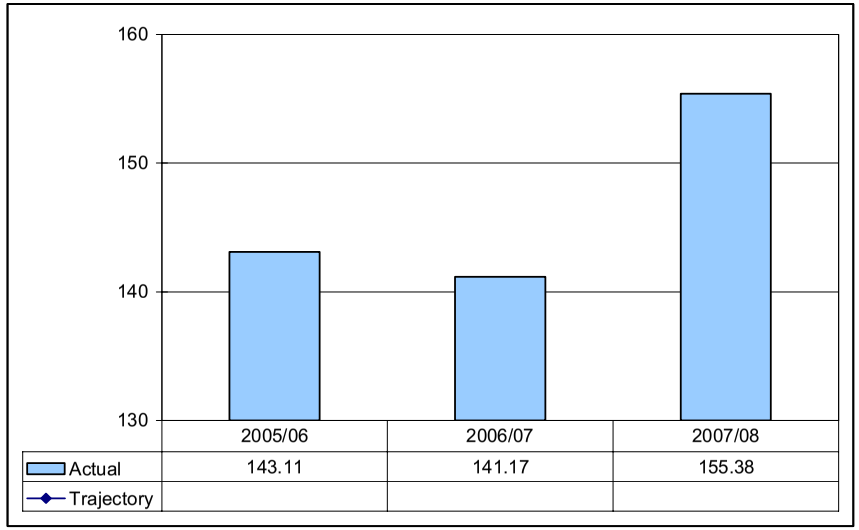
No target has been set for this indicator at this stage.

Data for this indicator will be available via the central Government Data Hub. A result for 2008/09 will be available by the end of July 2009.

No future targets have been set for this indicator at this stage.

National Indicator

NI 70: Reduce emergency admissions caused by unintentional/deliberate injuries to children



Overall Traffic Light Rating	N/A
Data Quality	Concerns

Lead Service: NHS Leeds
Executive Director: Jill Copeland
Management Lead: Sarah Sinclair
Operational Lead: Diane Hampshire

NI 50: Emotional health of children

Target:

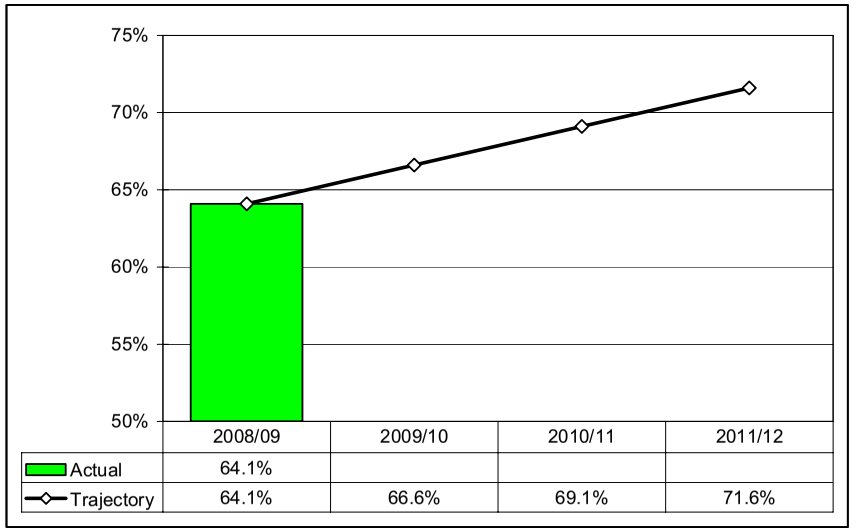
To improve performance from the 2008/09 baseline by 2.5% per year, to 2012.

This is a new indicator measured using results from questions in the TellUs Survey. The TellUs survey is based on a representative sample of pupils in School Years 6, 8 and 10 in maintained schools, including Academies and Pupil Referral Units, in a local area.

The 2008/09 result of 64.1% has been used as a baseline and future targets have been set at a year on year improvement of 2.5%.

National Indicator

NI 50: Emotional health of children



	2008/09	2009/10	2010/11	2011/12
Actual	64.1%			
Trajectory	64.1%	66.6%	69.1%	71.6%

Overall Traffic Light Rating	N/A
Data Quality	No Concerns

Lead Service: NHS Leeds
Executive Director: Jill Copeland
Management Lead: Sarah Sinclair
Operational Lead: tbc

NI 51: Effectiveness of child and adolescent mental health services

Target:

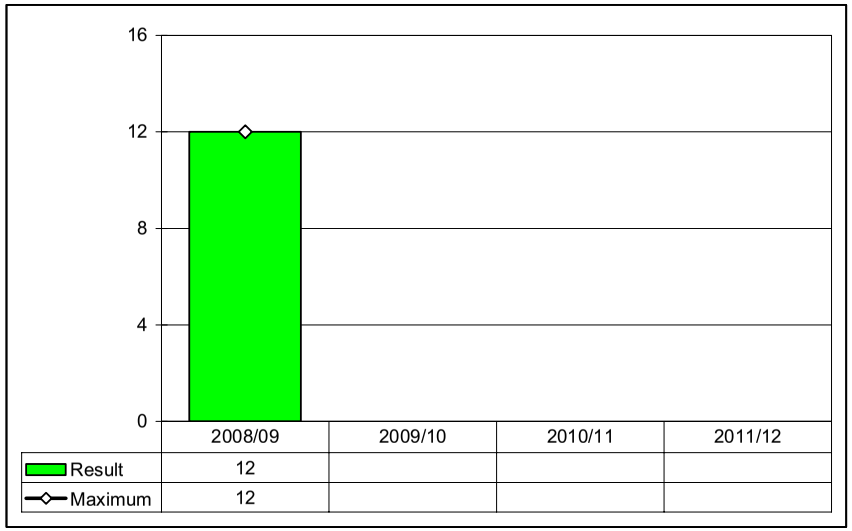
To be able to respond positively in each area of activity covered by a PCT level annual survey.

This indicator measures how effectively mental health services meet children's mental health needs, through a survey of PCTs. This measure is assessed by answering a series of four questions. During the year the questions were altered which also meant that the highest result possible and target was amended from 16 to 12. This is why the year end result differs from the previous three quarters results. Result 12 out of 12

The target has been met due to services being made more effective. This has been achieved by ensuring there is a full range of CAMHS for children with learning disabilities, providing accommodation appropriate to age and level of maturity and enhancing the provision of early intervention support services.

National Indicator

NI 51: Effectiveness of CAMHS



Overall Traffic Light Rating	
Data Quality	No Concerns

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

NI 113: Prevalence of chlamydia in under 25 year olds

Target:

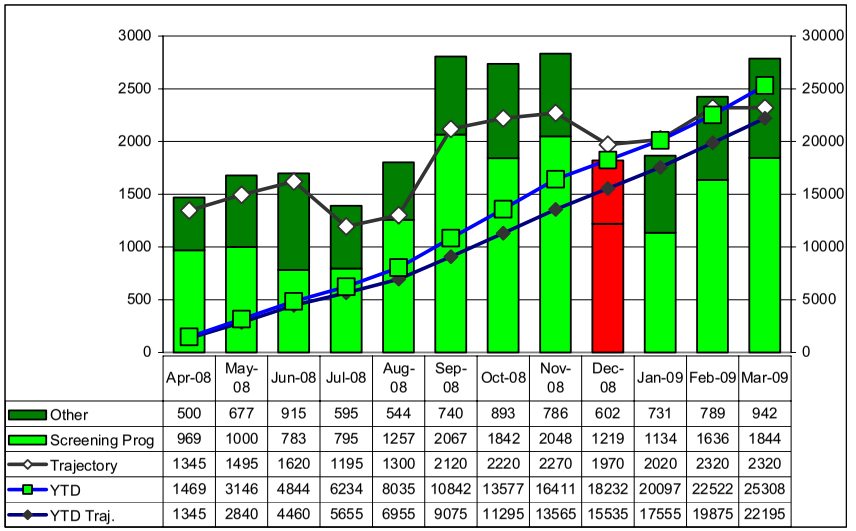
No target set at this stage. 2008/09 performance to be used as a baseline.

This indicator will be based on performance in 2008/09, which is illustrated in chart opposite. Final, confirmed data will be available from the Data Hub at the end of July.

The target trajectory for 2008/09 was delivered.

Periodic Review Standard

Chlamydia 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
Other	500	677	915	595	544	740	893	786	602	731	789	942
Screening Prog	969	1000	783	795	1257	2067	1842	2048	1219	1134	1636	1844
Trajectory	1345	1495	1620	1195	1300	2120	2220	2270	1970	2020	2320	2320
YTD	1469	3146	4844	6234	8035	10842	13577	16411	18232	20097	22522	25308
YTD Traj.	1345	2840	4460	5655	6955	9075	11295	13565	15535	17555	19875	22195

Overall Traffic Light Rating	
Data Quality	No Concerns

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

NI 115: Substance misuse by young people

Target:

To reduce the number of young people reporting frequent misuse of drugs/volatile substances or alcohol.

This indicator is measured through the TellUs Survey. The TellUs survey is based on a representative sample of pupils in School Years 6, 8 and 10 in maintained schools, including Academies and Pupil Referral Units, in a local area.

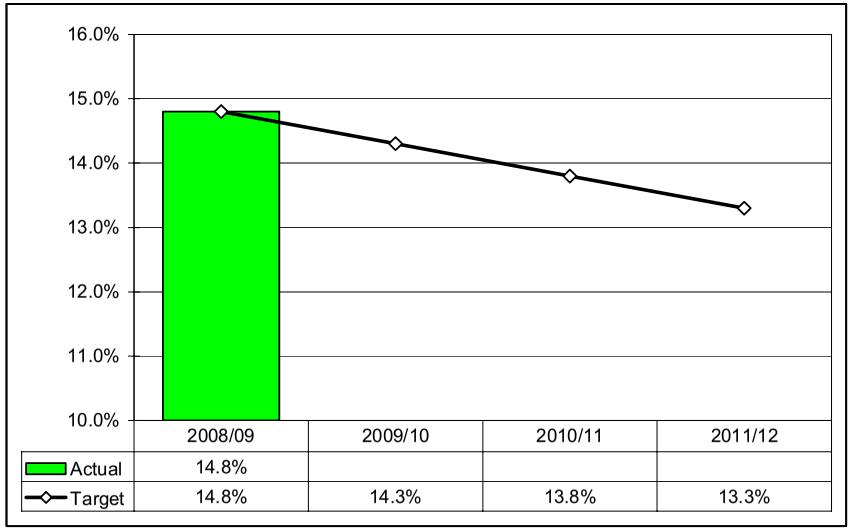
The indicator measures the percentage of young people reporting frequent misuse (twice or more in the last four weeks) of either drugs/volatile substances or alcohol.

The targeted reduction of 0.5% per year equates to five children.

S

National Indicator

NI 115: Substance misuse by young people



Overall Traffic Light Rating	N/A
Data Quality	No Checklists

Lead Service: NHS Leeds
Executive Director: Jill Copeland
Management Lead: Sarah Sinclair
Operational Lead: tbc

NI 124: People with a long term conditions supported to independent

Target:

The percentage of people with a long-term condition who receive enough support to help manage their long-term health condition(s).

The Self Care Operating Framework is now produced in draft form. It makes specific reference to people with Long Term Conditions. It is now out for consultation with partner agencies and service users. It identifies three thematic areas for action. Meeting with Strategic Development colleague to discuss the way forward.

The Expert Patient Programme now has a full annual programme of sessions. Additional development work is planned on specific condition focussed Programme work (including neurological conditions, mental health etc).

The Health Trainer Programme focuses on health behaviours and lifestyle choices, the work of the trainers overlaps with wider considerations relating to long term conditions. Full re-commissioning of the Health Trainer programme over a 3 year programme is to be taken forward through appropriate PCT mechanisms.

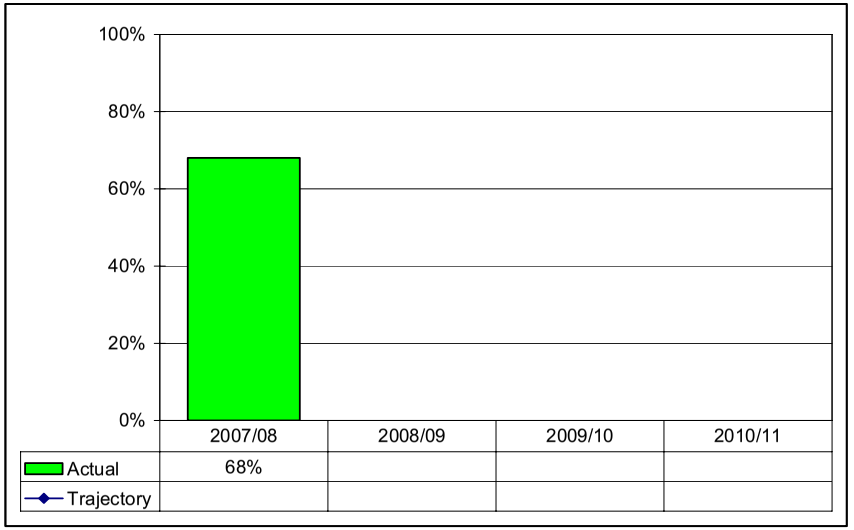
The Staywell System is aimed at ensuring people with long term conditions are fully informed about their condition and able to self-assess their ability and knowledge to manage the condition. This is being taken to the Leodis practice based commissioning consortium as a possible demonstration site for testing the system.

Overall Traffic Light Rating	N/A
Data Quality	No Concerns

Lead Service: NHS Leeds
Executive Director: Ian Cameron
Management Lead: Brenda Fullard
Operational Lead: Judy Carrivick

National Indicator

NI 124: People with long term condition supported to be independent



NI 129: End of life care – access to care enabling people to choose to die at home

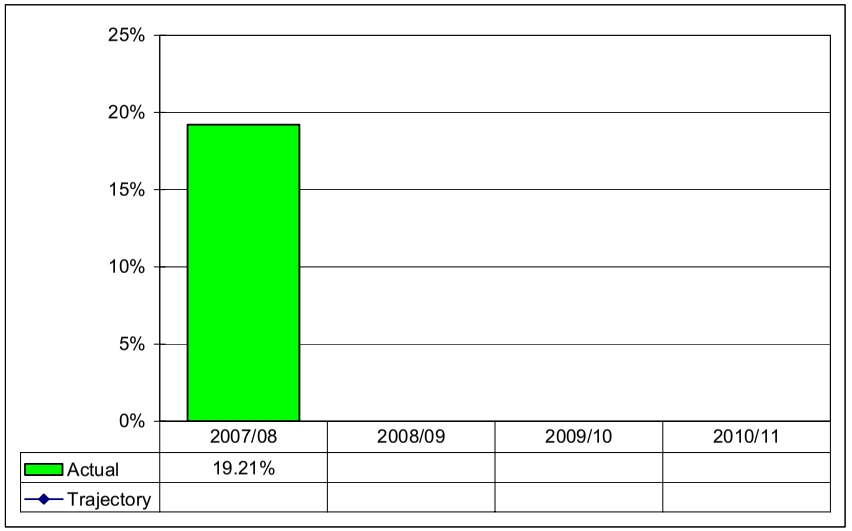
Target:

The percentage of people that die at home should rise over time. No specific target has been set at this stage.

Data for this indicator is provided via ONS. No target has been set at this stage. Further performance information will be provided in future reports.

National Indicator

NI 129: End of life care: percentage of deaths that occur at home



Overall Traffic Light Rating	N/A
Data Quality	No Concerns

Lead Service: NHS Leeds
Executive Director: Jill Copeland
Management Lead: Carol Cochrane
Operational Lead: Diane Boyne

NI 134: Number of emergency bed days per head of population

Target:

The rate of emergency bed days per head of population should reduce over time.

Whilst there are no concerns with the medium to long term availability of data to support the performance management of this indicator, it is presently not available.

Data will be available for the next issue of this performance report.

Overall Traffic Light Rating	N/A
Data Quality	No Concerns

Lead Service: NHS Leeds
Executive Director: tbc
Management Lead: tbc
Operational Lead: tbc

NI 149: Adults receiving secondary mental health services in settled accommodation

Target:

The percentage of people receiving secondary mental health services and who are in settled accommodation should rise.

NI 150: Adults receiving secondary mental health services in employment

Target:

The percentage of people receiving secondary mental health services and who are in employment at the time of their last assessment should rise.

Data for these indicators is provided via the Mental Health Minimum Data Set. No targets have been set at this stage. Further performance information will be provided in future reports. Data will be available from the Data Hub during the summer.

NHS Leeds will support provision of the information for these indicators for future reports and also co-ordinate the reporting of supporting narrative.

Overall Traffic Light Rating	N/A
Data Quality	No Checklists

Lead Service: Leeds Partnership Foundation Trust/NHSL
Executive Director: tbc
Management Lead: tbc
Operational Lead: tbc

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Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 28 July 2009

Subject: Recommendation Tracking

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 In December 2006, the 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. This allows the Scrutiny 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 Scrutiny 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 the Scrutiny Board to determine whether a recommendation has been completed and identify any further action required.

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

1.6 The Scrutiny Board is asked to:

- Consider the updates provided;
- Determine whether or not progress is satisfactory;
- Determine whether or not any additional work in required.

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 Scrutiny Board.

2.0 Recommendations

2.1 Members are asked to consider the progress updates provided against the Scrutiny Board's previous recommendations not yet completed (outlined in Appendix 2), and:

2.1.1 Agree those recommendations which no longer require monitoring;

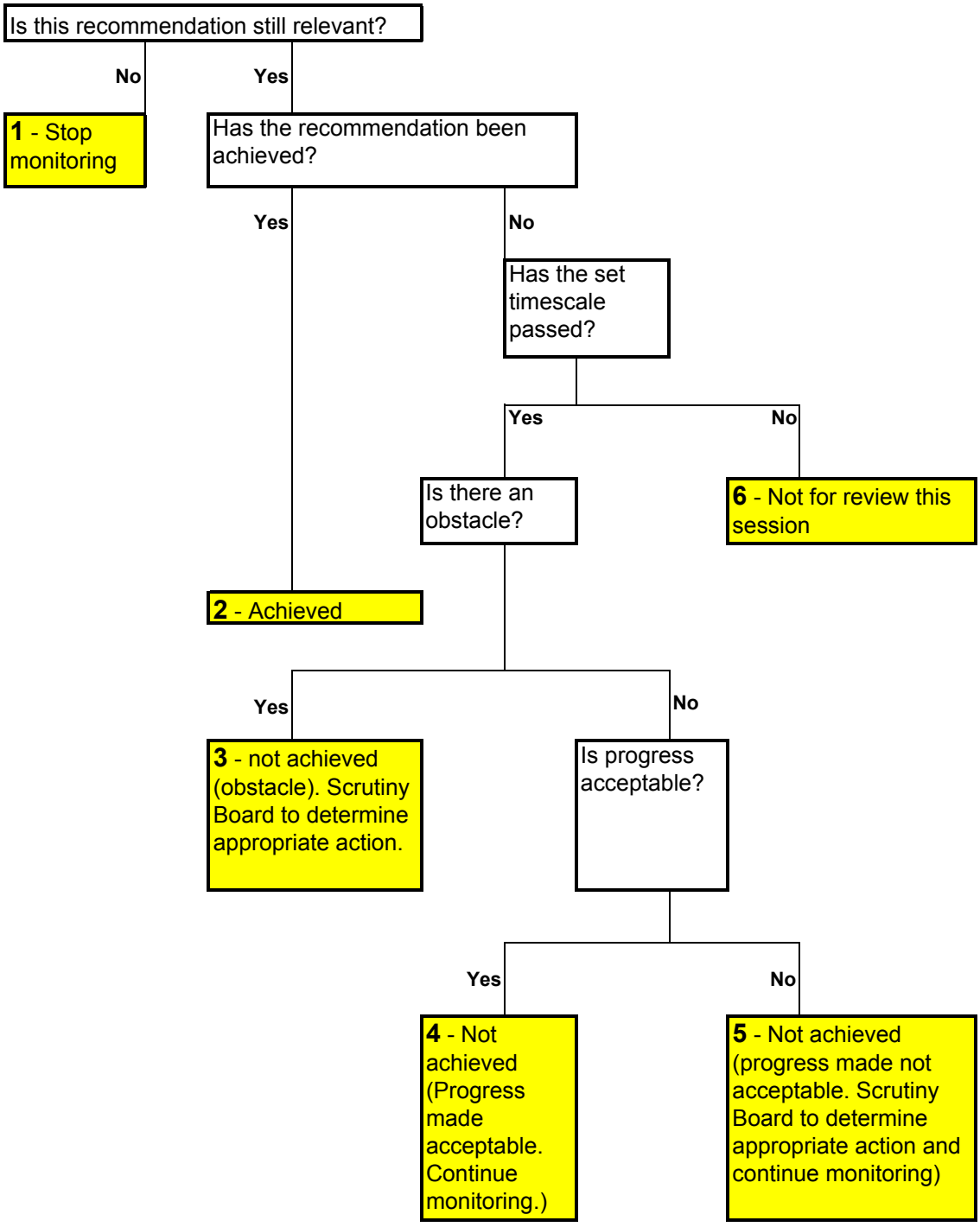
2.1.2 Identify any recommendations where progress is unsatisfactory and determine any action the Scrutiny Board wishes to take as a result.

3.0 Background Papers

None

APPENDIX 1

Recommendation tracking flowchart and classifications: Questions to be Considered by Scrutiny Boards



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APPENDIX 2

Community Development – Report published July 2007: Last update received March 2009 (considered in April 2009)

	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 position 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)		

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 2009 (considered in April 2009)

	Recommendation	Where we are up to	Stage	Complete
		July 2009 update The VCFS Partnership Group chaired by Sandie Keene was established by the Narrowing the Gap Board to deliver against the LAA National Indicator 7 – a environment for a thriving third sector. It has established task groups to look at both resourcing issues and community engagement. The resources task group has established the Supporting Commissioning Links scheme and commissioned Leeds Voice and Renew to work in partnership with service managers to deliver a 2 year programme to enable and support third sector organisations to access opportunities to deliver public sector commissioned services and activities. The VCFS Partnership Group has agreed terms of reference for a community engagement task group that will meet at the end of August to undertake the work identified by the City and Regional Partnerships Scrutiny Board. It will identify opportunities and initiatives that will further improve and enhance links with local VCFS organisations to support the delivery of the Area Committee's work in localities and will map the available resource and expertise within the sector to improve the targeting and engagement of "hard to reach" groups. It will also seek to map the existing strategic groups with a 'community engagement' remit groups and their activities to avoid duplication and silo approaches and develop and recommend more sustainable ways of working. The Leeds Initiative Harmonious Communities partnership has held its first meeting and agreed to meet with the community engagement subgroup of the VCF sector Partnership. NHS Leeds has made explicit a number of community development outcomes within CVFS SLA's. These include: Increased number of people participating in or engaging with local community activities; Increase in the size and range of social networks for local people; Equality of access to services for all local		

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 2009 (considered in April 2009)

	Recommendation	Where we are up to	Stage	Complete
		people; Increased levels of satisfaction of service users with the delivery and outcomes of the service; Increased levels of involvement of service users in the design, delivery, management, review and development of services; Improvement in productive and co-operative working with other partners – indicators for this outcome include 'Input to Local Forum/planning sessions' and 'Input to Local Delivery Plans (Area Committee, through Area Management)' These outcomes have been commissioned from approx 20 agencies. The agencies all work in neighbourhoods in worst 10% nationally (using IMD) and with specific vulnerable groups eg gypsies and travellers, South Asian communities, women fleeing violence.		
4	**That the Healthy 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.**	<u>March 2008 position</u> 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. <u>March 2009 position</u> 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.		

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 2009 (considered in April 2009)

	Recommendation	Where we are up to	Stage	Complete
		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. **July 2009 update** Healthy Leeds partners are not currently visibly championing the Network and, apart from NHS Leeds's contribution, there has been no funding or other resources from partners to support the work. The network has been supported and continued by funding from within Public Health, NHS Leeds, and the commitment of the Task Group, which includes staff from NHS Leeds, VCF sector and Healthy Leeds. In terms of training, Leeds University is taking forward a needs analysis relating to CD; and we have identified and are publicising courses available through local providers. Training offered through the Network failed to attract staff to attend and would have had difficulties accrediting learning in a useful way. Leeds is extremely well provided with opportunities for training at the University of Leeds, Leeds Metropolitan University and Bradford College; commissioners need to ensure agencies are funded with sufficient allowance for staff development within Full Cost Recovery Service Level Agreement's, rather than expecting VCF sector partners to meet the need for training themselves.		
5	**That the Healthy Leeds Partnership carries out an evaluation of the Community Health Development**	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		

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 2009 (considered in April 2009)

	Recommendation	Where we are up to	Stage	Complete
	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.	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. <u>March 2009 position</u> 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. **<u>July 2009 update</u>** An independent evaluation was undertaken in 08/09 on the delivery of the Community Health Development Network, including work on training. As a result of this evaluation, the Task Group met in April and recommended two main activities for 09/10: • the delivery of a CHDN leadership programme, to strengthen		

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 2009 (considered in April 2009)

	Recommendation	Where we are up to	Stage	Complete
		partnership and leadership for CHD work in Leeds – this is being delivered October 09 to March 10, externally facilitated and will be internally evaluated. • the delivery of two events for CHDN frontline staff which are being planned and co-ordinated by staff from NHS Leeds, Touchstone and Health for All. Leeds Voice is the commissioned agency to administer these activities. Investment in the Network from NHS Leeds has been reduced from 08/09 levels, from 40k to 25k, but a Service Level Agreement has been agreed with Voice for 3 years to for this investment to continue at this level. There is still no joint funding for this work.		

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 March 2009 (considered in April 2009)

	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 position</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. introduction of these partnerships they will be supported in part by the joint funded appointment of three Locality Enablers for Health and Wellbeing.		

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Localisation – Statement published May 2008: Last update received March 2009 (considered in April 2009)

	Recommendation	Where we are up to	Stage	Complete
		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 **<u>July 2009 update</u>** NHS Leeds and Adult Social Care have been working with the Leeds Initiative to progress the development of a thematic group for health and wellbeing, including adult social care, in each of the three areas. Workshops were held at the end of March 2009 to engage a wide range of stakeholders in shaping the development of locality health and wellbeing partnerships arrangements. These were supported by local Councillors and LCC Area Managers. Approximately 50 people attended each workshop, from different sections of NHS Leeds and the Council, the Voluntary, Community and Faith Sector and Practice Based Commissioning consortia. These workshops generated enthusiasm amongst stakeholders for the development of three thematic groups and gave key pointers in relation to the types of systems and structures that stakeholders felt both help and hinder partnership working, issues to consider around health evidence, involvement, linkages, delivering improvement locally, communication, and wider influences on health. A paper was taken to the Healthy Leeds Joint Strategic Commissioning Board in May proposing the establishment of three locality health and wellbeing theme groups, which was endorsed. A planning group has since met to consolidate the outputs from the workshops and agree the key actions for taking this development forward. Meetings of an initial core health and wellbeing group for each of the three areas have been convened for July 2009. These core groups will consist of representatives from NHS Leeds, Adult Social Care, LCC Officers, Councillors, the VCFS, PBC, and Children's Services.		

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Localisation – Statement published May 2008: Last update received March 2009 (considered in April 2009)

	Recommendation	Where we are up to	Stage	Complete
		The purpose of the group is to inform the production of consistent Terms of Reference across the three areas through the development of detailed proposals for the purpose and functioning of the groups. These proposals will result from discussions on areas such as the overall purpose and benefits of the partnerships, what they will deliver in their first year, who needs to be involved, how the group will operate in practical terms, links to other local partnerships, communication, involvement and engagement mechanisms, and governance (including accountability structures, identification and management of risks, reporting, and performance management in relation to the Health and Wellbeing Theme Plan). It is envisaged that the first meetings of the full groups will take place in the early autumn. A recruitment process is in progress to appoint three jointly funded Locality Health Improvement Managers to support Locality partnership working. They will be a key link between the thematic groups and the Area Committees and will facilitate appropriate dialogue.		
2	**That the results of the PCT's review of minor surgery in Leeds be reported to this scrutiny board at the earliest opportunity.**	<u>September 2008 position</u> 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). <u>March 2009 position</u> 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 **<u>July 2009 update</u>** NHS Leeds continues to review the provision of minor surgery in facilities across NHS Leeds.		

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Localisation – Statement published May 2008: Last update received March 2009 (considered in April 2009)

	Recommendation	Where we are up to	Stage	Complete
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.**	<u>September 2008 position</u> 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. <u>March 2009 position</u> 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. **<u>July 2009 update</u>** The newly created outpatient service at Wetherby Health Centre (reported in March) has increased the range of specialities being provided; they now include paediatrics, vascular, gastroenterology and neurology. MSK and Rehabilitation Services have been able to expand their service in both East Leeds and Woodhouse Community Health Centres. In May the Leeds New Entrant TB Screening Service moved from Beeston Hill to larger accommodation within Parkside Community Health Centre. This move has provided the service with dedicated space enabling it to increase its clinical capacity as well as offering patients improved accessibility.		

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Localisation – Statement published May 2008: Last update received March 2009 (considered in April 2009)

<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</td><td></td><td></td></tr>
</table>

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Localisation – Statement published May 2008: Last update received March 2009 (considered in April 2009)

	Recommendation	Where we are up to	Stage	Complete
		enables activity and financial information to be made available to support commissioning. 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. <u>March 2009 position</u> 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.		

Key

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Localisation – Statement published May 2008: Last update received March 2009 (considered in April 2009)

	Recommendation	Where we are up to	Stage	Complete
		<u>July 2009 update</u> The 2009/2010 Clinical Commissioning Local Enhanced Service (LES) has been implemented to further progress the development of practice based commissioning within the health economy. Clinical engagement is core to the LES and provides incentive funding for primary care practitioners to undertake peer review of clinical care pathways and referrals and provide clinical input in the health economy through clinical data validation.		

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

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Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 28 July 2009

Subject: Work Programme

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

1.0 Purpose

1.1 The purpose of this report is to present an outline work programme for the Board to consider, amend and agree as appropriate.

2.0 Introduction

2.1 At its meeting on 30 June 2009, the Board received a number of inputs to help members consider the Board's priorities during the current municipal year. This included specific inputs from:

- Executive Board Member for Adult Health and Social Care
- Deputy Director (Adult Social Services)
- NHS Leeds
- Leeds Teaching Hospitals NHS Trust (LTHT)
- Leeds Partnerships Foundation Trust (LPFT)

2.2 A number of potential areas were identified by members of the Board, and it was agreed that the Principal Scrutiny Adviser, in consultation with the Chair, present an outline work programme for consideration at the July meeting.

2.3 The main issues discussed/ agreed at the meeting on 30 June 2009 were:

- Quarterly progress updates from NHS partners on the identified key issues and priorities, including updated information on proposed services changes, current consultations and implementation of previously agreed service changes/ developments.

- To consider Renal Services (Dialysis) Provision at Leeds General Infirmary (LGI).
- To consider alcohol and its related harm, including the role of the Authority in:
  - Promoting sensible and responsible alcohol consumption;
  - Highlighting the associated health implications, especially for those living in the most deprived areas of the city.
- Health priorities within the Council's decision-making processes.
- To consider the health of young people across a range of issues, including:
  - Alcohol consumption;
  - Obesity and levels of physical activity;
  - Smoking;
  - Sexual health and teenage pregnancies;

3.0 Work programme

3.1 An outline work programme that reflects those areas identified above in paragraph 2.3, is presented at Appendix 1.

3.2 Draft terms of reference for the Boards proposed inquiry into alcohol related harm are presented at Appendix 2. An associated Scrutiny Inquiry Selection Criteria pro-forma is attached at Appendix 3.

3.3 It should be recognised that the Board's work programme is 'live'. As such, Appendix 1 should be considered as an evolving document that may change over time to reflect any in-year change in priorities and/or emerging issues over the course of the year.

4.0 Recommendations

4.1 Members are asked to;

(i) Consider the outline work programme attached at Appendix 1 and agree / amend as appropriate:
(ii) Consider the draft terms of reference in relation to the proposed inquiry into reducing alcohol related harm (Appendix 2) and the associated inquiry selection criteria pro-forma (Appendix 3)
(iii) Consider the information provided in relation to the proposed GP-led Health Centre, and in particular the consultation analysis provided.
(iv) Agree the revised terms of reference for the inquiry into Improving Sexual Health among Young People.

5.0 Background Documents

None

APPENDIX 1

Scrutiny Board (Health)
Work Programme 2009/10

Item	Description	Notes	Type of item
Meeting date – 28 July 2009			
Renal Services	To consider current proposals from Leeds Teaching Hospitals NHS Trust (LTHT) regarding the provision of dialysis at Leeds General Infirmary (LGI).	Input from a range of stakeholders, including: • NHS Leeds • Leeds Teaching Hospitals NHS Trust • Kidney Patients Association	RP/DP
Renal Patient Transport	To consider the current performance of the renal patient transport service.		PM
Quarterly Accountability Reports	To receive quarter 4 performance reports		PM
Recommendation Tracking	To monitor progress against the recommendations agreed following previous Scrutiny Board inquiries.		MSR

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

APPENDIX 1

Scrutiny Board (Health)
Work Programme 2009/10

Meeting date – 22 September 2009			
Update on local NHS priorities	To consider an update on the previously identified priorities for each local NHS Trust.	Updates from: • NHS Leeds • Leeds Teaching Hospitals NHS Trust • Leeds Partnerships NHS Foundation Trust	PM
Quarterly Accountability Reports	To receive quarter 1 performance reports		PM
KPMG Health Inequalities Report	To consider the KPMG report and its associated action plan.	Due to be considered by Corporate Governance and Audit Committee on 29 July 2009.	
Improving Young Peoples Sexual Health	To consider the initial response to the Boards inquiry published in April 2009.		RP
Recommendation Tracking	To monitor progress against the recommendations agreed following previous Scrutiny Board inquiries.		MSR

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

APPENDIX 1

Scrutiny Board (Health)
Work Programme 2009/10

Meeting date – 20 October 2009			
Scrutiny Inquiry – Alcohol related harm	To consider evidence relevant to the Board's inquiry		RP/DP
Meeting date – 24 November 2009			
Scrutiny Inquiry – Alcohol related harm	To consider evidence relevant to the Board's inquiry		RP/DP
Meeting date – 15 December 2009			
Update on local NHS priorities	To consider an update on the previously identified priorities for each local NHS Trust.	Updates from: • NHS Leeds • Leeds Teaching Hospitals NHS Trust • Leeds Partnerships NHS Foundation Trust	PM
Quarterly Accountability Reports	To receive quarter 2 performance reports		PM

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

APPENDIX 1

Scrutiny Board (Health)
Work Programme 2009/10

Recommendation Tracking	To monitor progress against the recommendations agreed following previous Scrutiny Board inquiries.		MSR
Health Scrutiny – Department of Health Guidance	To receive and consider revised guidance associated with health scrutiny and any implications for local practice.	Guidance due to be published in November 2009	B
Meeting date – 19 January 2010			
Scrutiny Inquiry – Alcohol related harm	To consider evidence relevant to the Board's inquiry		RP/DP
Meeting date – 16 February 2010			
Young Peoples Health	To consider a range of health issues (as they relate to young people) and the role of the Council and its partners.		B/RP

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

APPENDIX 1

Scrutiny Board (Health)
Work Programme 2009/10

Meeting date – 16 March 2010			
Update on local NHS priorities	To consider an update on the previously identified priorities for each local NHS Trust.	Updates from: • NHS Leeds • Leeds Teaching Hospitals NHS Trust • Leeds Partnerships NHS Foundation Trust	PM
Quarterly Accountability Reports	To receive quarter 3 performance reports		PM
Annual Health Check	To receive and consider the local NHS Trusts self assessment against the 24 "core standards" set by Government under the domains: • Safety; • Clinical and Cost Effectiveness; • Governance; • Patient Focus; • Accessible and Responsive Care; • Care Environment and Amenities; and, • Public Health	Precise timing and scope to be confirmed	PM
Recommendation Tracking	To monitor progress against the recommendations agreed following previous Scrutiny Board inquiries.		MSR

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

APPENDIX 1

Scrutiny Board (Health)
Work Programme 2009/10

Meeting date – 27 April 2010			
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

APPENDIX 1

Scrutiny Board (Health)
Work Programme 2009/10

Working Groups (TBC)			
Working group	**Membership**	**Progress update**	**Dates**

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.
Hospital Discharges	To consider a follow up report on progress against the recommendations (i.e. 15, 16 and 17) detailed in the Independence, Wellbeing and Choice inspection report	Consider report in September/ October 2009.
Out of Area Treatments (Mental Health)	To consider the report prepared by Leeds Hospital Alert and the response from LPFT.	Leeds Hospital Alert report received 1 July 2009. Response from LPFT requested on 1 July 2009.
Health priorities within the Council's decision-making processes	To consider current arrangements for integrating health and wellbeing considerations within the Council's decision=making process.	Identified in June 2009

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

APPENDIX 2

Scrutiny Board (Health)

Inquiry into the role of the Council and its partners in reducing alcohol related harm

Draft Terms of reference

1.0 Introduction

1.1 The negative impacts associated with high levels of alcohol consumption have a national profile across the country, often receiving frequent attention from the national and local media.

1.2 Alcohol related harm can be measured in many ways, including short, medium and long-term health concerns; levels of crime, disorder and anti-social behaviour; and general economic loss.

1.3 In 2004, the number of deaths linked to alcohol across the Yorkshire and Humber region rose by more that 46% – the largest rise in the country. Alcohol consumption in Leeds is a particular concern with an estimated 155,000 adults drinking above the 'safe drinking' guidelines and an estimated 25,000 thought to be dependent. Alcohol related death rates are 45% higher in areas of high deprivation.

1.4 The annual cost of alcohol misuse in Leeds is estimated to be £275 million, of which £23 million is health related.

1.5 The reduction of alcohol related harm is a specific improvement priority within the Health and Well-being Partnership Plan[1] (2009-2012), supported by the Leeds Alcohol Strategy (2007-2010).

2.0 Scope of the inquiry

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

- The role of all partners in developing and delivering the targets associated with reducing alcohol related harm, as set out in the Leeds Health and Well-being Plan (2009-2012) and associated strategies.

- The role of the Council in terms of licensing policy and associated enforcement/ control procedures.
    - What is the role of the Council in licensing the sale of alcohol?
    - What are the Council's legislative powers in licensing the sale of alcohol? What scope is there for the Council to consider the health implications of alcohol consumption within its licensing role and function?
    - What is the role of the Director of Public Health in helping to inform the Council within its decision-making processes?

[1] This reflects the priorities set out in the Leeds Strategic Plan (2008-2011)

- The social responsibility role of breweries, retailers and licensees and how this shapes the consumption of alcohol in Leeds.
    - What are the social responsibilities of those organisations associated with the production and sale of alcohol, including its promotion and managed consumption across Leeds?
    - How is the consumption of alcohol promoted and managed by those responsible for its production and sale across Leeds?

- The role of the Council and its NHS health partners in:
    - Raising general public awareness of the health risks associated with alcohol consumption.
    - Identifying and targeting those groups most at risk from the affects of alcohol abuse and ensuring they have access to the most appropriate services and treatments.
    - Assessing the quality and effectiveness of services and treatments associated with reducing alcohol related harm.

2.2 The Board hopes that its findings will provide a timely and positive contribution to the management of change.

3.0 Comments of the relevant director and executive member

3.1 Comments received on these draft terms of reference will be reflected in the final version.

4.0 Timetable for the inquiry and submission of evidence

4.1 The inquiry will commence in October 2006 and is likely to take place over a number of sessions. Throughout the inquiry, the Board will consider any emerging issues to inform further sessions and/or the production of the final inquiry report.

4.3 The Board will aim to conclude the inquiry before April 2010, with the publication of a formal report setting out the Board's findings, conclusions and recommendations.

5.0 Witnesses

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

- Executive Board Member (Adult Health and Social Care)
- Healthier Leeds Partnership representatives (TBC)
- Director of Public Health (NHS Leeds)
- Head of Licensing and Registrations (Leeds City Council)
- Business Development Manager (Drug Action Team)
- Ministerial representative (TBC)
- Brewery representatives (TBC)
- Licensee representatives (TBC)
- Retailer (supermarket) representatives (TBC)
- Service provider representatives (alcohol services and treatments) (TBC)

6.0 Monitoring Arrangements

6.1 Following the completion of the scrutiny inquiry and the publication of the final inquiry report and recommendations, the implementation of the agreed recommendations will be monitored.

6.2 The final inquiry report will include information on the detailed arrangements for monitoring the implementation of recommendations.

7.0 Measures of success

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

7.2 The Board will look to publish practical recommendations.

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APPENDIX 3

INQUIRY SELECTION CRITERIA

Scrutiny Board **Health**

Inquiry Title **The role of the Council and Health Partners in reducing alcohol related harm**

Anticipated Start Date **October 2009**

Anticipated Finish Date **January / February 2010**

The Inquiry meets the following criteria

• It addresses the Council's agreed Strategic outcomes by reviewing the effectiveness of policy to achieve strategic outcomes as defined by the Council Corporate plan	✓
• Shaping and developing policy through influencing pre-policy discussion	✓
It fulfils a performance management function by	
• Reviewing performance of significant parts of service	
• Addressing a poor performing service	
• Addressing a high level of user dissatisfaction with the service	
• Addressing a pattern of budgetary overspends	
• Addressing matters raised by external auditors and inspectors	
• Addresses an issue of high public interest	
• Reviews a Major or Key Officer decision	
• Reviews an Executive Board decision	
• Reviews a series of decisions which have a significant impact	
• Has been requested by the Executive Board/Full Council/Overview and Scrutiny Committee	
• looks at innovative change	✓

Comments of relevant Director and Executive Member: *To be confirmed*

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