Public Document Pack

Leeds CITY COUNCIL

SCRUTINY BOARD (HEALTH)

Meeting to be held in Civic Hall, Leeds on
Tuesday, 20th October, 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;
D Hollingsworth	-	Burmantofts and Richmond Hill;
J Illingworth	-	Kirkstall;
M Iqbal	-	City and Hunslet;
G Kirkland	-	Otley and Yeadon;
A Lamb	-	Wetherby;
P Wadsworth	-	Roundhay;
L Yeadon	-	Kirkstall;

Co-opted Members

E Mack	-	Leeds Voice
Vacancy	-	Leeds LINk

Agenda compiled by:
Janet Pritchard
Governance Services
Civic Hall
LEEDS LS1 1UR
Telephone No: 247 4327

Principal Scrutiny Advisor:
Steven Courtney
Tel: 247 4707

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:- **No exempt items or information have been identified on this agenda.**	

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 22nd September 2009.	1 - 10
7			**SCRUTINY INQUIRY: THE ROLE OF THE COUNCIL AND ITS PARTNERS IN PROMOTING GOOD PUBLIC HEALTH (SESSION 1)** To consider a report of the Head of Scrutiny and Member Development in relation to the first session of the Scrutiny Board's inquiry that will consider the role of the Council and its partners in promoting good public health.	11 - 48
8			**UPDATED WORK PROGRAMME 2009/10** To consider the attached report of the Head of Scrutiny and Member Development presenting the Board's current outline work programme for the remainder of the current municipal year, for the Board to consider, amend and agree as appropriate.	49 - 108

Item No	Ward/Equal Opportunities	Item Not Open		Page No
9			**DATE AND TIME OF NEXT MEETING** To note that the next meeting of the Board will be held on 24th November 2009 at 10.00am with a pre-meeting for Board Members at 9.30am.	

SCRUTINY BOARD (HEALTH)

TUESDAY, 22ND SEPTEMBER, 2009

PRESENT: Councillor M Dobson in the Chair

Councillors S Bentley, J Chapman,
D Congreve, D Hollingsworth, J Illingworth,
G Kirkland and A Lamb

CO-OPTEE: E Mack

24 Chair's Welcome

The Chair welcomed everyone to the September meeting, and particularly Councillor Hollingsworth who was attending for the first time as he had recently been appointed to the Board in place of Councillor Rhodes-Clayton.

The Chair also welcomed as an observer Tracy Wallis, Scrutiny Officer for the City of York.

25 Declarations of Interest

Councillor Dobson declared a personal interest in respect of Agenda Item 8 'KPMG Health Inequalities Report' (Minute No. 29 refers) in his capacity as a member of Leeds Initiative - Healthy Leeds Partnership.

(Councillor Kirkland declared a personal interest later in the meeting under Minute No. 28.)

26 Apologies for Absence

Apologies for absence were submitted on behalf of Councillors Yeadon, Iqbal and Wadsworth. The Chair advised that Councillor Wadsworth had been recently appointed to the Board in place of Councillor Latty.

27 Minutes of the Previous Meeting

The Minutes were agreed as a correct record although it was noted that one Member of the Board did not consider that the minutes reflected the depth of concern that Members felt with regard to the provision of renal services in Leeds.

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

28 Update on local NHS priorities

The Head of Scrutiny and Member Development submitted a report outlining for Members previously identified priority areas for each local NHS Trust for the current year and explaining that each of the Trusts had been invited to attend the meeting to provide an update on progress against these priority areas.

The following representatives from local NHS Trusts were welcomed to the meeting:

- Beverley Bryant (Executive Director of Performance, Improvement and Delivery) – NHS Leeds, and
- Chris Butler (Chief Executive) – Leeds Partnerships NHS Foundation Trust (LPFT).

Sylvia Craven (Director of Planning) – Leeds Teaching Hospitals NHS Trust (LTHT) joined the meeting later during the consideration of this item.

The representatives reported on progress against the key issues and priorities as outlined in the report and responded to queries and comments from the Board.

In brief summary, the issues raised with the Executive Director of Performance, Improvement and Delivery (NHS Leeds) were:

- **Exercising Choice - concern was expressed by Members that the choice element had been removed for patients where services were being concentrated in one centre:**
  Members were advised that it was recognised that it was necessary to have an open debate with the public as to where services were to be placed.
- **Dentistry Services – approval was expressed that there were proposals to increase the number of NHS dentists but concern that the Trust was putting obstacles in the way of a particular group of dentists who were trying to set up a practice in Otley:**
  Officers could not comment on the specific example given but Members were advised that although many dentists left the NHS in 2006, they were now returning from private practice. Contracts had gone out to tender and it was important to ensure equity in the contracts. The north west of the city had experienced particular problems but a Helpline had been set up to assist patients find an NHS dentist.
- **Dentistry services and short-term contracts:**
  Members were advised that an additional 28,000 NHS dental places for patients had been secured. 20,000 of these were permanent places and 8,000 were short-term places. It was intended to convert the short-term places to permanent arrangements through either current or alternative providers. It was agreed to establish whether patients of dentists working under short-term arrangements would be told of the potential short-term nature of their place and provide this information to the Board.
- **Dentistry and disabled access:**
  With regard to disabled access to practices being a condition in the new contracts, Members were advised that it was a requirement that any new dentist premises met the minimum standards. It was not known however

how may existing practices were fully compliant with DDA legislation and officers agreed to provide this information to the Board.

- **Patient Choice of three GP Practices and how this might impact on hospital admissions:**
  Members were advised that it was believed that choice of GP was an important right for the individual. Accident and Emergency services were under pressure and it was hoped that the new system of choice would increase the number of GP home visits rather than patients having to telephone for an ambulance. NHS Leeds monitored GP performance and those practices that were not performing well were given help to improve.
- **Sexual Health and Teenage Conception:**
  Members were advised that there was a large public health team which focused on help and prevention. There was a city-wide team but it was found that the best results were achieved when specific areas were targeted. Mobile phone technology and the internet were being used to reach young people, as well as attendance at specific events, for example the Leeds Festival.
- **Partnership work between NHS Leeds and LCC:**
  Members were advised that the partnership worked well but could always be improved on.
- **Public Health Reports:**
  It was agreed to supply a copy of the Director of Public Health's latest Annual Report to each Member of the Board.

The issues raised with the Chief Executive – Leeds Partnerships NHS Foundation Trust were in brief summary:

- **Concern with regard to facilities for patients that suffered from mental and physical problems:**
  Members were advised that there were services available for these patients in Ward 40 at the LGI but it was recognised that improvements could be made, particularly for younger people who suffered from dementia, as these services were currently structured towards older people. Work was also ongoing to improve access for those with physical disabilities to mental health services.
- **Patient Safety:**
  Members were advised that all three buildings where there had previously been concerns over fire safety had recently been through a fire safety audit by the fire service and the report was awaited. However the Chief Executive was confident that fire safety provision was as it should be.
- **Health Fair at Pudsey Civic Centre:**
  Members were informed that the event was well attended by people with learning disabilities.

Sylvia Craven, (Director of Planning) – Leeds Teaching Hospitals NHS Trust, was welcomed to the meeting and offered to deliver a longer presentation to the Board at a later date on the issues that faced the Trust.

After updating the Board on the key issues for the LTHT, Members raised, in brief summary, the following issues:

- **More productive bed space and the management of C. difficile and MRSA:**
  It was confirmed that there was an integrated programme across the Trust that would lead to better patient care. The management of C. difficile and MRSA were linked to bed space, as any patient contracting the infections would have to stay longer in hospital. Members were also assured that although bed space would be reduced as services improved, patient care would not be compromised and the Trust would be able to treat more patients.
- **Theatre efficiency – operations being cancelled due to the unavailability of surgeons:**
  Members were assured that this was not a problem in Leeds. Operations however could be cancelled due to a variety of other reasons and the Trust were seeking to minimise these.
- **Missed appointments:**
  Members were advised that 'Did Not Attend' rates were improving and the Trust acknowledged the need to work in partnership with patients to reduce the figures.

The Chair thanked the officers from the NHS Trusts for attending and for their comprehensive reports.

RESOLVED –

(a) That the report and presentations from each of the local NHS Trusts be noted.

(b) That the following information be provided to Members by the Executive Director of Performance, Improvement and Delivery – NHS Leeds:
- Whether patients of dentists on short-term NHS contracts were being told of the potential short-term nature of their place.
- How many existing dental practices were fully compliant with DDA legislation.
- A copy of the Director of Public Health's latest Annual Report.

(NB: Councillor Kirkland declared a personal interest during the consideration of this item as the premises referred to in the discussions on dentistry provision were next door to his home.)

(Note: Councillor Lamb joined the meeting at 11.05am during the consideration of this item and Mr Mack left the meeting at 11.25am at the conclusion of this item.)

29 KPMG Health Inequalities Report

The Head of Scrutiny and Member Development submitted a report presenting Members with the KPMG report on Health Inequalities (June 2009) which provided an assessment of how the Council and NHS Leeds were addressing health inequalities across the city. Also attached was the report of the Director of Adult Social Services to the Corporate Governance and Audit

Committee (29th July 2009) which included the response to the recommendations contained within the KPMG report.

The Chair welcomed the following officers to address any questions identified by the Board:

- John England (Deputy Director – Partnerships and Organisational Effectiveness) – Leeds City Council, Adult Social Services, and
- Brenda Fullard (Head of Healthy Living and Inequalities) – NHS Leeds.

Members were advised that Leeds City Council and NHS Leeds were working together on a detailed action plan to address the recommendations made in the KPMG report and this would be presented to the Executive Board in December 2009.

Officers advised the Board of the key issues brought out in the annual Public Health Report and the challenges that faced the Council and NHS Leeds to reduce health inequalities. These were in brief:

- Reducing smoking levels.
- Locality commissioning.
- A programme management approach relating to:
  - Increasing the number of people coming through GP surgeries for health checks,
  - Infant mortality,
  - Excessive winter deaths,
  - Healthy living services.
- Joint working and a partnership approach to reducing cardiovascular deaths and levels of obesity.
- Reducing alcohol related hospital admissions.
- Maintaining investments with the voluntary sector as an interface between services and disadvantaged groups.
- Strengthening the need for staff to be accountable for delivering targets.
- Encouraging hard to reach groups to access services.
- Considering the impact of the recession on health and well being across the City.

Officers also advised that it was a relatively short period of time that health inequalities had been included on the Council agenda but inroads were being made in terms of Council services recognising the contribution that they could make to address these issues.

In brief summary, the main issues raised by Members were:

- That health inequalities were a manifestation of other inequalities in society.
- Alcohol excess and promotions - the restrictions that local authorities had in terms of licensing laws and the need to press the Government for change.
  Members were advised that it was an infringement of a bar's license if their staff served alcohol to people that were already drunk.
- High levels of obesity.

- Air pollutants eg high pollen and sulphur dioxide levels created under certain weather conditions which resulted in hospital admissions due to respiratory problems.
- Recreation provision in the inner city - the importance of protecting playing fields and ensuring that planning regulations and legislation were robust.
- Addressing the life expectancy gap between the highest area of the city (Adel and Wharfedale) and the lowest (City and Hunslet):
  – the affects of pollution from the many major roads and motorways in the south of the city on people suffering from respiratory problems,
  – the proposed closure by the Council of facilities in the south of the city such as the sports centre and a day centre, which would seem at conflict with the health needs of people in that area.
- Drugs.
  Members were advised that officers had recently agreed to revitalise and update the drug misuse strategy and that consultation had started on the content.
- Greater investment required in the third sector and hard to reach people – that good practice should be rolled out across the city and not just limited to the south of the city.
- Weight loss summer camp run by Carnegie Weight Management in Leeds – Concern that Leeds did not send children to this camp but other authorities did.

The Chair referred Members of the Board to the proposed Inquiry into the role of the Council and its partners in promoting good public health, the draft terms of reference of which were attached as Appendix 1 to the Report on the Updated Work Programme later on in the agenda and where the above issues would be scrutinised if Members agreed to hold this revised Inquiry.

RESOLVED –

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

(b) That the issues be further scrutinised in the Board's proposed Inquiry into the role of the Council and its partners in promoting good public health, subject to Members agreeing to hold this Inquiry and agreeing the terms of reference (see Minute No. 32).

30 Joint Performance Report: Quarter 1 - 2009/10

The Head of Scrutiny and Member Development submitted a joint report from NHS Leeds and Leeds City Council providing an overview of progress against key improvement priorities and performance indicators relevant to the Board at Quarter 1, 2009/10.

The following officers were welcomed to the meeting to address any specific questions identified by the Board:

- Graham Brown (Performance Manager) – NHS Leeds, and
- John England (Deputy Director – Partnerships and Organisational Effectiveness) – Leeds City Council, Adult Social Services.

The issue of concerns regarding the data quality of NI 70 (Reduce emergency hospital admissions caused by injury to children) was raised by Members. Members were advised that this was a fairly new indicator and the data was to be available via the central Government Data Hub, but it had not been made available when it was promised.

The Board agreed to ask the Director of Children's Services to respond to the Board's concerns on the quality of the data of NI 70.

RESOLVED –

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

(b) That the Director of Children's Services be requested to respond to the Board's concerns to the quality of the data of NI 70: Reduce emergency hospital admissions caused by injury to children.

31 Scrutiny Inquiry: Improving Sexual Health Among Young People - response to recommendations

The Head of Scrutiny and Member Development submitted a report attaching the formal response by the Director of Children's Services to the Executive Board on 22nd July 2009 to the recommendations presented in the Scrutiny Inquiry report: 'Improving Sexual Health Among Young People (April 2009)'.

Also attached to the report was the Ministerial Report presenting the outcome of the March 2009 review by the Teenage Pregnancy National Support Team.

Steven Courtney, Principal Scrutiny Advisor, advised Members that the Executive Board approved the proposed responses to the previous Scrutiny Board (Health)'s recommendations, as contained within the report of the Director of Children's Services and that the progress of each recommendation would be monitored in future quarterly recommendation tracking reports to the Board.

The following Officers were welcomed to the meeting to respond to any questions identified by the Board:

- Paul Bollom, Priority Outcome Commissioner (Leeds City Council, Children's Services), and
- Keira Swift, Teenage Pregnancy Co-ordinator (Leeds City Council, Children's Services).

In brief summary, Members raised the following issues:

- That YSHAG (Young Sexual Health Action Group) should be consulted on the response – The Chair referred to the proposed inquiry into the role of the Council and its partners in promoting good public health which was to be considered under the next agenda item and where under Session 1 it was proposed to consider issues associated with improving sexual health and reducing the level of teenage pregnancies.
  The Priority Outcome Commissioner advised that his was a new post and assured the Board that young people would be involved in setting up strategic commissioning.

The Teenage Pregnancy Co-ordinator advised that workshops had been held recently which had proved very useful.

- Teenage Pregnancy – Concern was expressed that this data (NI 112: Teenage pregnancy rates) was 18 months out of date, that it was therefore difficult to monitor progress and that the targets should be challenged as unachievable.
  Members were also keen that officers should adopt the good practice of other local authorities such as Derby, which had greatly reduced teenage pregnancy rates.
  Officers advised that it was a national target to reduce teenage pregnancy rates to 22.7 per 1,000 girls aged 15 to 17 by 2010 and agreed that it was worth investigating national as well as European best practice to reduce rates.

RESOLVED –

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

(b) That the issues raised above be further scrutinised in the Board's proposed Inquiry into the role of the Council and its partners in promoting good public health, subject to Members agreeing to hold this Inquiry and agreeing the terms of reference (see Minute No. 32).

32 Work Programme

The Head of Scrutiny and Member Development submitted a report presenting an outline work programme for the Board to consider, amend and agree as appropriate.

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

- Draft Terms of Reference for a Scrutiny Board (Health) Inquiry into the role of the Council and its partners in promoting good public health (Appendix 1 refers) with the associated inquiry selection criteria pro-forma (Appendix 2).
- Scrutiny Board (Health) - Draft Work Programme 2009/2010 (Appendix 3).
- Scrutiny Board (Health) – Health Proposals Working Group Terms of Reference (Appendix 4).
- Minutes of the Executive Board meetings held on 22nd July and 26th August 2009 (Appendices 5 and 6).

The Chair advised Members that the Board were being requested to reconsider their decision at their meeting on 30th June 2009 not to re-establish the Health Proposals Working Group. The was due to subsequent discussions with officials at NHS Leeds revealing the degree to which the working group had provided a useful vehicle to keep members of the Scrutiny Board appraised of developments across local NHS Trusts. As such, the previously proposed terms of reference were attached to the report for Members' reconsideration.

Following discussion, Members agreed to reinstate the Health Proposals Working Group. With regard to membership of the working group, it was

agreed that there would be a core membership of Councillors Dobson and Chapman and that all other members of the Board would attend whenever possible.

With reference to the Executive Board Minutes of 26th August 2009 and the Council's proposal to establish barbecue areas on Woodhouse Moor, a Member of the Scrutiny Board raised the issue of whether respiratory conditions were affected by barbecue smoke.

Following discussion it was agreed to seek advice from NHS Leeds regarding the impact of air pollutants, such as barbecue smoke and emissions caused by road traffic and power stations, on people with respiratory difficulties.

RESOLVED –

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

(b) That the draft terms of reference for the Inquiry into the role of the Council and its partners in promoting good public health (Appendix 1) and the associated inquiry selection criteria pro-forma (Appendix 2) be agreed in lieu of the previously agreed terms of reference for a scrutiny inquiry solely around alcohol related harm.

(c) That the outline work programme, as attached at Appendix 3 to the report, be agreed.

(d) That the Health Proposals Working Group be re-established in line with the draft terms of reference as attached at Appendix 4 to the report, and that there would be a core membership of Councillors Dobson and Chapman, with other Members of the Board attending whenever possible.

(e) That NHS Leeds be requested to provide advice on the impact of air pollutants, such as barbecue smoke and emissions caused by road traffic and power stations, on people with respiratory difficulties, in order for the Board to determine whether this issue required scrutiny.

33 Date and Time of Next Meeting

Noted that the next meeting of the Board would be held on Tuesday 20th October 2009 at 10.00am, with a pre-meeting for Board Members at 9.30am.

The meeting concluded at 12.40pm.

This page is intentionally left blank

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 20 October 2009

Subject: Scrutiny Inquiry: The role of the Council and its partners in promoting good public health (Session 1)

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 introduce the first session of the Scrutiny Board's inquiry that will consider the role of the Council and its partners in promoting good public health.

2.0 Background

2.1 At its previous meeting (22 September 2009), the Scrutiny Board (Health) agreed terms of reference for the above inquiry. In this regard, the Board agreed to consider arrangements relating to four specific areas of public health, namely:

- Improving sexual health and reducing the level of teenage pregnancies;
- Reversing the rise in levels of obesity and promoting an increase in the levels of physical activity;
- Promoting responsible alcohol consumption; and,
- Reducing the level of smoking;

2.2 In considering the promotion of good public health, the overall purpose of the inquiry is to make an assessment of the role of all partners in developing, supporting and delivering targets associated with improving specific aspects of public health.

3.0 Health and Wellbeing

3.1 Health and wellbeing is one of eight key themes within the Leeds Strategic Plan (2008-2011), with reducing teenage conception and improving sexual health being a specific improvement priority.

3.2 The recently agreed Health and Wellbeing Partnership Plan (2009 – 2012) is part of the broader Leeds Strategic Plan, and is based on the outcomes and priorities agreed by the Council and its partners and shaped by local people.

3.3 The Health and Wellbeing Partnership Plan (2009 – 2012) concentrates on the main high level actions necessary to help deliver the agreed strategic outcomes and priorities. These high level actions are detailed in the attached action plan for the improvement priorities (Appendix 1).

Reducing teenage conception and improving sexual health

3.4 Actions associated with reducing teenage conception and improving sexual health are detailed in action plan number 5. Within the action plan, four other key and related strategies are identified – the main two being:

- Teenage pregnancy and parenthood strategy (2008 – 2011) – attached at Appendix 2; and,
- Sexual health strategy (2009 – 2014) – identified as 'under development'.

3.5 To help members of the Scrutiny Board consider this particular aspect of its inquiry, relevant officers from the Council and NHS Leeds have been invited to attend the meeting.

Previous Scrutiny Inquiry

3.6 Members will recall that during the previous municipal year (2008/09), the Scrutiny Board (Health) conducted an inquiry into improving sexual health among young people. The Scrutiny Board concluded its inquiry and agreed its inquiry report in April 2009, setting out its conclusions and recommendations.

3.7 At its previous meeting, on 22 September 2009, the Scrutiny Board (Health) was presented with the agreed response to the recommendations identified during the previous inquiry, alongside a ministerial report arising from a review by the Teenage Pregnancy National Support Team (TPNST), undertaken in March 2009.

3.8 Members are reminded that, as a matter of routine, recommendations arising from inquiries are incorporated into the quarterly recommendation tracking reports. These reports help the Scrutiny Board to monitor and review progress against previous recommendations. The next recommendation tracking report is scheduled for the meeting in December 2009.

4.0 Recommendations

4.1 Members are asked to consider the details presented in this report and discussed at the meeting and:

(i) Identify any specific areas/ issues to be included in the Board's scrutiny inquiry report; and,

(ii) Determine any specific matters where additional information may be required and/or where further scrutiny may be needed.

5.0 Background Documents

Leeds Strategic Plan (2008 – 2011)

Scrutiny Inquiry: The role of the Council and its partners in promoting good public health – Terms of reference (agreed 22 September 2009)
Scrutiny Board (Health) – Inquiry Report: *Improving Sexual Health Among Young People* (April 2009)
Scrutiny Inquiry: Improving Sexual Health Among Young People – response to recommendations – report to the Scrutiny Board (Health) – 22 September 2009

This page is intentionally left blank

Improvement Priorities

Improvement priorities

The agreed improvement priorities for health and wellbeing are:

1. Reduce premature mortality in the most deprived areas.
2. Reduce the number of people who smoke.
3. Reduce alcohol related harm.
4. Reduce rate of increase in obesity and raise physical activity for all.
5. Reduce teenage conception and improve sexual health.
6. Improve the assessment and care management of children, families and vulnerable adults.
7. Improve psychological, mental health, and learning disability services for those who need them.
8. Increase the number of vulnerable people helped to live at home.
9. Increase the proportion of people in receipt of community services enjoying choice and control over their daily lives.
10. Improve safeguarding arrangements for vulnerable children and adults through better information, recognition and response to risk.

Notes

For each improvement priority the attached table gives the following information:

- the jointly accountable directors, the key partnerships, strategic leads and the related strategies;
- the national indicators and targets together with the measures of success that are being used;
- an overview of the main areas for action over the next three years. This is not intended to duplicate the detailed individual strategies and action plans which are signposted so that further details can be found.

These action plans will inform the performance management process for the Leeds Strategic Plan. The action plans and outcomes will be reviewed and updated annually. Following a preliminary Equality Impact Assessment in April 2009, further work will be undertaken to define issues and actions for the different equality strands (race, gender, disability, sexual orientation, age, religion or belief.) This process will be informed by continuous self-assessment and developments will be formally included in the annual refresh.

1. Reduce premature mortality in the most deprived areas

Accountable Directors and Key Partnerships	Lead and contributing partners
Ian Cameron / Sandie Keene Healthy Leeds Joint Strategic Commissioning Board – Promoting Health and Wellbeing Subgroup **Rosemary Archer/Sarah Sinclair** Children Leeds Integrated Strategic Commissioning Board	**NHS Leeds** Leeds City Council Leeds Partnership Foundation NHS Trust Leeds Teaching Hospitals NHS Trust VCF sector through Leeds Voice Health Forum Natural England West Yorkshire Fire and Rescue Service
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Brenda Fullard, NHS Leeds John England, Leeds City Council Sharon Yellin, NHS Leeds	**Infant Mortality Action Plan 2009** **Leeds The Leeds Children and Young People's Plan 2009 to 2014** **Leeds Tobacco Control Strategy 2006 to 2010** **Food Matters: a food strategy for Leeds 2006 to 2010** **Active Leeds : a physical activity strategy 2008 to 2012** **Accident Prevention Framework 2008 to 2011** **Older Better 2006 to 2011** **Alcohol Strategy 2007 to 2010** **Self Care Strategy 2009** Leeds Housing Strategy 2009 to 2012 Leeds Affordable Warmth Strategy 2007 to 2016 Leeds Financial Inclusion Project

1. Reduce premature mortality in the most deprived areas

Indicators and targets	Measures of success
NI 120 All Age All Cause Mortality rate per 100,000 Disaggregated to narrow the gap between 10% most deprived SOAs and all of Leeds) **Baseline 2001 -2003** *(for population living in 10% most deprived SOAs)* Men Women 1178 692 **3 year target trajectory for 2010 -2012** *(for population living in 10% most deprived SOAs)* Men Women 918 602 *For Leeds as a whole* Men Women 662 463 Citywide target 472 per 100,000 **NI 121 Mortality rate from circulatory diseases at ages under 75 (per 100,000 population)** Baseline 145 per 100,000 population (1995-7) Target 69.3 per 100,000 population (2010-11)	• Further reduction in the proportion of children living in poverty • 1200 families in fuel poverty will have been referred into a programme for improving warmth in their home • Wider availability of quality, affordable housing • Clear city wide framework for development in place and clear expectations for community provision fulfilled in deprived areas. • Improved learning outcomes and skill levels • More engaged and informed better designed programmes **By 2013 in Leeds as a whole:** • 603 people will have been prevented from having an early death • The infant mortality rate will have been reduced from 8 deaths per 1000 to 7 per 1000 • 75,000 women will have been screened for breast cancer. • All women in Leeds will be receiving cervical screening results in 14 days • We will have reduced the number of people under 75 dying from Cardio Vascular Disease by 269 • 349,000 People aged over 40 will have had a vascular check of whom 70,000 People will receive clinical interventions to reduce their risk of becoming unwell **By 2013 in the most deprived areas of Leeds** • 344 people will have been prevented from having an early death • 147 lives will be saved from people under 75 dying from cancer • 109,000 people aged over 40 will have had a vascular check of whom 22,000 will receive clinical interventions to reduce their risk of becoming unwell • We will have prevented 157 people under the age of 75 from dying prematurely from Cardio Vascular Disease **In the most deprived areas of Leeds** • increased percentage of people who are successful in achieving lifestyle behaviour changes (weight management/healthy eating/ smoking cessation/alcohol harm reduction/increased physical activity) • increased percentage of people who engage with local processes and feel they can influence decisions in their locality • environment created for a thriving third sector

1. Reduce premature mortality in the most deprived areas

High Level Actions 2009 - 2012

Influences on health:

- Develop and expand our programme of work on key influences on health such as housing, low income, skills and employment, transport system and the availability of facilities for people to be active.
- Issue a revised housing strategy aimed at creating opportunities for people to live independently in quality and affordable housing.
- Implement fuel poverty action plan and co-ordinate other winter deaths initiatives.
- Promote financial inclusion adapted to the effects of recession.
- Develop a strategic Child Poverty action plan delivering a range of coordinated services to enable families to move out of poverty.
- Improve access to quality early years resources.
- Improve educational achievement for children and young people in disadvantaged areas and from vulnerable groups.
- Complete Planning Policy Guidance 17 - 'Planning for open space, sport and recreation' assessment, ensuring that gaps in provision are identified and appropriate standards for new facilities are implemented.

Lives people lead:

- Action on key behaviour changes which have a high impact on life expectancy; these to include providing systematic brief interventions; marketing materials and peer / community engagement.
- Develop work around smoking, targeted at the worst 10% deprived neighbourhoods *(see Improvement Priority 2)*.
- A targeted programme of work around alcohol *(see Improvement Priority 3)*
- Programmes addressing obesity, physical activity and healthy eating *(see Improvement Priority 4)*.
- Promote Healthy Ageing with the direct involvement of older people.

Services people use:

- Develop Healthy Living services within neighbourhoods (weight management/smoking cessation/alcohol brief interventions/health trainers) and broader poverty/well being services.
- Implement a comprehensive social marketing approach to Putting Prevention First (vascular check for those between 40-75).
- Interventions to target circulatory diseases including increasing the number of smoking quitters and improved blood pressure and cholesterol control.
- Develop an action plan to ensure equitable access to primary care services for vulnerable groups.
- Work with Practice Based Commissioning to ensure these high impact interventions happen in the 10% most deprived neighbourhoods.
- Implement the Self Care Framework to ensure that individuals are enabled, empowered and supported to self care and that professionals have the relevant knowledge and expertise to promote and deliver self care approaches.
- Develop a programme of initiatives at LTHT in order to utilise that setting to address issues around alcohol, smoking and weight management, and to ensure the equitable provision of CHD, cancer and respiratory care secondary services.
- Develop targeted cancer programmes and increase uptake and awareness in areas of low uptake, high deprivation and within vulnerable groups.
- Implement the Leeds Strategic Maternity Matters and Infant Mortality Action Plans and associated initiatives.

Community development and involvement:

- Develop local infrastructures where partners engage with residents, particularly those 'seldom seen, seldom heard' in services.
- Involve communities, groups and individuals in the preparation and, when appropriate, delivery of health improvement programmes.
- Improve health literacy and provide motivation and support for appropriate health-seeking behaviour.
- Support growth and development of quality local services and community development by the Voluntary, Community & Faith sector.

2. Reduce the number of people who smoke

Accountable Directors and Key Partnerships	Lead and contributing partners
Ian Cameron / Sandie Keene Healthy Leeds Joint Strategic Commissioning Board – Promoting Health and Wellbeing Subgroup	**NHS Leeds** Leeds City Council Leeds Partnership Foundation NHS Trust Leeds Teaching Hospitals NHS Trust VCF sector through Leeds Voice Health Forum
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Brenda Fullard, NHS Leeds John England, Leeds City Council	**Leeds Tobacco Control Strategy 2006 to 2010** **The Leeds Children and Young People's Plan 2009 to 2014** **Infant Mortality Action Plan 2009**

2. Reduce the number of people who smoke

Indicators and targets	Measures of success
NI 123 Stopping smoking (target disaggregated to narrow the gap between 10% most deprived SOAs and the rest of Leeds)	• contribute to the overall reduction in adult and infant mortality rates and to increasing life expectancy by - helping 22,000 people to stop smoking by 2013 - Protecting non-smokers
Baseline (2004) 31% smokers in the Leeds population	• Increase in the rate of smoking cessation in women of child bearing age • Reduce smoking in pregnancy rate by 2 percentage points by 2010 • Increase in the rate of prisoners who quit smoking with NHS Stop Smoking Services in the prison setting
Target (2010-11) 21% smokers in the Leeds population 27% smokers in 10% most deprived SOAs	• By 2013 in practices with 30% or more of their population living in the 10% most deprived SOAs: 7% of registered smokers will be referred to smoking services per year
Vital signs VSB05 4 weeks smoking quitters who attended NHS Stop Smoking Services.	• There will be community based healthy living programmes and activities available in the 50% of the 10% SOAs by 2013
Target 2010/11 4345 people stopping smoking with NHS Stop Smoking Services	

2. Reduce the number of people who smoke

High Level Actions 2009 - 2012

Influences on health:

- Make sure that local capacity for delivery of the tobacco programme and tobacco control is strengthened and sustained.
- Maintain compliance across the city with smoke free legislation.
- Maintain and promote smoke free environments not included within the boundaries of smoke free legislation.
- Contribute to, and develop, local response to national and regional media campaigns to promote all elements of tobacco control work including: access to support for smoking cessation, promotion of smoke free homes and campaigns to reduce the availability of smuggled and illicit tobacco products.
- Gather and use comprehensive data (e.g. prevalence among the general population, specific target groups such as pregnant women and access to smoking cessation services) to inform tobacco control and commissioning of smoking cessation services.

Lives people lead:

- Review the schools pilot programme to reduce uptake of smoking amongst teenagers, further develop if necessary and deliver particularly in the most deprived areas.
- Deliver high impact actions to reduce smoking before, during and after pregnancy, including:
  - Promoting smoking cessation to women of child bearing age and link with the city wide infant mortality action programme.
  - Reaching pregnant smokers as soon as possible and throughout pregnancy.
  - Supporting pregnant women to stop smoking throughout pregnancy.
- Explore the feasibility of extending smoke free to public areas.
- Further extend the Smoke Free Homes Project, particularly in the most disadvantaged areas.

Services people use:

- Commission further smoking cessation services in new settings to increase the accessibility of services including: hospitals, workplaces and prisons.
- Focus the specialist element of services in the most deprived communities.
- Review current stop smoking services for specific groups e.g. South Asian Communities, pregnant women and consider recommendations for further development.
- Work with health care professionals to ensure the issue of smoking is raised in a systematic and routine manner and effective referral pathways are developed and maintained.

Community development and involvement:

- Develop work with communities around reducing accessibility to tobacco products and particularly counterfeit and smuggled tobacco products.
- Commission Voluntary, Community and Faith sector to deliver Healthy Living Activity that includes signposting to smoking cessation support and the provision of activities to support behaviour change.
- Engage service users and potential service users in the development of community based delivery of smoking cessation interventions.

3. Reduce alcohol related harm

Accountable Directors and Key Partnerships	Lead and contributing partners
Ian Cameron / Sandie Keene / Neil Evans Healthy Leeds Joint Strategic Commissioning Board – Promoting Health and Wellbeing Subgroup Safer Leeds/ Healthy Leeds Alcohol Board	**NHS Leeds** Leeds City Council Leeds Partnership Foundation NHS Trust Leeds Teaching Hospitals NHS Trust Voluntary, Community and Faith sector through Leeds Voice Health Forum
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Brenda Fullard, NHS Leeds John England, Leeds City Council Jim Willson, Leeds City Council	**Leeds Alcohol Strategy 2007 to 2010** **Safer Leeds Partnership Plan 2008 to2011** The Leeds Children and Young People's Plan 2009 to 2014

3. Reduce alcohol related harm

Indicators and targets	Measures of success
NI 39 Hospital admissions for alcohol related harm Reduce the increase in the rate of alcohol-related hospital admission by at least 1% per year	• Reduced economic loss due to alcohol • Increased understanding of the culture of alcohol use across the population of Leeds • Reduced number of prisoners needing alcohol detoxification programmes in prisons • Fewer people will perceive drunk and rowdy behaviour to be a problem • Reduced alcohol-related harm experience among children, young people and families • Reduction in alcohol-related crime and disorder and hospital admissions

3. Reduce alcohol related harm

High Level Actions 2009 - 2012

Influences on health:

- Reduce the rate of alcohol related crime and disorder, anti-social behaviour and domestic abuse.
- Promote responsible management of licensed premises through effective implementation of the Licensing Act 2003 and encourage the licensing authority to consider safeguarding issues for children and young people.
- To have data in place that will be able to demonstrate:
  - the alcohol related recorded violent crime;
  - the percentage of cases where alcohol use is linked to offending;
  - the percentage of domestic violence where alcohol is a contributing factor;
  - the use of alcohol in young people aged under 18; and
  - the rate of alcohol- specific hospital admissions in under 18s.
- Tackle domestic violence linked to the misuse of alcohol.

Lives people lead:

- Improve the quality of, and have a consistent approach to, alcohol education provision in school and non-educational settings.
- Enable parents and carers to discuss the issue of alcohol consumption with their children.
- Target vulnerable children (i.e. those excluded from school) and work with youth services.
- Ensure that support is available, in terms of housing, to those who misuse alcohol.
- Develop a communication plan about alcohol so that the population of Leeds can make informed choices about their alcohol use and shift attitudes to harmful drinking.
- Target high-risk health settings, such as primary care, A&E departments, mental health settings, sexual health settings, maternity services and older people's services.
- Provide individuals who want, or need, to reduce their alcohol consumption with self-help guides.
- Promote activity and policy change towards reducing the promotion, accessibility and availability of alcohol.
- Implement the National Youth Alcohol Action plan.

Services people use:

- Promote a model of prevention which fully addresses alcohol issues throughout the education system.
- Increase the number of staff working in health, social care, criminal justice, community and the voluntary sector who are trained to identify alcohol misuse and offer brief advice.
- Develop strategies for prisoners in Leeds district with alcohol related problems.
- Develop a programme of activities to reduce the level of alcohol related health problems, including alcohol related injuries and accidents, and to improve facilities for treatment and support.
- Ensure that a co-ordinated, stepped programme of treatment services for people with alcohol problems is effective, appropriate and accessible, with adequate capacity to meet demand, following the 4 tiered framework from Models of Care for Alcohol Misusers
- Increase in the number of high risk groups (offenders, people with mental health conditions, people admitted to A&E and/or hospital with alcohol-related disease) who are assessed, offered brief interventions and where appropriate referred to alcohol treatment services.
- Have a well informed workforce equipped to provide information on the effects of substance misuse, including smoking.

Community development and involvement:

- Develop work with communities around reducing promotion and accessibility of alcohol products.
- Develop the young people led alcohol minimisation action plan.
- Ensure commissioning of Voluntary, Community and Faith sector around healthy living activity includes signposting to services that support reduction in alcohol harm and the provision of activities to support behaviour change.
- Engage service users and potential service users in the developing community based delivery of alcohol treatment interventions.

4. Reduce rate of increase in obesity and raise physical activity for all

Accountable Directors and Key Partnerships	Lead and contributing partners
Rosemary Archer Children Leeds Integrated Strategic Commissioning Board **Ian Cameron / Sandie Keene** Healthy Leeds Joint Strategic Commissioning Board – Promoting Health and Wellbeing Subgroup	**Leeds City Council** Children Leeds Partners NHS Leeds Sport England Education Leeds Youth Sports Trust VCFS Sector
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Sarah Sinclair, NHS Leeds/ Leeds City Council John England, Leeds City Council Brenda Fullard, NHS Leeds	**Active Leeds : a Healthy City 2008 to 2012** **Taking the Lead: strategy for sport and active recreation in Leeds 2006 to 2012** **Food Matters: a food strategy for Leeds 2006 to 2010** **Leeds Childhood Obesity Strategy 2001 2016** **Adult Obesity Strategy (in preparation)** **Leeds School Meals Strategy Jan 2007** **The Leeds Children and Young People's Plan 2009 to 2014** Local and West Yorkshire Transport Plans & Cycling Strategy Parks and Green Space Strategy 2009 Leeds Play Strategy 2007 Older Better 2006 to 2011

4. Reduce rate of increase in obesity and raise physical activity for all

Indicators and targets	Measures of success
NI 57 Children and young people's participation in high quality PE and sport Baseline 91% 2007/08 Target 93% 2009/10' **NI 8** Adult participation in sport and active recreation Baseline 20.6% 2005/06 Target 21.6% March 2011	• Halt, by 2010 (from the 2002-04 baseline) the year-on-year increase in obesity among children under 11 • Reduce rate of increase in obesity in adults • More children eating healthily and participating in play, cultural activities and quality physical exercise programmes • More people of all ages participating in walking, cycling and general activities • Increase in the number of disabled people accessing sport and active recreation programmes • Improved uptake of quality sport and active recreation opportunities including those provided by provided by Leeds City Council Sport and Active Recreation Service, • Increased number of people who have an average consumption of a variety of fruit and vegetables of at least five portions per day • More mothers breastfeeding (2% annual increase) • Systematic health checks are provided in primary care for childhood and adult obesity linking to interventions provided by a variety of providers • Increase in accessible weight management services, targeted to those already obese and most at risk • More people (including older people and disabled people) taking up healthy living opportunities in care programmes or self-directed care • Developed programmes to increase physical activity levels in priority areas

4. Reduce rate of increase in obesity and raise physical activity for all

High Level Actions 2009 - 2012

Influences on health:

- Ensure that planning for the built environment, green spaces and transport encourage a more active lifestyle, complemented by attention to disability issues and to safety.
- Introduce flexibilities in planning arrangements and urban design to manage the proliferation of fast food outlets and tackle issues of poor food access.
- Complete Planning Policy Guidance 17 - 'Planning for open space, sport and recreation' assessment, ensuring that gaps in provision are identified and appropriate standards for new facilities are implemented.
- Implement the delivery plan for the 'Active Leeds: a Healthy City' strategy.
- Ensure a co-ordinated approach to food work to develop effective communication and promote consistent healthy eating messages using principles of social marketing.
- Work with employers to promote healthy eating (including LCC / NHS Leeds) and business sign up to healthy workplace programmes.
- Increased achievement of Healthy Food Mark Standard or equivalents.
- Ensure the public sector addresses issues of healthy eating, safe and sustainable food and malnutrition within its catering arrangements and food provision.

Lives people lead:

- Ensure regular physical activity is sustained beyond 16 years+.
- Increase the number of trips made by walking and cycling ensuring that safety is taken into account.
- Increase the number of older people taking part in regular physical activity.
- Expand opportunities for disabled people to lead an active life.
- Improve people's ability to choose and obtain healthy food that meets nutritional requirements that are right for their stage of life.
- Commission healthy eating cooking skills and food access programmes for targeted neighbourhoods and community groups.
- Use the National Change 4 Life social marketing programme to support and empower people to make changes to diet and activity.
- Develop and implement Leeds Strategic Maternity Matters action plan and Breastfeeding Strategy.

Services people use:

- Ensure there are appropriate pathways to identify and manage overweight and obese individuals linking to a variety of agencies.
- Invest in Putting Prevention First programmes in primary care.
- Developing healthy living services within neighbourhoods including weight management services.
- Develop further joint health and physical activity programmes for people experiencing poor health, or in danger of developing poor health to change their lifestyles and become healthy.
- Develop and implement a range of physical activity training programmes and opportunities including free swimming for young people and older people from April 2009.
- Develop healthy eating programmes within priority neighbourhoods and encourage adoption of healthy eating principles in community based facilities (all sectors).
- Implement School Meals and Packed Lunch strategies.
- Promote the use of Active Leeds Physical Activity Tool Kit.
- Ensure a proactive workforce with knowledge and skills to address healthy behaviour change including using consistent messages around behaviour change, healthy weight, balanced diet and physical activity.
- Embed the practice of screening for malnutrition in facilities and in the community by health, social care and community service providers and professionals.
- Support a range of organisations to promote and provide practical support around health lifestyle messages around being a healthy weight, eating a balanced diet and increasing physical activity.

Community development and involvement:

- Ensure user involvement in the development and continuation of all programmes and services relating to food, physical activity and weight management.
- More participants in food and exercise activities commissioned from local organisations especially in target areas.
- Voluntary, Community and Faith sector agencies commissioned to develop physical activity opportunities within a community development approach.

5. Reduce teenage conception and improve sexual health

Accountable Directors and Key Partnerships	Lead and contributing partners
Rosemary Archer Children Leeds Integrated Strategic Commissioning Board – Teenage Pregnancy and Parenthood Board **Ian Cameron / Sandie Keene** Healthy Leeds Joint Strategic Commissioning Board – Promoting Health and Wellbeing Subgroup	**Leeds City Council** Children Leeds Partners NHS Leeds Education Leeds Leeds Teaching Hospitals NHS Trust VCF sector through Leeds Voice Health Forum
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Sarah Sinclair, NHS Leeds/ Leeds City Council Victoria Eaton, NHS Leeds John England, Leeds City Council	**Teenage pregnancy and parenthood strategy 2008 to 2011** **Sexual health strategy 2009 to 2014** The Leeds Children and Young People's Plan 2009 to 2014 Alcohol Strategy 2007 to 2010

5. Reduce teenage conception and improve sexual health

Indicators and targets	Measures of success
NI 112 Under 18 conception rate *disaggregated to focus on the 6 wards in the city with the highest rates of conception* **Baseline (1998)** 50.4 per 1000 girls aged 15-17 **Leeds 2006 rate** 50.7 per 1000 girls aged 15-17 **Target (2009/10)** Target rate 42.7 per 1,000 girls aged 15-17 *Based on 15% reduction in 6 wards with highest conception rate* **Vital Signs** Guaranteed access to a GUM clinic within 48 hours of contacting a service	• Fewer unplanned pregnancies • Gonorrhoea infections reduced by 15% • Fewer girls under 18 conceiving • 217,000 people aged 15 – 24 will have been screened for Chlamydia • 10% increase year on year in number of STI and HIV tests in non GUM settings • 90% of gay men accessing all sexual health services will receive a hepatitis B vaccine

5. Reduce teenage conception and improve sexual health

High Level Actions 2009 - 2012

Influences on health:

- Campaigns to target the general population of Leeds to reduce stigma related to sexual health.
- Increase positive work with the local media.

Lives people lead:

- Develop a communications plan for both young people, adults and professionals and links between sexual health and teenage pregnancy work.
- Develop local teenage pregnancy data and set up system for sharing data across agencies.
- Review existing provision of Sex and Relationship Education within educational and non-educational settings.
- Increase parents' confidence to discuss sexual health and relationship issues.
- Review impact of transition from Youth Service Health Education Team to generic services.
- Deliver programme of improving skills, knowledge, confidence, aspirations and empowering the most vulnerable to sexual health.
- Increase programmes developing skills and knowledge of gay men, young people and African and African Caribbean communities.
- Support the health and wellbeing for those living with HIV and AIDS.

Services people use:

- Ensure access to local services that are integrated, holistic and sensitive and appropriate to people from different backgrounds.
- Develop single access point for all sexual health services.
- Increase access to and improve knowledge of contraception.
- Increase access to emergency contraception and improve the uptake of contraception post pregnancy or terminations.
- Support for parents and carers on talking to children about sex and relationship issues at Children's Centres.
- Expand the Chlamydia screening programme.
- Ensure screening programmes are accessible and acceptable to target groups.
- Ensure prevention is integral to all clinical services.
- Increase HIV testing in a range of settings.
- Increase service provision in deprived areas, through GP practices, pharmacies, prisons.
- Improve the skills and knowledge of professionals in offering all forms of contraception and STI and HIV testing, STI treatment and sex and relationships education.
- Increase access to HIV treatment for gay men and African communities.
- Review existing services against the needs and identify gaps.

Community development and involvement:

- Increase community based and outreach initiatives with vulnerable groups.

6. Improve the assessment and care management of children, families and vulnerable adults

Accountable Directors and Key Partnerships	Lead and contributing partners
Rosemary Archer Children Leeds Integrated Strategic Commissioning Board **Sandie Keene / Jill Copeland** Healthy Leeds Joint Strategic Commissioning Board – Priority Groups sub-group	**Leeds City Council** NHS Leeds Leeds Partnership Foundation NHS Trust Leeds Teaching Hospitals NHS Trust VCF sector through Leeds Voice Health Forum Children Leeds partners
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Jackie Wilson, Leeds City Council Dennis Holmes Leeds City Council Carol Cochrane, NHS Leeds	**Adult Social Care Service Plans** **The Leeds Children and Young People's Plan 2009 to 2014** **Putting People at the Centre (Learning Disability Strategy) 2009 to 2012** Carers Strategy for Leeds 2009

6. Improve the assessment and care management of children, families and vulnerable adults

Indicators and targets	Measures of success
NI 132 Timeliness of social care assessment (all adults) Baseline 80.9% 2010-11 Target 90.0% 2007 **NI 133** Timeliness of social care packages following assessment (all adults) Baseline 85% 2010-11 Target 95.0% **NI 63** Stability of placements of looked after children: length of placement Baseline 70.5% 2010-11 Target 80.0% **NI 66** Looked after children cases which were reviewed within required timescales Baseline 60.2% 2009-10 Target 90.0%	• More people, especially with long term conditions, are able to lead independent lives • Appropriate support for vulnerable adults • Carers receive appropriate and timely support • Improved patient and carer experience • Young adults are fully supported in transitions between services, especially on entering adulthood

6. Improve the assessment and care management of children, families and vulnerable adults

High Level Actions 2009 - 2012

Lives people lead:

- Improve the awareness of the needs of carers.
- Increase the number of carers who receive a health check.

Services people use:

- Provide efficient and effective out of hours service and redesign care management process.
- Reduce delayed transfers of care.
- Improve outcomes for people from BME backgrounds.
- Improve outcomes for people with personality disorders.
- Improve outcomes for young people who have committed offences.
- Ensure arrangements are in place for protecting vulnerable people from abuse through improved assessment and care management.
- Implement self directed support pilot for the full range of client groups.
- Improve care planning for young people in transition by creating a joint team from both Children's and Adult Social Care.
- Embed the Common Assessment Framework for children and young people in Children's Services to provide early assessment and multi-agency actions centred around individual children and young people's needs.
- Undertake regular reviews for vulnerable people and their carers.

Community development and involvement:

- Involve and engage service users and carers.
- Involve voluntary, community and faith sector.
- Ensure the availability of advocacy for vulnerable people.

7. Improve psychological, mental health, and learning disability services for those who need them

Accountable Directors and Key Partnerships	Lead and contributing partners
Sandie Keene / Jill Copeland Healthy Leeds Joint Strategic Commissioning Board – Priority Groups sub-group **Rosemary Archer** Children Leeds Integrated Strategic Commissioning Board	**Leeds City Council** NHS Leeds Leeds Partnership Foundation NHS Trust Children Leeds Partners Leeds Colleges VCF sector through Leeds Voice Health Forum
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Dennis Holmes, Leeds City Council John Lennon, Leeds City Council Carol Cochrane, NHS Leeds Jackie Wilson, Leeds City Council	**Leeds Mental Health Strategy 2006 to 2011** **Leeds Emotional Health Strategy 2008 to 2011 (CYP)** **Putting People at the Centre (Learning Disability Strategy) 2009 to 2012** **Social Inclusion and Mental Health Strategy (in preparation)** The Leeds Children and Young People's Plan 2009 to 2014 Carers Strategy for Leeds 2009

7. Improve psychological, mental health, and learning disability services for those who need them

Indicators and targets	Measures of success
NI 58 Emotional and behavioural health of looked after children (new indicator) **NI 130** Social Care Clients receiving self-directed support Target 30% take up of self directed support options by March 2011 **VSCO2** Proportion of people with depression and/or anxiety disorders who are offered psychological therapies. Targets and milestones to be determined by March 2009	• People from all backgrounds get timely and appropriate care • Individuals feel valued and included • Improved access to appropriate housing for vulnerable groups • Learning disabled people enjoy better health • Learning disabled people with complex health needs receive effective and person centred treatment care and support provided locally • Learning disabled people and their carers benefit from accessible and person centred services with specialist health supports in primary and secondary care • More people using and enjoying mainstream facilities • Evidence of more personalised care and support • Earlier intervention to reduce risk of crisis • More rapid and effective recognition and support for people suffering anxiety and depression. • Number of people accessing dementia services

7. Improve psychological, mental health, and learning disability services for those who need them

High Level Actions 2009 - 2012

Influences on health:

- Reduce stigma and discrimination.
- Increase opportunities to access employment and meaningful education.
- Improve access to arts and leisure activities.
- Ensure vulnerable groups to have access to a range of housing opportunities.

Lives people lead:

- Develop services from community based locations with partners and reduce reliance on use of segregated buildings.
- Increase choice and control in support including increasing the take up of self directed support and individualised budgets.
- Implement Mental Health First Aid training for employers.
- Recognise needs of more mobile population by providing appropriate support including city centre changing places.

Services people use:

- Undertake options appraisal of models of integrated care.
- Transform mental health and learning disability day services.
- Ensure people with learning disabilities have health checks and Health Action Plans.
- Develop capacity of primary and secondary health services to meet the needs of people with learning disabilities.
- Improve access, uptake and information on health and health services, by developing accessible information.
- Review specialist health services for people with learning disabilities with continuing treatment needs and develop service model.
- Implement Independent Living Project to promote social inclusion through procuring a range of housing options in local communities and transforming care and support services.
- Development of Primary Care Mental Health Services to eradicate age discrimination.
- Joint Transitions Team for children & young peoples social care and adult social care in place by March 2010.
- Implementation of Dual Diagnoses Strategy (substance use and mental health).
- Expand services in primary care to increase access to psychological therapies for people with common mental health problems.
- Improve access to early intervention services.
- Improving public and professional awareness of Dementia.
- Improve early diagnosis and intervention for people with Dementia.
- Improved quality of life and support for people with Dementia.
- Develop strategy on autism.

Community development and involvement:

- Increase opportunities to enjoy a range of social activities and networks.
- Continue community development worker service for BME communities.
- Review user carer involvement structures to ensure fitness for purpose.
- Extend network of Dementia Cafés.

8. Increase the number of vulnerable people helped to live at home

Accountable Directors and Key Partnerships	Lead and contributing partners
Sandie Keene / Jill Copeland Healthy Leeds Joint Strategic Commissioning Board – Priority Groups sub-group **Sandie Keene / Philomena Corrigan** Healthy Leeds Joint Strategic Commissioning Board – Planned and Urgent Care sub-group	**Leeds City Council** Leeds PCT Leeds Partnership Foundation NHS Trust VCFS bodies through Leeds Voice Health Forum West Yorkshire Fire and Rescue Service Leeds Colleges
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Dennis Holmes, Leeds City Council John Lennon, Leeds City Council Carol Cochrane, NHS Leeds Jackie Wilson, Leeds City Council	**Leeds Housing Strategy 2005 to 2010** **Supporting People Strategy 2005 to 2010** **Carers Strategy for Leeds 2009 to 2012** **Older Better Strategy 2006 to 2011** The Leeds Children and Young People's Plan 2009 to 2014

8. Increase the number of vulnerable people helped to live at home

Indicators and targets	Measures of success
NI 141 Percentage of vulnerable people achieving independent living Baseline 2007-8 58.6% Targets 2010-11 76% **NI 139** The extent to which older people receive support they need to live independently at home Baseline and target to be set from Place Survey **NI 136** People supported to live independently through social services (all adults) Baseline (new target) Target 66%	• Fewer inappropriate admissions to hospital • Falls reduced and more people who fall are treated at home • Stroke care pathway improved • People with mental health problems or learning disabilities can access wider range of housing, employment, training and leisure opportunities • Improved choice delivering a personalised service based on individual preferences for vulnerable groups

8. Increase the number of vulnerable people helped to live at home

High Level Actions 2009 - 2012

Influences on health:

- Use a social model approach to challenge the barriers faced by older people and disabled people to independence, inclusion and equality.
- Maintain and promote older people's and disabled people's independence for as long as possible.
- Better access to good quality housing for vulnerable people.

Lives people lead:

- Promote and increase take up of Personal Budgets.
- Increase the number of people with mental health problems and learning disabilities who are in employment , education or in voluntary activity.

Services people use:

- Expand interactive services such as telehealth, broadband/interactive access and telecare.
- Expansion of falls assessment and treatment service.
- Transform learning disability day services currently provided by LCC.
- Redevelopment of Windlesford Green hostel for people with learning disabilities.
- Provision of new, modern accommodation for people with learning disabilities through the Independent Living Project.
- Increase the number of vulnerable people utilising self directed support to deliver their care and support needs.
- Develop and improve information sources to ensure that the communication barriers affecting different groups are overcome.

Community development and involvement:

- Development of self care strategy supported by Health Trainers for people with long term conditions.

9. Increase the proportion of people in receipt of community services enjoying choice and control over their daily lives

Accountable Directors and Key Partnerships	Lead and contributing partners
Sandie Keene / Jill Copeland Healthy Leeds Joint Strategic Commissioning Board – Priority Groups sub-group **Sandie Keene / Philomena Corrigan** Healthy Leeds Joint Strategic Commissioning Board – Planned and Urgent Care sub-group	**Leeds City Council** NHS Leeds VCFS bodies through Leeds Voice Health Forum and Learning Disability Forum, Older People's Forum, Physical Disability Forum and Volition.
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Dennis Holmes, Leeds City Council John Lennon, Leeds City Council Carol Cochrane, NHS Leeds Jackie Wilson, Leeds City Council	**Adult Social Care Business Plans** **Older Better** The Leeds Children and Young People's Plan 2009 to 2014 Carers Strategy for Leeds 2009 to 2012

9. Increase the proportion of people in receipt of community services enjoying choice and control over their daily lives

Indicators and targets	Measures of success
NI 130 Social Care Clients receiving self-directed support Target 30% take up of self directed support options by March 2011	• More people aware of and accessing benefit and fuel support • People lead richer and more fulfilling lives whatever their age or condition • Increased satisfaction among service users and carers • Choice and control are enhanced by simpler access with less risk of duplication or gaps • Evidenced access to information, advice and advocacy • Better sharing of information subject to appropriate safeguards • Increased capacity for support within local communities

9. Increase the proportion of people in receipt of community services enjoying choice and control over their daily lives

High Level Actions 2009 - 2012

Influences on health:

- Continue work to promote financial inclusion.
- Develop and improve transport which meets people's needs.

Lives people lead:

- Promote Healthy Ageing with the direct involvement of older people, encouraging a positive view of old age and disability.
- Use social marketing to develop information about opportunities, accessible to all groups.

Services people use:

- Roll out of Common Assessment Framework.
- Continue work on the Self-Directed support programme.
- Promote and increase take up of Personal Budgets .
- Deliver services for older people and disabled people that are flexible and accessible and promote choice and control.
- Deliver care and support close to where people live or within their own homes.
- Ensure that older people and disabled people are treated with respect and dignity at all times.
- Take an holistic approach to care and support, joining up different elements across professions and agencies.
- Share good practice across the city, agencies, organisations and professions.
- Develop community support services for people with stroke and other neurological conditions.
- Provide excellent eye health and eye care and sight loss support in an inclusive city.

Community development and involvement:

- Ensure full participation of older people and disabled people in the decisions and processes which affect their lives.
- Enable older people and disabled people to lead an active and healthy life and be involved as citizens of the city.
- Tackle social isolation of older people .

10. Improve safeguarding arrangements for vulnerable children and adults through better information, recognition and response to risk

Accountable Directors and Key Partnerships	Lead and contributing partners
Rosemary Archer Children Leeds Integrated Strategic Commissioning Board - Children Leeds Safeguarding Board **Sandie Keene / Jill Copeland** Healthy Leeds Joint Strategic Commissioning Board -Adult Safeguarding Board	**Leeds City Council** Education Leeds NHS Leeds Children Leeds Partners VCFS bodies through Leeds Voice CYP Forum and Health Forum Leeds Colleges
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Dennis Holmes, Leeds City Council Sarah Sinclair, NHS Leeds/ Leeds City Council	**Adult Safeguarding Strategy** The Leeds Children and Young People's Plan 2009 to 2014 Carers Strategy for Leeds 2009 to 2012

10. Improve safeguarding arrangements for vulnerable children and adults through better information, recognition and response to risk

Indicators and targets	Measures of success
Number of children looked after *(expressed as a rate per 10,000 excluding unaccompanied asylum seekers)* Baseline 83.6 Target 2020-11 59.1 Estimated number of staff employed by independent sector registered care services in the council area that have had some training on protection of adults whose circumstances make them vulnerable that is either funded or commissioned by LCC - Target to be set following calculation of baseline	• Wider awareness of issues among staff and in wider communities • Risk factors are managed consistently and effectively • Arrangements for safeguarding vulnerable children and adults are effective across agencies and disciplines. • Everyone involved in safeguarding has the appropriate knowledge, skills and understanding

10. Improve safeguarding arrangements for vulnerable children and adults through better information, recognition and response to risk

High Level Actions 2009 - 2012

Influences on health:

- Increase overall awareness of safeguarding issues through communications and social marketing.

Lives people lead:

- Implement consistent assessment procedures for risk, mitigation and management.

Services people use:

- Ensure high quality safeguarding practice is embedded across partners.
- Revise and implement multi-agency adult safeguarding procedures.
- Implement mandatory specialist safeguarding training programme.
- Implement work programme of adult safeguarding board.
- Jointly appoint head of adult safeguarding.
- Establish practice standards and competencies.
- Ensure the work of the safeguarding adults partnership board is informed by the views and experiences of all stakeholders
- Improve safeguarding arrangements for children.

Community development and involvement:

- Increase general awareness of safeguarding issues and secure community support.
- Increase general awareness of capacity issues and secure community support.

Related plans

Plan title	Internet link (click to open)
NHS Leeds Strategy 2008 to 2011	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13970
Leeds Alcohol Strategy 2007 to 2010	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13938
Older Better 2006 to 2011	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13958
Leeds Housing Strategy 2009 to 2012	(under development)
Supporting People Strategy 2005 to 2010	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13956
Safer Leeds Partnership Plan 2008 to 2011	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13960
Active Leeds: a Healthy City 2008 to 2012	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13932
Leeds Food Matters 2006 to 2010	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13946
Leeds Tobacco Control Strategy 2006 to 2010	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13968
Infant Mortality Action Plan 2009	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13948
Accident Prevention Framework 2008 to 2011	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13930
Self Care Strategy 2009	(under development)
Leeds Affordable Warmth Strategy 2007 to 2016	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13934
Leeds Financial Inclusion Project	http://www.leeds.gov.uk/page.aspx?pageidentifier=cd4994f5-87a4-4935-858b-89e8a360643a
Taking the Lead 2006 to 2012	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13964
Leeds Childhood Obesity Strategy 2006 to 2016	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13942
Leeds School Meals Strategy	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13954
Adult Obesity Strategy	(under development)
Local and West Yorkshire Transport Plans and Cycling Strategy - various	http://www.leedsinitiative.org/transport/page.aspx?id=2410
Parks and Green Space Strategy 2009	(under development)
Teenage Pregnancy and Parenthood Strategy 2008 to 2011	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13966
Sexual Health Strategy 2009 to 2014	(under development)
Carers' Strategy for Leeds 2009 to 2012	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13940
Leeds Social Inclusion and Mental Health Strategy 2006 to 2011	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13962
Leeds Emotional Health Strategy 2008 to 2011	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13944
Putting People at the Centre (Learning Disability) Strategy 2009 to 2012	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13952
Adult Safeguarding Strategy	(under development)
The Leeds Children and Young People's Plan 2009 to 2014	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=14160

Teenage Pregnancy and Parenthood Strategy

2008-2011

Design for Health • Ref: 1266/08

Children Leeds

This strategy was developed by the Teenage Pregnancy and Parenthood Partnership Board (TPPPB). The partnership consists of representatives from:

Education Leeds
Leeds Careers
Leeds City Council
NHS Leeds
Leeds Teaching Hospitals Trust
Voluntary Community and Faith Sector
Youth Sexual Health Action Group (YSHAG)

Children Leeds

Children Leeds
Children's Services unit,
6th Floor East, Merrion House
Merrion Centre,
Leeds
LS2 8ET
Phone: 0113 3950247
Email: childrenleeds@leeds.gov.uk
Website: www.childrenleeds.gov.uk

the Leeds Initiative

Local partnerships making things happen

Foreword

We want every young person growing up in Leeds to have the opportunities and support to reach their full potential. Achieving this means giving them all the guidance and help they need to make informed choices about their lives and their actions.

Nowhere is this more important for us than in our efforts to reduce the number of teenage conceptions. This is a major challenge, but one we must meet, because we know about the impact that teenage pregnancy and parenthood can have on young lives. Of course there are successful teenage parents who also realise their individual potential, but evidence shows us that too often having children at a young age significantly limits young people's career and education prospects. It affects the health and wellbeing of both mother and child – teenage mothers are three times more likely to have post-natal depression than older mothers and are more likely to smoke during pregnancy. The infant mortality rate for babies born to teenage mothers is 60% higher then for babies born to older mothers. Not only this, but we also know about the strong links between teenage pregnancy and high levels of deprivation. As such, the challenges and social exclusion that teenage mothers face often gets passed from one generation to the next.

We have recognised the significance of this complex issue in Leeds and we are determined to address it. Reducing teenage conceptions has been identified as a priority in both our Local Strategic Plan and our Children and Young People's Plan. This places a shared responsibility on us all to work in partnership and play our part in understanding and addressing the challenge. Our Teenage Pregnancy Strategy underpins work to do that. It links to other relevant key strategies and recognises the direction our work needs to move in to engage effectively with those affected. It sets the tone for a more sophisticated, collective focus on guiding and supporting our young people. We will address this challenge by using strategic commissioning; by strengthening locality working and integrated service delivery; and by developing more integrated and personalised front line response.

We have a variety of positive developments that we can build on: examples of good work in local communities; more involvement from schools, who recognise their role and impact; recently commissioned innovative projects to target the most vulnerable groups and a strong collective to put young people's own views at the heart of guiding out work. Now we must bring all this together and take further steps so that determination, positive action and shared responsibility shapes our work in this area.

As one of our most important priorities, we can move forward knowing that doing more to reduce teenage conceptions will have a real and lasting positive impact on many, many young people's lives.

Rosemary Archer
Director of Children's Services

Councillor Stewart Golton
Executive Member for Children's Services

Executive summary

Teenage pregnancy is a complex issue, affected by young people's knowledge about sex and relationships and their access to advice and support; and influenced by aspirations, educational attainment, parental, cultural, peer influences and levels of emotional well-being.

Whilst some teenagers can be successful parents and fulfil their potential, especially with support, it remains that teenage pregnancy can have negative consequences on the health and well-being of both the young woman and the child[1]. Young pregnant women and teenage parents often experience difficulty in accessing mainstream services and are at greater risk of isolation and health inequalities.

In order to drive down the under-18 conception rate and provide appropriate support for teenage parents, there is a need to establish a clear vision for teenage pregnancy in Leeds within the wider Children and Young People's agenda. This strategy provides that vision and builds on the excellent work already going on across the city to reduce teenage conceptions and support young parents. It has been developed with the support of the National Support Team for Teenage Pregnancy, key stakeholders and most importantly young people.

Vision statement

To empower and support young people to make informed decisions to prevent teenage conceptions and make healthy life choices.

To support young people to fulfil their potential.

This vision needs to be integrated into all partnership arrangements with support for the strategy among local communities. This strategy should not be used in isolation but should link with other cross-cutting strategies. Only by working together can we achieve challenging targets and improve the health and well-being of our young people and future generations.

Relationship between Leeds Teenage Pregnancy and Parenthood Strategy and other cross-cutting strategies and action plans

- The Children and Young People's Plan for Leeds (2006-2009)[2] For all young people to reach their potential, strategies must work together to raise the aspirations, self-esteem and empowerment of young people in Leeds.
- Leeds Sexual Health Strategy (in progress)[3] Young people have other sexual health needs and cross cutting themes from both strategies will ensure that focused work targets young people in Leeds
- Alcohol Strategy (2007-2010)[4] The link between high alcohol consumption increase in numbers of sexual partners and lack of condom use must be addressed through decision making and negotiation skills and self-esteem work with young people.
- Drugs Strategy–Leeds multi-agency strategy to tackle substance misuse (2006-2008)[5] Similar to alcohol, the influence of substances can greatly impact on sexual health awareness and risk taking behaviour.
- Leeds Mental Health Strategy (2006-2011)[6] The effects of teenage pregnancy and becoming a teen parent can have a profound effect on mental health and well-being.
- The Leeds Health and Well-being plan (2005-2008)[7]. The healthy Leeds partnership recognises sexual ill health as an area for improvement as part of the Improving Leeds initiative.
- Leeds Family Support and Parenting Strategy (2007)[8]

Background

Whilst some young women make an informed choice to become pregnant, the majority of under 18 conceptions are unintended and around a half lead to abortion [1].

Teenage pregnancy and parenthood can have a significant effect on physical, social, emotional and economic health and well-being. Teenage mothers are less likely to finish their education and are more likely to bring up their child as lone parents or in poverty. The infant mortality rate for babies born to teenage mothers is 60 per cent higher than for babies born to older mothers. Teenage mothers are three times more likely to smoke during pregnancy than older mothers and are less likely to breastfeed, both of which have negative health consequences for the child. Teenage mothers have three times the rate of post-natal depression of older mothers and a higher risk of poor mental health for three years after the birth. Children of teenage mothers are generally at increased risk of poverty, low educational attainment, poor housing and poor health and have lower rates of economic activity in adult life. Rates of teenage pregnancy are highest among deprived communities, so the negative consequences of teenage pregnancy are disproportionately concentrated among those who are already disadvantaged [1].

Teenage pregnancy also heavily burdens the NHS and wider public health services, with the cost to the NHS alone estimated to be £63 million a year. Teenage mothers are more likely to require targeted support from a range of services, for example to help them re-engage in education, employment and training or to access supported housing. Benefit payments for those who do not enter employment in the three years following birth can total between £19,000 and £25,000 over three years [1].

Reducing teenage conceptions is an important national and local priority.

There is a national target to reduce teenage conceptions (15-17 year olds) by 50% by 2010 (from 1998 baseline).

The target for Leeds is to reduce teenage conceptions by 55% by 2010.

There is an additional national target to increase the participation of young parents into education, employment and training to 60% by 2010.

Scale of the Challenge

The Leeds picture

Leeds has high rates of teenage conceptions. Whilst much good work is currently being done to reduce teenage conceptions and support young parents, driving down conception rates remains difficult.

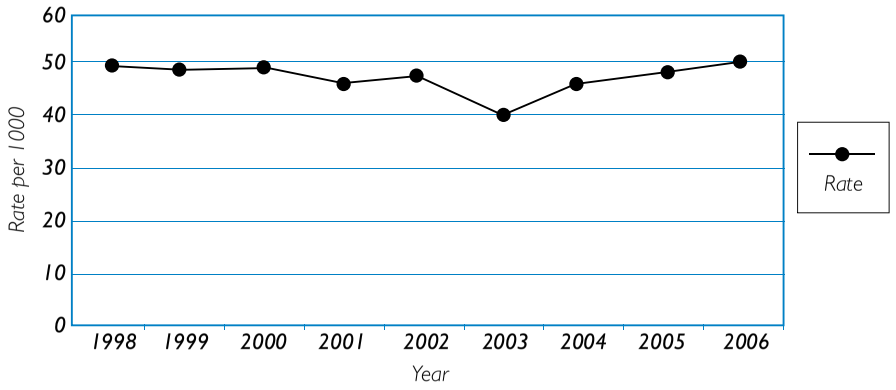
The table below shows progress in Leeds up to 2006 (this being the latest available data).

	1998 Baseline	2006	Difference
Leeds	*50.4*	*50.7*	*0.4%*
West Yorkshire	*53*	*47.8*	*-9.8%*
England	*46.6*	*40.4*	*-13.3%*

(Rates are per thousand 15-17 year olds)

In 2006 the number of conceptions was 715, which compared to 2005 figures of 683 shows an increase of 32.

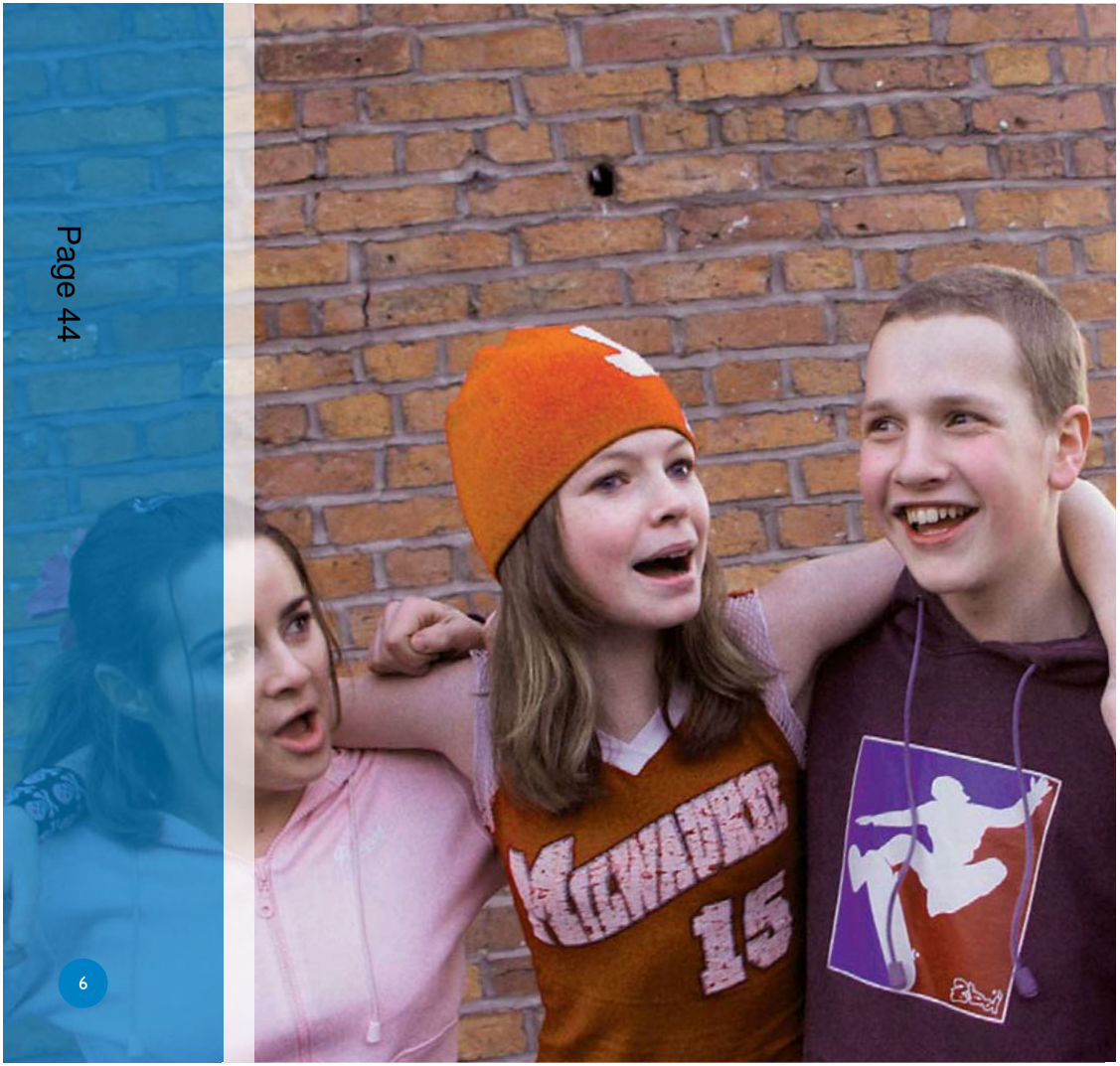
Leeds PCT
Teenage conception rate per 1000 (fifteen to seventeen years olds)



As can be seen from the table above, reducing teenage conceptions remains a difficult task. The rate of conceptions amongst 15-17 year olds per 1000 population in Leeds has increased since 2003. Conception rates vary between wards in Leeds and are strongly associated with deprivation. A third of Leeds wards are hotspots with rates amongst the highest in England.

The problem is confounded by the delay in the national reporting of data. This means that the effect of interventions is not immediately apparent.

Leeds has been working with the National Support Team for Teenage Pregnancy since November 2007 to review progress to date and to identify areas for improvement. The National Support Team praised the good work already being done across the city as well as recommending areas for improvement. They highlighted the need to review the Teenage Pregnancy and Parenthood Strategy.



Strategy

This strategy was developed by the Teenage Pregnancy and Parenthood Partnership Board (TPPPB) which consists of representatives from NHS Leeds, Leeds City Council, Leeds Careers, Leeds Teaching Hospitals Trust, Education Leeds and Voluntary Community and Faith Sector, Youth Sexual Health Action Group (YSHAG), who share delegated responsibility for the local work around teenage pregnancy and parenthood. The strategy outlines areas for improvement and associated key actions.

Key areas for investment

Data and needs assessment

There is a clear need to undertake a Young People's Sexual Health Needs Assessment (HNA) as part of the broader Sexual Health Needs Assessment. This will help to identify gaps in service provision and highlight areas for improvement, focussing largely on vulnerable groups.

The production of a local teenage pregnancy data set is currently in development. This will provide more detailed information on the young people becoming pregnant in Leeds. It will include data on live births, stillbirths, terminations and second/subsequent teenage conceptions broken down by Super Output Areas/ ward level and vulnerable groups. The analysis and dissemination of local data will act as a lever to engage, inform and support partners to target interventions more effectively toward the young people who are most at risk. A local data set has the benefit of providing more timely data which will enable us to effectively monitor and review the impact of interventions on conception rates.

Key actions

- Develop local teenage pregnancy data
- Set up system for ongoing sharing of data across agencies
- Undertake Young People's Sexual Health Needs Assessment

Communication

There is a need for a comprehensive communication strategy. This should include the advertising and dissemination of information on the availability of sexual health and support services for young people. Information on services available must be effectively communicated to young people and other members of the public as well as to all professionals who have contact with young people in order that they can provide support and/or signpost as appropriate. Effective involvement of service users, including the continued involvement of YSHAG is a vital aspect of service planning, development and evaluation. Proactive and reactive media handling will need managing effectively. There needs to be a mechanism to facilitate the fluid exchange of information between partner organisations. This will ensure they remain fully informed of developments and progress relating to teenage pregnancy and parenthood in order to keep this high on the agenda. There will be effective engagement between the Teenage Pregnancy and Parenthood Partnership Board, Teenage

Pregnancy and Parenthood Commissioning Executive and the Overview and Scrutiny Committee in relation to the strategy, work programme and performance management.

Key actions

- Develop comprehensive communication strategy
- Develop single access point for all sexual health services

Implementation

Contraception and sexual health services

All young people should have access to high quality contraception and sexual health services which are delivered in a range of settings. These services should be young people friendly and comply with 'You're Welcome quality criteria: Making health services young people friendly'[9] and the MedFASH Recommended Standards for Sexual Health Services[10]. Service user involvement is essential to inform service improvements and evaluation. Feedback and recommendations from young people will be used along with available evidence on best practice to redesign and improve services where appropriate. Approximately 20% of births conceived to under-18s are second or subsequent conceptions and 7.5% of abortions to under-18s are to young women who have had a previous abortion. All pregnant teenagers and teenage mothers will be referred to and followed up by contraceptive services as an approach to reduce second and subsequent pregnancies. All commissioned services should have clear Service Level Agreements/ Service Specifications and will undergo rigorous performance management.

Key actions

- Review roll out of Healthy Young People's Services (HYPS)
- Ensure existing commissioned services have clear SLAs, informed by quality standards, and performance monitoring arrangements in place
- Review services currently being offered by gathering information from Young People's Sexual Health Needs Assessment

Sex & relationship education

All young people should have the right to good quality sex and relationship information to allow them to make informed decisions about their sexual health choices. The provision of this information and guidance should begin at an early age with parents and carers being encouraged to discuss and explore relationship issues with their children. There is a need to undertake a review of sex and relationship education provision within education and non-education establishments across Leeds to ensure that young people are offered appropriate information, advice and training to help them develop their ability to make safe, informed choices. This will include helping them to develop the confidence and skills to form healthy relationships, delay sex and resist peer pressure. School nurses have an important role to play and will work in partnership with education to explore rolling out Healthy Young People's Service (HYPS) across the city.

Key actions

- Review existing provision of Sex and Relationship Education (SRE) within education and non-educational settings
- Identify strong leadership for delivery of SRE in schools and youth service
- Co-ordinate the commissioning and performance management of effective Personal Social Health Education (PSHE)/ SRE

Targeted work/ Vulnerable groups

Looked after children

Young people who are or who have been looked after are at greater risk of becoming teenage mothers. Statistics on Looked After Children released by DFES in November 2005 showed that 4.1% of 15-17 year old females in care were mothers- this was around three times higher than the prevalence among all girls under 18 in England.

Black and minority ethnic groups

Young people from certain ethnic groups are more likely to experience teenage pregnancy than others. Rates are significantly higher among mothers of 'Mixed White and Black Caribbean', 'Other Black' and 'Black Caribbean' ethnicity. 'White British' mothers are also over-represented among teenage mothers.

Key actions

- Review existing services against the needs identified in the HNA identifying gaps in service provision, particularly in relation to vulnerable groups, those at risk from subsequent teenage pregnancies and geographical location of teenage pregnancy hotspots
- Externally evaluate the Sexual Health Nurse for Looked After Children role

Workforce training and development

There is the need to ensure that all those working with young people undertake ongoing training to equip them with the skills to enable them to talk to young people about sexual health and relationships. The training will consist of basic awareness to more advanced and specialist training. School Nursing, Midwifery and Health Visiting staff will receive training around SRE and steps to prevent second /subsequent pregnancies.

Key actions

- Identify Local Authority and Health workforce strategies in relation to SRE
- Develop training support around delay and one to one interventions in relation to NICE guidance
- Promote effective SRE training for School Nursing, Midwifery and Health Visiting staff

Youth services

There is a great deal of good work currently being done within youth services to build confidence and raise aspirations of young people. We need to identify areas of good practice and ensure a consistent approach across the city. There needs to be a particular focus on addressing the needs of vulnerable groups. Targeted Youth Support services have a role in helping teenage parents to cope with the challenges of early parenthood, by providing co-ordinated support from a lead professional who can act as an advocate for the young mother and father and put them in touch with any specialist support they may need. This support will help to address the emotional health needs associated with being a teen parent.

Key actions

- Review impact of transition from Youth Service Health Education Team to generic service

Raising aspirations

Raising aspirations has been found to have a positive effect in reducing teenage conceptions. Young people need to receive consistent messages from professionals. Careers education

and guidance is a key element of raising aspirations. Schools and colleges are ideally placed to provide young people with the skills and knowledge they require to develop their self-awareness, gain an understanding of occupational and learning opportunities and to be able to plan for the future and make appropriate career decisions. Leeds Careers provides the specialist information, advice, guidance and support to help young people apply what they have learned to their own individual circumstances and to turn these opportunities into reality.

Schools and colleges should be encouraged to maintain and develop PSHCE programmes and ensure that careers education and guidance is recognised as an important element of this.
For young mothers, their education is often disrupted at the most critical time, in the run-up to taking GCSEs. Young mothers' participation in education, employment or training (EET) beyond the compulsory school leaving age is very low. Studies show that men who become fathers at a young age (under age 23) are twice as likely to be unemployed at age 30 than men who became fathers aged over 23[11]. Support should focus on helping teenage parents to re-engage in EET.

Key actions

- Use SEAL to deliver consistency in messages to raise aspirations

Work with parents and carers

There is a strong need for parent and carer involvement. They should feel confident to address sexual health and relationship issues with young people to equip them with the skills and the confidence to resist peer pressure and delay sex.

Key actions

- Ensure Leeds Family Support and Parenting Strategy and work plan increases parent's confidence to discuss sexual health and relationship issues
- Children's Centres will prioritise support for parents and carers on talking to children about sex and relationship issues

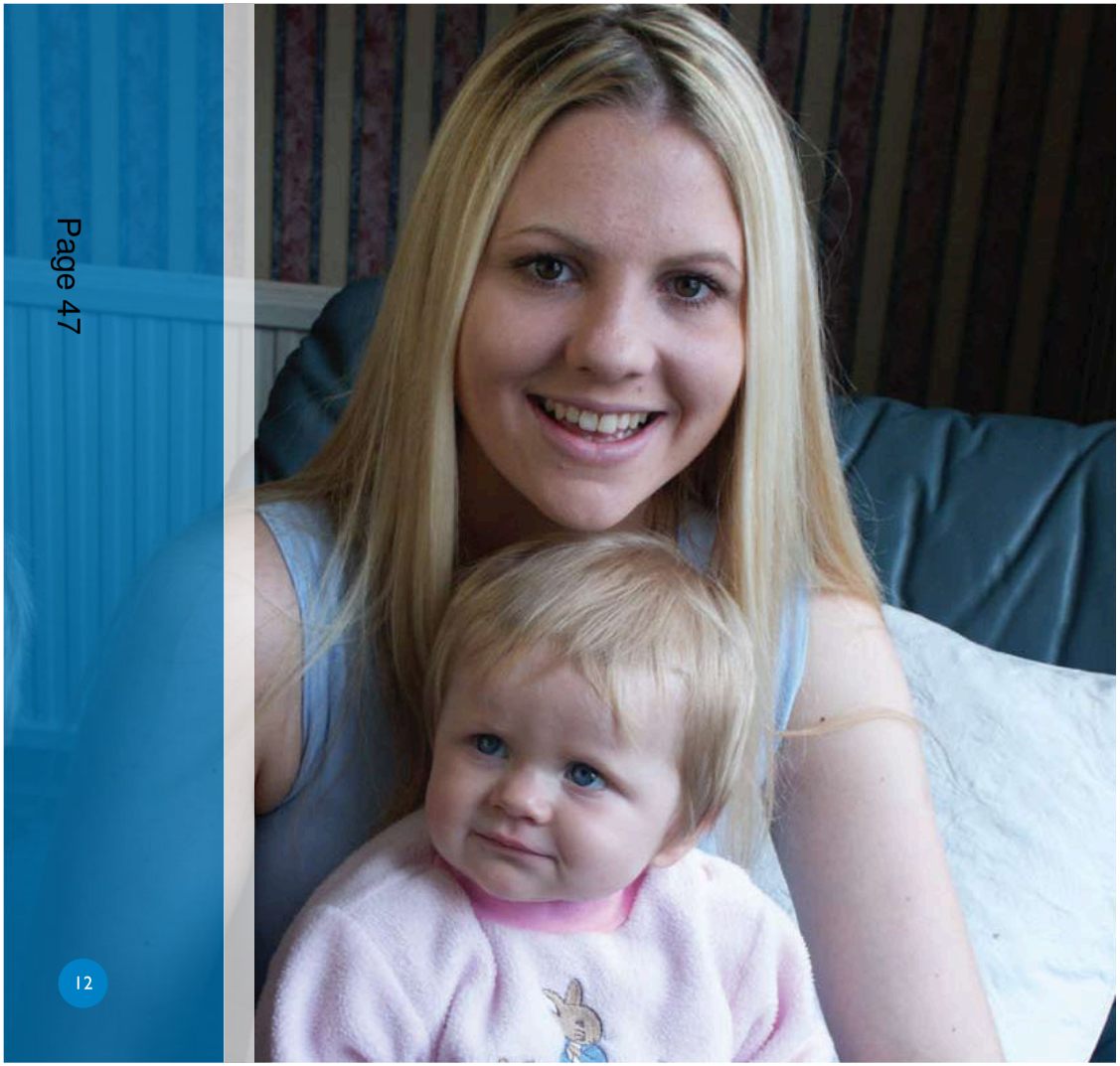
Supporting teenage parents

All parents should have good information about the services available to them and have access to parenting information, advice and support. This support should begin during pregnancy in order to maximise the chances of pregnant teenagers achieving a healthy and confident transition into parenthood. Good parenting is essential if children are to stay safe, be healthy, make a positive contribution, enjoy and achieve and be free from poverty [9]. We need to build on the good work which currently exists to provide support for teenage parents, including increased multi-agency working. Services should be tailored to meet the needs of young mothers and fathers. The pressures of early parenthood result in teenage mothers experiencing high rates of poor emotional health and well-being. Research shows that teenage mothers have higher rates of poor mental health after birth than older mothers, and that these higher rates are evident for up to three years after birth. Social isolation and high rates of relationship breakdown are key factors which contribute to this situation. For young fathers, particularly those separated from their children, there is also an increased risk of emotional and relationship problems. Young parents require additional support at this vulnerable time. Services need to be more attractive to young fathers to encourage them to be involved in the care of their children.

All parents should have access to appropriate housing in order to create a safe environment in which to raise their children. There needs to be close working with housing to ensure the availability of appropriately decent housing for young parents.

Key actions

- Establish pathway to ensure pregnant teenagers and mothers are followed up by contraception services
- Review support for young fathers



Reference

1 Department for Education and Skills (2006), Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies. Crown Copyright

2 Children Leeds (2006), Every Child Matters: The Children and Young People's Plan for Leeds 2006-2009. Leeds Initiative
www.childrenleeds.org.uk

3 Leeds Sexual Health Strategy (in progress)

4 Healthy Leeds & Safer Leeds, Alcohol strategy (2007 - 2010), Design for Health

5 Safer Leeds (2006), Drugs Strategy- Leeds multi-agency strategy to tackle substance misuse (2006-2008) Design for Health

6 Leeds Mental Health Modernisation Team (2006), Leeds Mental Health Strategy (2006-2011), Leeds

7 Healthy Leeds Partnership (2005), The Leeds Health and Well-being Plan 2005-2008, Leeds Initiative
www.leedsinitiative.org

8 Children Leeds (2007), Every Parent Matters: Family Support and Parenting Strategy. Leeds Initiative
www.childrenleeds.org.uk

9 Department of Health (2007), You're Welcome Quality Criteria: Making Health Services Young People Friendly. Crown Copyright. London
www.dh.gov.uk/publications

10 Medical Foundation for Aids and Sexual Health (2005), Recommended Standards for Sexual Health DH, London

11 Department for Education and Skills (2007) Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trusts. Crown Copyright
www.dcsf.gov.uk

This page is intentionally left blank

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 20 October 2009

Subject: Updated Work Programme 2009/10

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 and update members on the current outline work programme. The Board is asked to consider, amend and agree its work programme, as appropriate.

2.0 Background

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 At that meeting a number of potential work areas were identified by members of the Board. These potential areas were confirmed in a further report, along with an outline work programme, presented at the Board meeting held on 28 July 2009.

2.3 Subsequently, the outline work programme, including any emerging issues, is routinely presented to the Scrutiny Board consideration, amendment and/or agreement.

3.0 Specific work areas and the overall work programme (2009/10)

The role of the Council and its partners in promoting good public health – Scrutiny Inquiry

3.1 At the previous meeting (22 September 2009), members of the Scrutiny Board (Health) agreed terms of reference for the above inquiry. In this regard, the Board agreed to consider arrangements relating to four specific areas of public health.

3.2 The first session of this inquiry, which focused on issues around improving sexual health and reducing teenage pregnancies, has been considered elsewhere on the agenda. Further sessions are planned as follows:

- Obesity and levels of physical activity – November 2009;
- Alcohol consumption – January 2010; and,
- Smoking – February 2010;

Provision of renal services at Leeds General Infirmary (LGI)

3.3 At its meeting on 28 July 2009, the Scrutiny Board considered the current proposals from Leeds Teaching Hospitals Trust (LTHT) associated with the provision of renal services (dialysis) across the Trust, particularly in terms of provision at Leeds General Infirmary (LGI).

3.4 The Scrutiny Board was advised that, at its meeting on 30 July 2009, the LTHT Board would be presented with a recommendation that a renal dialysis unit should not be created at the LGI site. The Scrutiny Board took evidence froma range of stakeholders, including the service commissioners, LTHT, Yorkshire Ambulance Service and patient representatives from the Kidney Patients Association (KPA) for LGI and St. James' University Hospital (SJUH).

3.5 Based on the Department of Health Guidance on Overview and Scrutiny for Health and the evidence presented at the meeting, the Scrutiny Board concluded that the proposed changes to renal dialysis provision represented a substantial variation to service delivery. As such, the Board recommended that a statutory period of consultation should take place prior to any decision of the (LTHT) Board.

3.6 The Scrutiny Board produced a statement to this affect, which was presented to the LTHT Board meeting on 30 July 2009. At that meeting, the LTHT Board agreed to defer its decision

3.7 As part of the Scrutiny Board's statement, it was also highlighted that there were a number of outstanding issues that the Scrutiny Board wished to pursue. These were confirmed by way of a set of supplementary questions (Appendix 1), issued to LTHT and other key stakeholders on 6 August 2009. A formal response which addresses the issues raised is yet to be received.

Provision of dermatology services at Ward 43 (Leeds General Infirmary (LGI))

3.8 Members of the Scrutiny Board (Health) will be aware of the recent publicity associated with potential changes to the above service. The Board will also be aware that two separate requests for scrutiny (one coming from patients and one from the British Association of Dermatologists).

3.9 Given the timing of the recent publicity, the requests for scrutiny and the Board's meeting cycle, following discussions with members of the Scrutiny Board (Health),

the Chair of the Board has, initially, taken this issue forward on members' behalf. The action taken to date has included:

- Issuing a letter to the Chief Executive of LTHT (copied to NHS Leeds) seeking a moratorium on any further action until the Scrutiny Board has had the opportunity to consider the issues in more detail. The letter also sought a range of additional information and points of clarification regarding the proposals;
- Acknowledging receipt of the requests for scrutiny and inviting those making the requests to attend a future meeting of the Scrutiny Board (date to be determined). The letter also advised of the other action taken.

3.10 At the time of writing this report, a formal response from LTHT and/or NHS Leeds had not been received.

Use of 0844 Numbers at GP Surgeries

3.11 As Members of the Scrutiny Board will be aware, in September 2009, the Chair of the Scrutiny Board received correspondence from a member of Shadwell Parish Council, following concerns raised by local residents regarding the use of a 0844 telephone number at Shadwell Medical Centre.

3.12 The Department of Health undertook formal public consultation on the use of 084 telephone numbers within the NHS, between December 2008 and March 2009. The outcome of that consultation was published on 14 September 2009 and can be summarised as follows:

- The Department of Health intends to amend legislation and issue supporting guidance to NHS organisations to ensure that they review their current arrangements for telephony services and do not enter into future contracts/arrangements (or renew or extend an existing contract) where the overall effect of those arrangements is that patients pay more than the equivalent cost of calling a geographic number.
- The Department of Health intends to issue guidance to the NHS on the use of telephony systems that facilitate automated answering, recommending that the option to speak to a person should always be made available to the caller.
- The Department of Health does not intend to ban the 084 number range; rather, it intends to amend legislation and issue supporting guidance to the NHS to ensure that patients contacting the NHS do not pay more than the equivalent cost of a call to a geographic number, regardless of the number they call.

3.13 Following an exchange of correspondence between the Chair of the Scrutiny Board and NHS Leeds, it is clear that NHS Leeds intends to work with locally affected GP practices to understand the impact the results of the consultation may have. In a recent response, the Chair has asked that the Scrutiny Board be kept up-to-date with developments and has also sought clarification on the folowing:

- The overall number and location of the practices across Leeds currently utilising 0844 numbers;
- Who represent 'the providers of the service';
- Details of how NHS Leeds intend to reflect the concerns of patients and user groups, during any discussions with GP practices and the providers of the service;
- Details of the likely timescales involved.

3.14 The information received from NHS Leeds has been shared with the member of Shadwell Parish Council, along with details of how this is being taken forward on behalf of the Scrutiny Board. This has resulted in positive feedback both in terms of the action taken and the speed of response.

Health Proposals Working Group

3.15 At its previous meeting on 22 September 2009, the Scrutiny Board (Health) agreed to re-establish the working group and the associated terms of reference. The Board also agreed that Councillors Dobson and Chapman would form the core membership of the working group, with other members of the Board attending whenever possible.

3.16 At the time of writing this report, a date for the first meeting of this working group was yet to be agreed.

Openness in the NHS

3.17 The Department of Health publication 'Code of Practice on Openness in the NHS' (2003) sets out general principals for open and transparent decision-making within local NHS bodies.

3.18 In order to attempt to better understand how each of the local NHS Trusts interpret and implement the national guidance, Members will recall that, in August 2009, the Chair of the Scrutiny Board wrote to each Trust in this regard.

3.19 To date, responses from Leeds Partnerships NHS Foundation Trust (LPFT) and NHS Leeds have been received. A response from Leeds Teaching Hospitals NHS Trust (LTHT) is being actively sought. Once received, these details will be presented and considered by the Board, as appropriate.

Children's cardiac and neurosurgery services – national reviews

3.20 In September 2009, members of the Scrutiny Board were made aware of a national review of Children's Cardiac Surgery Services currently being undertaken. The review is at a relatively early stage, with the review programme expected to run for approximately two years. The key milestones are set out below:

Date	Milestone
Sep 2009	Draft clinical standards circulated to stakeholders for comment
Oct 2009	National stakeholder event in London
Nov 2009	Final version of clinical standards circulated
Jul 2010	SCGs submit recommendations for future service delivery
Jul 2010	NHS Management Board considers the recommendations
Sep 2010	Public consultation on the recommendations begins
Jan 2011	Implementation of recommendations begins (subject to the outcome of the consultation)

3.21 The draft clinical standards, received earlier this month and circulated to stakeholders for comment, are attached at Appendix 2.

3.22 Currently, 11 centres across England provide Children's Cardiac Surgery Services, with around 3,800 procedures being undertaken each year. One of the issues to be considered as part of the review will be a higher number of surgical procedures being carried out by each clinical team, with a larger number of surgeons in each surgical centre, and a smaller number of centres.

3.23 More recently, it has emerged that a similar national review of Children's Neurosurgery Services is also being undertaken.

3.24 Again, this review is at a relatively early stage and is expected to run for approximately two years. Currently, 15 centres across England provide Children's Neurosurgery Services. As yet, details of the key milestones and associated dates for the review have not been provided but are actively being sought.

3.25 A copy of the recently received Children's Neurosurgery Services Bulletin is attached at Appendix 3, for information.

3.26 Members of the Scrutiny Board will be interested to note that currently, both Children's Cardiac Surgery Services and Children's Neurosurgery Services are provided by Leeds Teaching Hospitals NHS Trust.

Executive Board Minutes

3.27 For information, the minutes from the Executive Board meeting held on 17 September 2009 are attached at Appendix 4. The Scrutiny Board is asked to consider these minutes within the context of making any adjustments to its work programme.

Work programme

3.28 A revised outline work programme is presented at Appendix 5 for consideration.

3.29 Members will be aware that the outline work programme should be regarded as a 'live' document, which may evolve and change over time to reflect any in-year change in priorities and/or emerging issues over the course of the year. As such, the Scrutiny Board is asked to consider the attached outline work programme and agree / amend as appropriate.

4.0 Recommendations

4.1 Members are asked to;

(i) Note the content of this report and associated appendices, particularly in terms of the updated positions reported across a number of work areas; and,
(ii) Consider the outline work programme attached at Appendix 5 and agree / amend as appropriate.

5.0 Background Documents

- Scrutiny Inquiry into the role of the Council and its partners in promoting good public health – agreed terms of reference (22 September 2009)
- Proposed Renal Services Provision at Leeds General Infirmary – Scrutiny Board Position Statement (29 July 2009)
- The use of 084 telephone numbers in the NHS – Department of Health response to consultation (September 2009)
- Code of Practice on Openness in the NHS – Department of Health (2003)
- Children's Cardiac Surgery Newsletter (August 2009)

This page is intentionally left blank

APPENDIX 1

Scrutiny Board (Health)

Renal Services: Provision at Leeds General Infirmary

Follow-up questions

Strategy

1. Following the decision to close the Wellcome Wing, and based on the information presented to the Scrutiny Board (dating back to early 2006), the provision of a 10 station dialysis unit at LGI has always been part of the longer-term plan for the provision of renal services. Please explain the rationale (including the clinical need) that informed the decision at that time, and outline what has subsequently changed.

2. At the recent Scrutiny Board meeting (28 July 2009), it was stated that renal dialysis formed part of a wider strategy for renal replacement therapy (RRT). Please provide the following information:

   - An outline of the wider/ overall RRT strategy and details of how and when this strategy was developed and adopted – including any involvement of overview and scrutiny committees across the region.
   - Confirmation of the renal centres across Yorkshire and the Humber, including the services/ treatments provided, the population/ geographical areas each centre serves and the current number of patients accessing haemodialysis.
   - Confirmation of the current number of kidney transplants per annum (regionally and locally).
   - Confirmation of the current number of patients using home dialysis (regionally and locally)
   - Confirmation of the 'ambitious targets' for increasing the number of transplants and the level of home dialysis (regionally and locally), including details of how this will be delivered.

Previously agreed plans

3. As recently as February 2009, it was reported to the NHS Leeds Trust Board that:

   'The longer term agreed plan for these stations is to maintain 18 stations at Seacroft and to relocate 10 stations to a renovated area within LGI. The new unit will open on Ward 44 at Leeds General Infirmary in December 2009. As of October 2008 LTH report that discussions were ongoing with patient representatives regarding the roll out of this development.'

   In March 2009, the LGI scheme had been withdrawn from the capital programme endorsed by the LTHT Board. This took place without the involvement or knowledge of the kidney patients, the wider population or the Scrutiny Board. It would also appear to have been taken forward without the knowledge or involvement of the service commissioners.

   Please explain how these circumstances arose. For example:

   - When did discussions about proposals not to proceed with the dialysis unit at LGI first take place within LTHT and who was involved?

- What, if any, considerations were given to involving other interested parties in these discussions, i.e. commissioners, patients and cares (i.e. KPA) and the Scrutiny Board.
- Why is there evidence to suggest that there was a parallel process running during the early part of 2009, whereby the KPA were still involved in discussions around the delivery of a unit at LGI?
- When did NHS Leeds and SCG first become aware of LTHT's proposals not to proceed with the dialysis unit at LGI?
- Does this signify a breakdown in communication between LTHT and NHS Leeds as commissioners?
- What does this situation say about the general relation between local NHS bodies?

4. The report presented to the LTHT Board (30 July 2009) refers to 34 dialysis stations on R&S ward at Seacroft

    - Who agreed this change?
    - When was this agreed?
    - Who was consulted over this change?
    - Why was the Scrutiny Board never specifically advised of this change in capacity/ provision and any implications for the longer-term strategy?
    - Was this a decision a deliberate move by LTHT to increase capacity at Seacroft by stealth and undermine the plans to re-provide services at the LGI as promised?

5. The LTHT report (30 July 2009) also states that *'…the ward 44 scheme involves a level transfer of 10 stations from Seacroft unit to LGI'.* Given the context of the LGI unit being part of the longer term plans, at what point did the planned unit at LGI involve the transfer of stations from Seacroft.

Demand and capacity

6. Please complete and/or correct the summary table presented at Appendix 1.

7. In the report presented to the LTHT Board (30 July 2009), the projected level of demand for renal haemodialysis is detailed as 558 (by 2013/14) from the current level of demand (i.e. 492). However, the Scrutiny Board received the following evidence from the National Kidney Federation:

    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).

    Please explain the methodology used that predicts local demand to rise by less than an average of 2% over 5 years.

8. The Scrutiny Board heard that currently there are 400 patients (approximately) awaiting pre-dialysis education. Please confirm the number of patients (both regionally and locally) and explain how this relates to the predicted level of demand.

9. The Scrutiny Board heard evidence to suggest that currently some patients are receiving a reduced level of dialysis – both in terms of time spent dialysing and

the number of dialysis sessions. Staff absence was cited as one reason. Please comment.

10. The Scrutiny Board also heard how current staffing issues across renal services is having an impact on the timely delivery of home dialysis. Please provide evidence that such services have adequate resources and capacity to offer this alternative to a wide group of patients in the short, medium and longer-term.

Patient survey

11. The report presented to the LTHT Board (30 July 2009) states that, *'…in a recent patient survey only 11 patients expressed a preference to dialyse at LGI…'.* Please provide a full summary of the outcome of the survey, including the questions posed and the options available. Please confirm whe the survey was carried out (and by whom) and the involvement of the KPAs.

Patient Transport

12. Pease provide details of the catchment areas for the current satellite units. i.e. Where are patients currently travelling from and to for their treatment?

13. What are the travelling times for patients from the North/ North-West of the City, who dialyse at Seacroft?

Role of the Scrutiny Board

14. The legislation and guidance around health scrutiny places a duty on local NHS bodies to consult with the Scrutiny Board on any proposed substantial development or variation in the provision of local health services. The guidance also states that NHS Trusts should discuss any proposals for service change at an early stage, in order to agree whether or not the proposal is considered substantial. In this instance it is clear that the local NHS bodies involved have failed in this duty.

- Please explain how this has happened and outline what steps will be taken to prevent a similar situation arising in the future.
- What evidence is there to demonstrate that the statutory role of the Scrutiny Board is recognised, understood and valued within the organisations that make up the local health economy?
- What assurances can be given to the Board that this situation is not reflective of a wider indifference to the role of scrutiny?

APPENDIX 1

LTHT RENAL CENTRE / SATELLITE UNITS – SUMMARY INFORMATION

Unit	No. of dialysis stations	Maximum capacity (2 sessions/day)	Current demand (2009)	Current utilisation/ occupancy[1]	Maximum capacity (3 sessions/day)	Projected demand (2013/14)	Comment
Beeston	10	40					
Halifax	10	40					
Huddersfield	10	40					
Seacroft (B ward)	10	40					
Dewsbury		48					
Wakefield		48					
Seacroft (R&S ward)	34	136					
SJUH (Wards 55/53)	27	110					17 adult stations 5 Hep B stations 5 paediatric stations
TOTALS		**502**	**492**	**98%**		**558**	

[1] Demand divided by capacity

APPENDIX 1

LTHT RENAL CENTRE / SATELLITE UNITS – SUMMARY INFORMATION

This page is intentionally left blank

NHS

National Specialised Commissioning Group

Safe and Sustainable

Paediatric Cardiac Surgery Services

Children's heart surgery centres in England

Draft service specification standards

September 2009

Contents

i. Welcome from the Chair of the working group

ii. Background to the *Safe and Sustainable* programme

iii. Draft service specification standards

iv. Related standards

v. Appendix A: Membership of the working group

vi. Appendix B: List of children's heart surgery centres in England

vii. Glossary (words in **bold** throughout this document appear in the glossary)

viii. How to make your views known

Welcome

In 2006, a national workshop attended by children's heart surgeons and cardiologists, other NHS staff and patient representatives concluded that the current configuration of children's heart surgery services in England was not sustainable. In response to this view the NHS Medical Director, Professor Sir Bruce Keogh, asked the **National Specialised Commissioning Group** to deliver recommendations that will ensure a safe and sustainable children's heart surgery service in England. This is called the *Safe and Sustainable* programme, and its motivation is to deliver the best possible care for children and their families into the future.

The *Safe and Sustainable* programme is overseen by a steering group chaired by Dr Patricia Hamilton, Director of Medical Education for England and Immediate Past President of the Royal College of Paediatrics and Child Health.

The steering group has asked me to chair a working group that has been tasked with developing a framework of service standards to inform and guide the process for future service configuration and future service delivery. Members of the working group are listed in this document. I would like to acknowledge the contribution of members of previous reviews of children's heart surgery services. Our work builds upon their previous recommendations, most notably the report of the Paediatric and Congenital Cardiac Services Review Group in 2003[1].

The standards working group will:

- examine existing standards, including international standards
- develop standards that will ensure that children's heart surgery centres are of the highest quality, responsive and ***sustainable.***

We will also identify the available evidence base for our recommendations and describe how centres will be measured on their compliance against standards in the future, though in this draft working document we wish to emphasise the standards we aspire to achieve.

My vision for children that need heart operations is nothing less than a world-class service and the very best possible outcomes. And to deliver this vision we need the surgeons who operate on these children and the teams who support them to be working to world-class standards. The draft standards in this document envisage a model of care that delivers as much care and treatment as close as possible to where children and their families live. This requires the surgical centres, local services and patients and their families, to work together to answer the question:

How do we achieve the very best, world class service?

This working document offers a first draft of these standards and we now invite all those with an interest in children's heart surgery services to give us their views on this draft by **10 November 2009**. You can find out how to do this at the back of this document.

I look forward to hearing your views.

Mr William Brawn
Consultant Paediatric Cardiac Surgeon
Chair of the Standards Working Group for the *Safe and Sustainable* Paediatric Cardiac Surgery Service Programme

[1] Report of the Paediatric and Congenital Cardiac Services Review Group, 2003, Department of Health; gateway ref: 1981

Background to the *Safe and Sustainable* Programme

On behalf of the **NHS Management Board**, the NHS Medical Director has asked the National Specialised Commissioning Group to undertake a review of the provision of children's heart surgical services in England with a view to reconfiguration. This is called the *Safe and Sustainable* Paediatric Cardiac Surgery Programme.

The programme is led by a steering group that includes representation from the following:

- Children's Heart Federation and lay representation
- British Congenital Cardiac Association
- Society for Cardiothoracic Surgery in Great Britain and Ireland
- Association of Cardiothoracic Anaesthetists
- Royal College of Paediatrics and Child Health
- Paediatric Intensive Care Society
- **NHS commissioners**
- NHS public health doctors
- **NHS Strategic Health Authorities**
- NHS in Scotland
- Health Commission Wales
- Department of Health.

There are currently 11 children's heart surgery centres in England. The centres are shown in Appendix B.

The programme aims to deliver robust proposals that will ensure that children's heart surgery services are world class into the future. We believe that children and their families will benefit from:

- a model of care that plans and delivers services around the needs of the child and which takes account of the transition to adult services
- improved communication and planning between specialised surgical centres and local hospitals that links care in an effective "**hub-and-spoke**" model
- a network of specialist surgical centres that collaborate with each other in the interests of clinical care, audit and research
- an NHS workforce that is highly trained and expert in the care and treatment of children and young people.

The draft standards that are set out in this working document form the quality framework that we envisage the centres will be working to in order to deliver a high quality, world class service. We welcome your views on the draft standards and we encourage you to make your views known.

The working group recommends that all of the draft standards in this document, if agreed, should be mandatory in all designated surgical centres, though it may be appropriate for some standards to become mandatory over a period of time.

The draft standards in this document do not apply to services for Grown-Ups with **Congenital Heart Disease** (GUCH services) as the NHS is developing a separate set of standards for GUCH services[2]. However, we have included draft standards that address the transition from child to GUCH services so that both sets of standards join-up in the interests of the patient.

No decisions have yet been made on the future shape of the children's heart surgery service in England, but the proposals may recommend that some existing centres stop performing surgery and interventional procedures in the interests of achieving the best possible clinical outcomes. The proposals will be developed in 2010 by **NHS commissioners** working in consultation with local stakeholders.

Once the proposals have been considered by the steering group we will hold a formal public consultation in 2010 so that all stakeholders have the opportunity to comment.

Further information on the *Safe and Sustainable* programme including terms of reference and minutes of meetings can be found on our website www.specialisedcommissioning.nhs.uk or by contacting us (our contact details are given at the back of this document).

Throughout this document, the term 'centres' refers to a number of NHS hospitals that will be designated in 2010 as specialised providers of children's heart surgery services.

[2] Designation of Specialist Service Providers for Grown-Ups with Congenital Heart Disease (GUCH)/ Adults with Congenital Heart Disease (ACHD)", East of England Specialised Commissioning Group, 2009

Draft service specification standards

Standard A – The network approach

We believe that care for children who need heart surgery is improved when all of the NHS services that treat them work together, and communicate with each other.

A1 Centres will agree pathways of care with their local services that reflect the principle that as much care and treatment should be provided as close as possible to the child's home, while ensuring the best possible outcome for the child.

A2 Centres should provide comprehensive care which is linked to local services as well as other tertiary centres. The centres are the hub of the clinical network providing the full range of surgery and interventional cardiology for all **congenital heart conditions**, and coordinating the care for children in their catchment area.

A3 Centres will collaborate with each other to manage demand (reflecting that collectively they provide a national service) and to develop and embed best practice and benchmark performance.

A4 Centres will establish models of care and service pathway mapping that will ensure quality care along the entire patient pathway.

A5 The centres will agree policies for referral criteria and discharge criteria between ***primary, secondary and tertiary care.***

A6 There will be written guidelines for the centres covering communication between clinicians, and between clinicians and parents / carers. The guidelines will be agreed with local referring ***paediatricians***, paediatric ***cardiologists*** and patient groups.

A7 There will be specific guidelines within each network for the transfer of children requiring heart surgery.

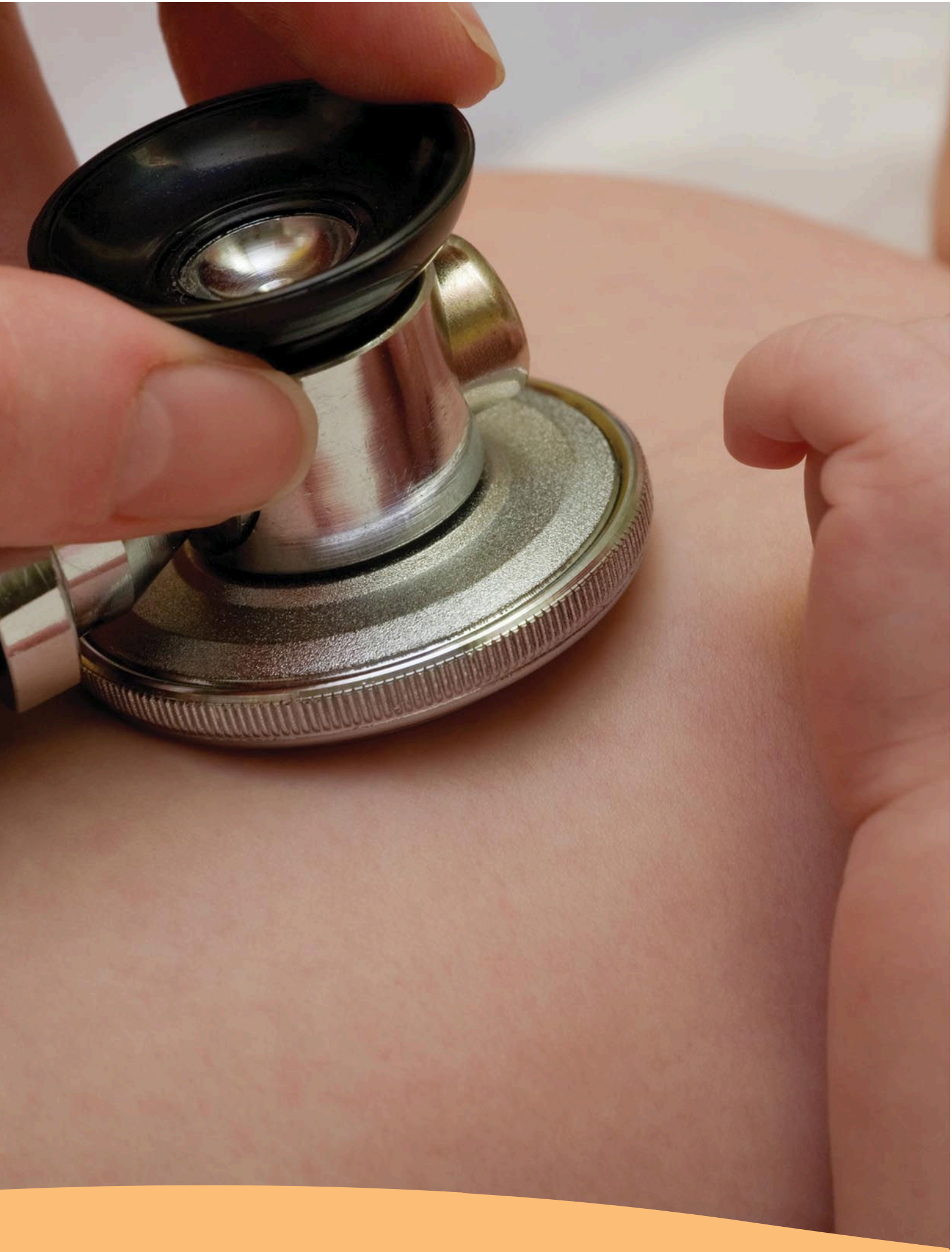
A8 Centres will provide active leadership and participation in their clinical networks in order to:

- manage and develop further referral, care and treatment pathways, policies, procedures, performance monitoring and audit, professional training and development
- facilitate the development of as much care and treatment as possible close to the child's home.

A9 Children transferring between services will be accompanied by high quality information, including a health records summary (with responsible clinician's name) and a management or follow up plan when appropriate.

A10 Children who require assessment for heart transplantation (including implantation of a mechanical device as a bridge to heart transplant) will be referred to a designated paediatric cardiothoracic transplant centre.

A11 The centres will agree clinical guidelines with their local networks, based upon nationally established standards. They will be responsible for advising colleagues within the network on the care for patients requiring associated non-cardiac interventions.



Standard B – Prenatal screening

We believe that babies with heart conditions and their mothers are best served by a specialised patient pathway that begins care before birth.

B1	Centres will agree and establish protocols with maternity and **neonatal** units in their catchment area for the care and treatment of pregnant women whose fetus has been diagnosed with a heart condition. The protocols must ensure that pregnant women are referred to the relevant specialist as early as possible, and that accurate diagnosis is made promptly.
B2	If the standard prenatal scan indicates that the fetus may have a heart problem, the mother should be offered a specialist heart scan as soon as possible, and in any event within 1 week.
B3	If the heart scan suggests that the fetus has a **cardiac lesion**, there should be a full medical assessment as soon as possible, and in any event within 1 week of the heart scan.
B4	All high-risk mothers (for example, where there is a history of congenital heart disease in the mother, father or previous child) should be offered a specialist heart scan at 18 -20 weeks.
B5	Parents who have been told that their expected child has a heart condition should have access to non-directive counselling and support to help them interpret the diagnosis and possible outcomes. Parents should also be given contact details for relevant local and national support groups at this point.
B6	A paediatric heart surgeon or paediatric cardiologist will be available for antenatal counselling for congenital cardiac anomalies.
B7	At diagnosis, a plan should be agreed between the centre, the maternity unit, the neonatal team and the parents about arrangements for the delivery of the baby.
B8	If the plan is for the delivery of the baby at the local maternity unit this should include arrangements for the transfer of the baby to the centre. An experienced paediatrician should be present at the delivery and a neonatal team must be available to care for the baby whilst awaiting transfer. There should be a facility to deliver the baby close to the centre if necessary (for example, at a linked obstetric unit).

Standard C – Making choices

We believe that NHS services should fully support parents and carers in making decisions about their child's treatment.

C1	Centres should encourage parents and carers to actively participate at every stage in their child's care.
C2	Parents and carers should be helped to understand their child's condition, the effect it may have on their child's health and future life and the treatment that they will receive.
C3	Information should be made available to parents and carers in a wide range of formats and on more than one occasion. It should be clear, understandable, and culturally sensitive and evidence based. When given verbally, information given should be precisely documented.
C4	When considering treatment options, parents and carers need to understand the potential risks as well as the benefits, the likely results of treatment and the possible consequences of their decisions so that they are able to give informed consent.
C5	Where surgery is planned, the child and their parents or carers should have the opportunity to visit the centre and to meet the clinicians who will be responsible for their care, including an opportunity to discuss the planned operation with a consultant paediatric heart surgeon who will obtain consent for the procedure.

C6 Parents, carers and their General Practitioners should be given details of all who they can contact in the clinical team should they have any questions or concerns. They should have immediate, 24-hour access to a member of the clinical team for advice, information and support.

C7 Parents and carers should receive support and cooperation in obtaining further opinions.

C8 Parents and carers whose first language is not English must be provided with appropriate interpreting and translation services.

C9 Parents and carers should be given details of available support groups. Involvement of these groups should be available early in the assessment process.

C10 Parents and carers should be given an agreed, written care plan that includes notes of discussions with the clinical team, the treatment options agreed and written record of consents.

Standard D – The patient and family experience

We believe that in addition to the best possible treatment, children and their families should have the best possible experience of their hospital.

D1	Each child should have a named cardiac liaison nurse who is responsible for coordinating their care, and who acts as a liaison between the clinical team and the child throughout their care.
D2	There must be facilities in place to ensure easy and convenient access for parents and carers. Facilities and support include accommodation for the whole family to stay at the hospital and for parents to stay with their child in the ward 24 hours a day when appropriate, access to refreshments, and to be able to play and interact with their child (and their other children). There should be a quiet room available on the ward or centre completely separate from general family facilities.
D3	There must be facilities, including access to maternity staff, that allow the mothers of new-born babies who are admitted as emergencies to stay with their baby for reasons of bonding, establishing breast feeding and the emotional health of the mother and baby.
D4	There should be dedicated clinical facilities that are designed around the needs of children (diagnostic, ward, theatre, staffing, support).
D5	Children should have access to general resources including toys, books, magazines, computers and other age appropriate activity coordinated by play therapy teams.

D6 Parents and carers should be provided with accessible information about the service and the hospital, including information about amenities in the local area, travelling, parking and public transport.

D7 Children, their parents and carers should be encouraged to provide feedback on the quality of care and their experience of the service, and they should be encouraged to participate in national Patient Reported Outcome Measures (PROMS) surveys. Centres must make this feedback openly available, and they must demonstrate how they take this feedback into account when planning and delivering their services.

D8 Staff in the multi-disciplinary team should have training and be supported in using communication skills. Staff should be trained in breaking bad news.

D9 There must be access to culturally appropriate support services including faith support, social workers, interpreters, clinical psychologists and bereavement counsellors. These should be made available at the specialist centre and links to facilitate this at a local level should also be developed.

D10 Parents, carers and support groups will be regularly updated with appropriate information on issues of clinical governance and the results of local and national audits.

D11 There should be formal arrangements for addressing complaints and other comments made by children, parents and carers.

Standard E – Access to services

We believe that heart surgery services should be planned and delivered around the needs of the child.

E1	There will be 24 hour, 7 day a week access to paediatric cardiac surgical advice and care. The consultant on duty will be available by phone for urgent advice and able to attend their own centre within 30 minutes.
E2	Each centre will provide a full 24 hour emergency service, sufficient to meet the needs of its catchment population.
E3	Each centre will provide interventional cardiology. This should not be undertaken without on-site surgical back up.
E4	Each cardiology team will have a lead interventionist who is responsible for assuring the quality of the cardiology team's work overall, including involvement in the planning of procedures and the audit of activity; taking steps to eliminate occasional practice; and ensuring that interventionists have received training and are competent in the procedures that they undertake.
E5	Each centre will be co-located with **anaesthetists** trained in paediatric cardiac anaesthesia.
E6	Each centre will be co-located with paediatric critical care services.
E7	All children requiring investigation and treatment will receive that care from staff trained in looking after children and trained specifically according to the requirements of their profession or discipline.
E8	There must be sufficient 24 hour access to the complete range of supportive paediatric medical and surgical services and other resources required for end to end management of the child's needs for the whole patient journey including Paediatric Intensive Care Units (PICU), accredited diagnostic laboratory services (Clinical Pathology Accreditation UK) and blood transfusion.

E9 Centres will have on-site access to:

- Experienced paediatric **Intensivists**
- Experienced PICU and High Dependency Unit (HDU) nurses
- **Extracorporeal mechanical support** (for support post-cardiac surgery)
- **Transoesophageal Echocardiography** (TOE)
- **Computed Tomography** and **Magnetic Resonance Imaging** (+/- GA)
- Paediatric competent **radiologist**
- Infection control nurse experienced in the needs of paediatric cardiac surgery patients
- Paediatric pain control nurse cover
- Paediatric pharmacist cover
- Paediatric physiotherapy
- Play therapy staff
- Paediatric dietician
- Paediatric social worker
- Hospital / school teacher
- Child and adolescent mental health professionals with dedicated sessions in congenital heart disease (for patients and staff).

E10 Centres must be able to provide (in accordance with the Framework of Critical Inter-Dependencies[3]):

- Specialised Paediatric Surgery: a transfer to, or visit from, a paediatric surgical specialist within 4 hours; it is desirable that this service is co-located but may not be practical in all configurations
- Paediatric Ear, Nose and Throat (Airway): a transfer to, or visit from, a paediatric ENT specialist by the next working day
- Paediatric Neurology: a transfer to, or visit from, a paediatric neurology specialist by the next working day
- Paediatric Respiratory Medicine: a transfer to, or visit from, a paediatric respiratory specialist by the next working day
- Neonatology: a transfer to, or visit from, a neonatal specialist by the next working day
- Nephrology: a transfer to, or visit from, a nephrology specialist by the next working day
- Clinical Haematology: a transfer to, or visit from, a clinical haematology specialist by the next working day

E11 Admission for planned surgery will be booked for a specific date rather than from a waiting list.

E12 Same-day cancellations for non-clinical reasons of elective cases shall not be more than 0.8 per cent. There shall not be more than 0.8 per cent of patients who are not offered a binding date for operation within 28 days of the cancellation.

E13 Transfers in and out of the centres should be dictated by individual patient need.

E14 Un-planned readmission to Paediatric Intensive Care Unit (PICU) should only occur in less than 10 per cent of admissions.

E15 All paediatric cardiac surgical cases should be carried out on theatre lists with appropriately trained staff.

E16 Nursing staff numbers will be sufficient to allow HDU nursing and one to one PICU nursing.

E17 Sufficient staff will be available to provide in-patient beds, critical care beds, theatre capacity and service provision.

a) There must be sufficient access to on-site beds (suitably staffed) to guarantee 100 per cent acceptance rates for emergency referrals

b) There must be sufficient access to formal cardiac surgery beds (suitably staffed) to guarantee 100 per cent acceptance rates

When a centre cannot admit a patient for whatever reason it is the responsibility of that centre to find another bed (suitably staffed) at another centre.

E18 There must be an appropriate mechanism for arranging retrieval and back transfer of patients which takes into account the following:

- clinical transfers should be arranged in a timely manner according to patient need
- critically ill children must be transferred/retrieved in accordance with the standards set out within the designation standards for Paediatric Intensive Care services[4].

E19 Sufficient capacity will be available to allow urgent cases to be accommodated in daytime lists by providing a dedicated paediatric cardiac surgery operating theatre with access for emergency cases.

E20 There should be arrangements for accepting patients transferred by incoming helicopter and fixed wing aircraft. It is not mandatory for centres to have on-site landing facilities, though this is desirable.

E21 There must be an appropriate network of care to facilitate repatriation in a timely fashion. Acute beds must not be used for this purpose once patients have been deemed fit for discharge from acute cardiac surgical care.

[3] "Commissioning Safe and Sustainable Specialised Paediatric Services: A Framework of Critical Inter-Dependencies" Department of Health, 2006, Gateway Ref: 10044

[4] Currently draft with a Paediatric Intensive Care Society working party for consultation

Standard F – Age appropriate care

We believe that children and adolescents should receive care that is appropriate to their age and which facilitates the transition to adult services.

F1	Centres should make the patient aware and responsible for their condition from an appropriate age.
F2	The patient's management plan should be reviewed at each consultation to make sure that it continues to be relevant to their particular stage of development.
F3	When the patient begins school or moves to a new school the cardiac liaison service should be available to provide information or visit the school in person at the parent's request, in order to help teachers and other staff understand the patient's condition.
F4	Centres should provide the patient with information on relevant life-style issues at an appropriate stage and in a way that is accessible. Parents should be involved in decisions over timing of this information.
F5	Young people should have the opportunity to be seen by the consultant for part of the consultation without a parent being present.
F6	Appropriate "transition clinic" arrangements should be in place with designated centres for Grown-Ups with Congenital Heart Disease to ensure a seamless pathway of care, led jointly by paediatric and adult cardiologists. There should be access to adolescent beds for the care and treatment of adolescents and young people. These adolescent beds may be on site or off site or part of a broad adolescent unit.
F7	There will not be a fixed point of transition between children's and adult services but the process should be initiated no later than 14 years of age. Children, parents and carers should be fully involved in discussions around the clinical issues. The views, opinions and feelings of the child should be fully heard and considered.

Standard G – Excellent Care

We believe that children are entitled to the best possible care and treatment, delivered by exceptional clinical and nursing staff.

G1 All clinicians and nursing staff will take part in a programme of continuing professional development.

G2 All clinical teams will operate within a robust and documented clinical governance framework that includes undertaking clinical audit.

G3 All members of the Multi-Disciplinary Team (MDT) will take part in continuing education and continuing professional development. Training Programmes will where possible submit to regular external review of content, facilities and results. Staff will have an annual appraisal and re-licensing and re-validation consistent with their appropriate professional registration. There must be appropriate resources to support educational needs (such as seminar rooms and technical equipment).

G4 Each centre will have a robust internal database and outcome monitoring tool, with standardised coding. All aspects of clinical practice where recognised standards exist, or improvements might be made, should be considered for audit. Individual and collective outcomes will be analysed, deficiencies identified and corrected by formal audit. At least one audit of clinical practice of demonstrable clinical significance should occur annually.

G5 The patient's outcome will be assessed with results monitored and compared against national and international outcome statistics.

G6 Centres will participate in national programmes for audit and contribute to national databases:

1. **National Central Cardiac Audit Database**
2. In-house computerised database

There must be a specific paediatric cardiac surgery/cardiology data collection manager responsible for timely audit and database submissions, no more than 3 months after patient is discharged.

G7 Systems will be in place to allow the managed introduction of new treatments and techniques into the centre. The centres will follow mandatory **NICE** guidance and work within the constraints set within relevant NICE Interventional Procedures Guidance[5].

G8 Centres will collaborate at a clinical, audit, research and administrative level, and will take part in formal inter-unit peer review.

G9 Each centre should have, and regularly up-date, a research strategy and programme which documents current and planned research activity, the resources needs to support the activity and objectives for development.

G10 The research strategy shall include a commitment to working in partnership with other centres in research activity which aims to address research issues which are important for the further development and improvement of clinical practice, for the benefits of children and their families.

G11 Each centre shall strive to continuously improve its research infrastructure, and such improvements will be monitored regularly.

G12 Each centre will have a dedicated management group for the internal management and coordination of service delivery. The group will comprise the different departments and disciplines delivering the service.

[5] A summary of how NICE develops interventional procedures guidance is available at www.nice.org.uk/guidance

Standard H – Team delivered

We believe that the standard of care is at its highest when the skills and experience of the whole clinical team is brought to each case.

H1 The management of each patient should be discussed and planned at combined cardiac surgery and cardiology MDT meetings to ensure the best possible care and outcomes for children.

H2 Patients will be cared for by MDTs containing adequate numbers of specifically trained staff. The team shall include the following personnel:

- Clinicians directly responsible for patient care, including paediatric cardiac surgeons, paediatric cardiologists and paediatric anaesthetists / critical care specialists, together with junior staff in each of these specialties. All consultant clinicians are expected to have expertise in the management of patients with paediatric cardiac disease
- Paediatric cardiac liaison nurses
- Dietician, pharmacist, physiotherapist, social worker
- Clinicians involved in specialist diagnostic services, including paediatric cardiac radiology, histopathology and microbiology

The composition of the MDT can be adjusted according to the needs of different aspects of the service (for example, assessment, post-operative care, clinico-pathological and audit meetings).

H3 Centres must provide appropriately trained and experienced medical staff sufficient to provide 24 hour, 7 day cover within legally compliant rotas.

H4 The attendance and activities of the MDT should be maintained in a register.

H5 There must be a 24 hour, seven day a week cover by paediatric cardiology consultants who should do ward rounds on all paediatric cardiology patients on a daily basis. There must also be 7 day access to interventional cardiology medical cover on an emergency or elective basis.

H6 The paediatric intensive care unit should be staffed on a 24 hr basis by PICU consultants with appropriate skills in paediatric cardiac critical care.

Consultant allocation to paediatric cardiology/surgery care will allow adequate clinical cover of the centre including on-call responsibility, management, audit, teaching, retrieval, follow up, research and development.

H7 Each centre will have a continuous and documented availability of formally trained paediatric cardiac anaesthetists including a specialist on-call rota which is separate from the intensive care rota. Cardiac anaesthetists involved in cardiac surgical services should have experience and training in the peri-operative care of the paediatric cardiac patient.

H8 There will be sufficient recovery staff with experience in paediatric cardiac surgery to allow a constant throughput of paediatric cardiac patients. Full monitoring of the paediatric cardiac surgical patient should be available in the immediate post-operative period.

H9 There must be an appropriate number of paediatric cardiac liaison nurses within each centre. The Steering Group will make a recommendation on the minimum number of cardiac liaison nurses.

Standard I – Safe and Sustainable

We believe that children's heart surgery services must be *safe and sustainable* into the future, taking account of the need to avoid occasional surgical practice.

I1	Each centre must perform a minimum number of surgical procedures each year.	Evidence suggests that centres that perform a higher number of surgical procedures have better clinical outcomes. A summary of the evidence that relates specifically to children's heart surgery is available on our website www.specialisedcommissioning.nhs.uk To avoid occasional practice the Steering Group will make a recommendation on the minimum number of annual surgical procedures per centre.
I2	All children requiring heart surgery will be managed by consultant paediatric surgeons.	
I3	Each centre must have a minimum number of paediatric surgeons. a) Paediatric cardiac surgeon is defined as having two years dedicated training in a designated paediatric heart surgical centre. b) No new appointments without the equivalent of a formal two year fellowship training.	To ensure that centres are able to implement a legally compliant rota and to ensure that centres can deliver the range of surgical procedures the Steering Group will make a recommendation on the minimum number of surgeons within each centre.

Related standards

Centres must also meet these related standards and best practice guidance in full:

National Standards for the Care of Critically Ill Children	2009, Paediatric Intensive Care Society; (currently draft)
Improving Services for Children in Hospital	2007, Commission for Healthcare, Audit and Inspection
"Transition: Getting It Right For Young People"	2006, Department of Health; product number 271558; gateway ref: 5914
The National Service Framework for Children, Young People and Maternity Services	2004, Department of Health, and Department of Education and Skills; product number: 40496; gateway ref: 3779
Recommendations of the British Paediatric Cardiac Association for Therapeutic Cardiac Catheterisation in Congenital Heart Disease	2002, British Cardiac Society

Centres must take these standards and best practice guidance into account:

"Designation of Specialist Service Providers for Grown-Ups with Congenital Heart Disease (GUCH)/ Adults with Congenital Heart Disease (ACHD)"	2009, East of England Specialised Commissioning Group
National Heart and Lung Transplant Standards	2006, National Specialist Commissioning Advisory Group
National Service Framework for Long Term Conditions	2005, Department of Health; product number 265109; gateway ref: 2005

Appendix

Appendix A: Membership of the Standards Working Group

Name	Constituency	Role
Mr William Brawn (Chair)	British Congenital Cardiac Association (President)	Consultant Paediatric Cardiac Surgeon, Birmingham Children's Hospital NHS Foundation Trust
Dr Martin Ashton-Key	Specialised Commissioning / Public Health	Medical Adviser, National Specialised Commissioning Team
Dr Geoffrey Carroll	NHS in Wales	Medical Director, Health Commission Wales
Steve Collins	National Specialised Commissioning Team	Deputy Director Policy and Coordination, NSC Team
Michaela Dixon	Nursing	University Hospitals Bristol NHS Foundation Trust
Professor Martin Elliott	British Congenital Cardiac Association	Consultant Paediatric Cardiac Surgeon, Great Ormond Street Hospital for Children NHS Trust
Jeremy Glyde	National Specialised Commissioning Team	Programme Manager, NSC Team
Dr Kate Grebenik	Association of Cardiothoracic Anaesthetists	Consultant Anaesthetist, Oxford Radcliffe Hospitals NHS Trust
Mr Leslie Hamilton	Society for Cardiothoracic Surgery in Great Britain and Ireland (President)	Consultant Cardiac Surgeon, Newcastle upon Tyne Hospitals NHS Foundation Trust
Dr Sue Hobbins	Royal College of Paediatrics & Child Health	Consultant Paediatrician, South London Healthcare NHS Trust
Dr Ian Jenkins	Paediatric Intensive Care Society (President)	Consultant Intensivist, University Hospitals Bristol NHS Foundation Trust
Anne Keatley-Clarke	Patients and public	Chief Executive, Children's Heart Federation
Dr Shakeel Qureshi	British Congenital Cardiac Association (President Elect)	Consultant Paediatric Cardiologist, Guy's and St Thomas' NHS Foundation Trust
Peter Ripley	Ambulance NHS Trust	Assistant Director of Operations, East Midlands Ambulance Service NHS Trust
Dr Graham Stuart	British Congenital Cardiac Association	Adult Cardiologist, University Hospitals Bristol NHS Foundation Trust

Appendix B: Children's heart surgery centres in England

- Freeman Hospital, Newcastle
- Leeds Teaching Hospital
- Alder Hey Children's Hospital, Liverpool
- Glenfield Hospital, Leicester
- Birmingham Children's Hospital
- Oxford John Radcliffe Hospital
- Bristol Royal Hospital for Children
- Great Ormond Street Hospital for Children, London
- Royal Brompton Hospital, London
- Evelina Children's Hospital, London
- Southampton General Hospital

Glossary

Page 04 **National Specialised Commissioning Group**: The group that oversees specialised commissioning in the NHS in England.

Page 06 **NHS Management Board**: The group that supports the NHS Chief Executive in managing NHS performance and shaping policy and strategy in the NHS.

Page 06 **NHS strategic health authorities**: There are 10 strategic health authorities in England, responsible for the local management of the NHS in their regions.

Page 06 **'Hub and spoke':** A model of care that has a specialist centre (the hub) working very closely with a number of local centres that each provide the non-specialist element of care (the spokes).

Page 06 **NHS commissioners**: NHS commissioners ensure that health services effectively meet the needs of the population. Commissioners assess the health needs of the population, develop a strategic plan, procure health services from health providers and manage their performance in the delivery of services.

Page 07 **congenital heart disease**: An abnormality of the heart present since birth.

Page 08 **primary care**: Health services provided in the local community, such as General Practitioners and dentists.

Page 08 **secondary care**: Health services provided in hospitals, either on a planned or emergency basis.

Page 08 **tertiary care**: Health services that are provided on a specialised basis in hospitals, for rare and complex conditions.

Page 08 **Paediatrician**: A medically qualified doctor who specialises in the diagnosis and treatment of children.

Page 08 **Cardiologist**: A medically qualified doctor who specialises in the investigation, diagnosis and treatment of heart disease. Cardiologists do not perform surgery, but may undertake interventional cardiology.

Page 11 **neonatal**: refers to new born infants.

Page 11 **cardiac lesion**: An abnormality of the heart.

Page 16 **Anaesthetist**: A medically qualified doctor who induces sleep during surgical procedures.

Page 17 **Intensivist**: A medically qualified doctor who specialises in treatment in intensive care units.

Page 17 **Extracorporeal mechanical support**: A device that removes blood from the patient's body, introduces oxygen into the blood, and then pumps the oxygenated blood back into the patient's body.

Page 17 **Transoesophageal Echocardiography**: A specialised means of taking ultrasound images of the heart.

Page 17 **Computed Tomography and Magnetic Resonance Imaging**: Specialised methods of taking images of the internal body.

Page 17 **Radiologist**: Medically qualified doctors who specialise in the use of imaging techniques to diagnose and treat conditions.

Page 22 **National Central Cardiac Audit Database**: A database available to the public that provides information on every children's heart surgical centre in the United Kingdom, including the number and range of procedures they carry out and survival rates for the most common types of treatment.

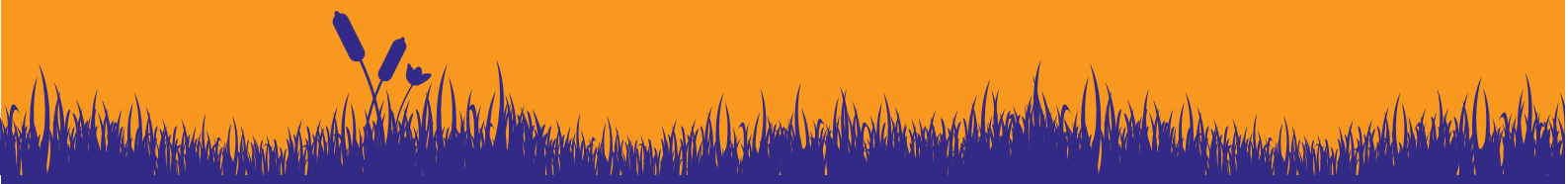
Page 23 **National Institute for Health and Clinical Excellence (NICE)**: An independent organisation responsible for providing national guidance on promoting good health, and preventing and treating ill health.

How to make your views known

We value the opinions of everyone concerned and are keen for you to contribute to the development of these draft standards. You can do so in the following ways:

- write to Jeremy Glyde, Programme Manager, National Specialised Commissioning Team, 2nd floor, Southside, 105 Victoria Street, London SW1E 6QT
- call Jeremy on 020 7932 3958
- e-mail ChildHeart@nsscg.nhs.uk

Visit our website **www.specialisedcommissioning.nhs.uk**



www.specialisedcommissioning.nhs.uk

September 2009

Welcome

Welcome to the first e-bulletin for the ***Safe and Sustainable*** review of children's neurosurgical services.

The aim of this and future e-bulletins is to up-date you on progress, key developments and diary dates, and remind you how you can contribute to the review. The ***Safe and Sustainable*** Steering Group wants to hear from as many people as possible, so please pass this bulletin onto your colleagues.

Building a world class service

In 2009, the NHS Medical Director, Professor Sir Bruce Keogh asked the National Specialised Commissioning Group (NSCG) to conduct a review of children's neurosurgical services in England.

The aim of the review is to deliver, within two years, robust proposals that will secure a safe, sustainable and world class service for children and their families.

The NSCG has established a Steering Group to lead the review, chaired by Mr Paul Chumas, a consultant paediatric neurosurgeon and former chair of the British Paediatric Neurosurgeons Group. The Steering Group will report regularly to the NSCG.

The Steering Group is supported by a working group, responsible for developing service specification standards for children's neurosurgery services. This group is jointly chaired by Mr Ian Pople, a consultant paediatric neurosurgeon and member of the Society of British Neurological Surgeons and Dr Geoffrey Carroll, Medical Director of Health Commission Wales.

Secretariat support for the review is provided by the National Specialised Commissioning Team.

Full details of the membership of these groups, terms of reference and meeting papers can be found at **www.specialisedcommissioning.nhs.uk** or by contacting the review team (contact details are provided below).

Review update

The focus for the ***Safe and Sustainable*** Steering Group in 2009 is to:

- review current arrangements for children's neurosurgical services including levels of need and activity in each of the 15 centres in England
- develop criteria for a formal designation process that ensures that children's neurosurgical services meet service specification standards, as well as meet national demand
- develop service specification standards that will form a national quality framework within which children's neurosurgery centres will be assessed
- canvass the views of stakeholders on the future shape of children's neurosurgical services.

The Steering Group will be asking for views on the draft designation and service specification standards at its first national stakeholder event in November 2009. See the item below for event details.

Delivering recommendations

The process for developing recommendations for future service configuration will be overseen by the National Specialised Commissioning Group (NSCG). In 2010 the NSCG will consider the outcome of the Steering Group's initial review, and will ask NHS commissioners to develop recommendations for future service configuration. These recommendations will be worked up in consultation with local stakeholders, and the NSCG will ensure that recommendations are consistent with the overall aims of the ***Safe and Sustainable*** programme.

Once the NSCG has considered the recommendations, it will seek views and opinions from all stakeholders via a comprehensive public consultation.

National stakeholder event

The NSCG and the Steering Group want the process for review to be inclusive and for all stakeholders to be able to contribute to the work of the review. A series of stakeholder events will be held over 2009 and 2010, starting with a national event in London on 30 November 2009.

Do you want to help build world class children's neurosurgical services for the future? Then secure your place at the first national stakeholder event for the ***Safe and Sustainable*** children's neurosurgery services review by contacting **Robin Matheou** on **020 7932 9122** or **robin.matheou@nsscg.nhs.uk**

Event details are as follows:

Date: Monday, 30 November 2009

Time: From 9.30am to 4.30pm

Venue: Dexter House, No.2 Royal Mint Court, Tower Hill, London, EC3N 4QN.

Have your say

The ***Safe and Sustainable*** Steering Group wants to hear from anyone who has views on the future delivery of children's neurosurgical services in England.

You can do so by:

- writing to Jeremy Glyde, Programme Manager, National Specialised Commissioning Team, 2nd floor Southside, 105 Victoria Street, London, SW1E 6QT
- call Jeremy on 020 7932 3958
- e-mailing **ChildNeuro@nsscg.nhs.uk**

This page is intentionally left blank

EXECUTIVE BOARD

THURSDAY, 17TH SEPTEMBER, 2009

PRESENT: Councillor R Brett in the Chair

Councillors A Carter, J L Carter,
R Finnigan, S Golton, R Harker, P Harrand,
J Procter, K Wakefield and J Monaghan

Councillor R Lewis – Non-voting advisory member

85 Exclusion of the Public

RESOLVED – That the public be excluded from the meeting during the consideration of appendices 2 and 3 to the report referred to in Minute No. 87, under the terms of Access to Information Procedure Rule 10.4(3) and on the grounds that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, as disclosure could prejudice the commercial interests of the Council and other outside bodies.

86 Late Items

There were no late items submitted for consideration, however, a revised version of exempt appendix 2 and exempt appendix 3 to agenda item 5 were circulated prior to the meeting (Minute No. 87 refers).

DEVELOPMENT AND REGENERATION

87 Leeds United Thorp Arch Academy

Further to Minute No. 73, 26th August 2009, the Director of Resources, the Director of City Development and the Assistant Chief Executive (Corporate Governance) submitted a joint report regarding an approach received from Leeds United Football Club with respect to possible Council involvement in the purchase of the Thorp Arch training facility.

A revised version of exempt appendix 2 and appendix 3 to the report were circulated prior to the meeting for Members' consideration.

Following consideration of appendices 2 and 3 to the report, designated as exempt under Access to Information Procedure Rule 10.4(3) which were considered in private at the conclusion of the meeting, it was

RESOLVED –

(a) That the Director of Resources, the Director of City Development and the Assistant Chief Executive (Corporate Governance) be authorised to continue negotiations with the Club with a view to agreeing terms that incorporate the conditions now specified by the Executive Board; and

(b) That, subject to such terms as finally negotiated being agreed by the Chair, the Executive Member for Development and Regeneration, the Leader of the Morley Borough Independent Group and the Leader of the Labour Group, the officers named above be given delegated

authority to enter into any documentation necessary to conclude the relevant transactions.

DATE OF PUBLICATION: 21st September 2009
LAST DATE FOR CALL IN: 28th September 2009

(Scrutiny Support will notify Directors of any items called in by 12.00 noon on 29th September 2009)

APPENDIX 5

Scrutiny Board (Health)

Work Programme 2009/10 – updated October 2009

Item	Description	Notes	Type of item
Meeting date – 20 October 2009			

Scrutiny Inquiry – promoting good public health	**Session 1:**
	To consider issues associated with ***improving sexual health and reducing the level of teenage pregnancies***, such as:
	• The role of the Council and its NHS health partners in developing and delivering appropriate strategies that:
	  ○ Raises general public awareness of the health risks associated with poor sexual health and the impact of teenage pregnancies.
	  ○ Identifies and targets those groups most at risk of poor sexual health and teenage conceptions.
	  ○ Promotes easy access to associated services and treatments.
	  ○ Assesses the quality and effectiveness of associated services and treatments.
	• Progress against the recommendations identified in the Scrutiny Inquiry report – *Improving Sexual Health Among Young People (April 2009).*
			RP/DP

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 5

Scrutiny Board (Health)

Work Programme 2009/10 – updated October 2009

Item	Description	Notes	Type of item
Meeting date – 24 November 2009			

Scrutiny Inquiry – promoting good public health	**Session 2:**
	To consider issues associated with ***reversing the rise in levels of obesity and promoting an increase in the levels of physical activity***, such as:
	• The role of the Council and its NHS health partners in developing and delivering appropriate strategies that:
	  ○ Raises general public awareness of the health risks associated with obesity and inactive lifestyles.
	  ○ Identifies and targets those groups most at risk of becoming obese and leading inactive lifestyles.
	  ○ Assesses the quality and effectiveness of services and treatments associated with obesity.
	  ○ Promotes easy access to leisure facilities and activities.
	• The role of the Council in terms of its power of well-being through planning policies and associated enforcement/ control procedures.
	• The role of commercial sector partners in promoting healthier lifestyles.
			RP/DP

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 5

Scrutiny Board (Health)

Work Programme 2009/10 – updated October 2009

Item	Description	Notes	Type of item
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
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

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 5

Scrutiny Board (Health)

Work Programme 2009/10 – updated October 2009

Item	Description	Notes	Type of item
Meeting date – 19 January 2010			

Scrutiny Inquiry – promoting good public health	**Session 3:**
	To consider issues associated with ***promoting responsible alcohol consumption***, such as:
	• The role of the Council in terms of licensing policy and associated enforcement/ control procedures.
	• The role of the Council and its NHS health partners in developing and delivering an alcohol strategy that:
	  ○ Raises general public awareness of the health risks associated with alcohol consumption.
	  ○ Identifies and targets those groups most at risk from the affects of alcohol abuse, ensuring they have access to the most appropriate services and treatments.
	  ○ Assesses the quality and effectiveness of services and treatments associated with reducing alcohol related harm.
	• The social responsibility role of breweries, retailers and licensees and how this shapes the consumption of alcohol in Leeds.
			RP/DP

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 5

Scrutiny Board (Health)

Work Programme 2009/10 – updated October 2009

Item	Description	Notes	Type of item
Meeting date – 16 February 2010			

Scrutiny Inquiry – promoting good public health	**Session 4:**
	To consider issues associated with ***reducing the level of smoking*** , such as:
	• The role of the Council and its NHS health partners in developing and delivering appropriate strategies that:
	  ○ Raises general public awareness of the health risks associated with smoking.
	  ○ Identifies and targets those groups most at risk of smoking and smoking related illnesses.
	  ○ Assesses the quality and effectiveness of services and treatments associated with smoking cessation.
			B/RP

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

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 5

Scrutiny Board (Health)

Work Programme 2009/10 – updated October 2009

Item	Description	Notes	Type of item
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
Meeting date – 27 April 2010			
Scrutiny Inquiry – promoting good public health	To agree the Board's final inquiry report.		
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 5

Scrutiny Board (Health)

Work Programme 2009/10 – updated October 2009

Working Groups (TBC)			
Working group	**Membership**	**Progress update**	**Dates**
Health Proposals Working Group	*All Scrutiny Board members. Core membership of Cllr. Dobson and Cllr. Chapman*	• Working group re-established and terms of reference agreed. • Membership established	*To be confirmed*
Supporting working age adults with severe and enduring mental health problems	*Cllr. John Illingworth* *Mr. Eddie Mack*	**This inquiry is being undertaken by the Scrutiny Board (Adult Social Care) with nominated representatives from Scrutiny Board (Health)** • Working group re-established and terms of reference agreed. • Membership established • Initial meeting dates arranged	*19 October 2009* *15 December 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 5

Scrutiny Board (Health)

Work Programme 2009/10 – updated October 2009

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Provision of Renal Dialysis at Leeds General Infirmary	To consider proposals around the provision of renal dialysis services across the City, with particular reference to the previously proposed unit at LGI.	28 July 2009 – proposals considered at the Scrutiny Board on and position statement produced for LTHT Board meeting 30 July 2009. 30 July 2009 – LTHT Board decision deferred. 7 August 2009 – request for additional information/ series of questions issued to health partners. 3 September 2009 – follow-up letter to request sent 7 August 2009. 10 September 2009 – letter from LTHT advising that it was hoped to respond formally in 2nd week of October 2009 (following the Trust Board meeting on 7 October 2009) 6 October 2009 – letter to LTHT seeking clarification on progress, given that no formal report scheduled for the LTHT Board meeting on 7 October 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 5

Scrutiny Board (Health)

Work Programme 2009/10 – updated October 2009

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Provision of dermatology services at Ward 43 (Leeds General Infirmary (LGI))	To consider proposals around the provision of dermatology services at Ward 43 (Leeds General Infirmary (LGI))	2 separate requests for scrutiny received. 8 October 2009 – letter sent to LTHT / NHS Leeds seeking a moratorium on the proposals until more detailed examination by the Scrutiny Board.
Use of 0844 Numbers at GP Surgeries	To consider the impact of the recent Government guidance on local GP practices and any implications for patients.	Various correspondence exchanged and clarification sought. The Board to maintain a watching brief and kept up-to-date with any developments
Openness in the NHS	To consider how the Department of Health guidance is interpreted and implemented locally.	An outline of the approach adopted by the local NHS Trusts requested. Responses from NHS Leeds and LPFT received. Reply from LTHT awaited.

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 5

Scrutiny Board (Health)

Work Programme 2009/10 – updated October 2009

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Children's Cardiac Surgery Services	To contribute to the national review and consider any local implications.	First newsletter published (August 2009) National stakeholder event scheduled for 22 October 2009. Draft clinical standards issued for consultation.
Children's Neurosurgery Services	To contribute to the national review and consider any local implications.	First bulletin published (September 2009) National stakeholder event scheduled for 30 November 2009.
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.

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