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Leeds CITY COUNCIL

SCRUTINY BOARD (HEALTH)

Meeting to be held in Civic Hall, Leeds on
Tuesday, 24th November, 2009 at 9.30 am*

NOTE: An adjournment will take place at approximately 1.00pm.
Lunch will be provided for Members of the Board

(No pre-meeting)

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

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A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded). (* In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the Chief Democratic Services Officer at least 24 hours before the meeting).	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND PUBLIC** 1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report. 2 To consider whether or not to accept the officers recommendation in respect of the above information. 3 If so, to formally pass the following resolution:- **RESOLVED –** That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows:- **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 20th October 2009.	1 - 6
7			**PROVISION OF RENAL SERVICES** To consider the attached report of the Head of Scrutiny and Member Development presenting the Scrutiny Board (Health) with additional information to assist members to consider current proposals associated with the provision of renal services (dialysis) across the Trust, particularly in terms of provision at Leeds General Infirmary (LGI).	7 - 70
8			**PROVISION OF DERMATOLOGY SERVICES** To consider the attached report of the Head of Scrutiny and Member Development presenting the Scrutiny Board (Health) with a range of information to assist members to consider current developments associated with the provision of dermatology services, particularly in terms of inpatient provision on ward 43 at Leeds General Infirmary.	71 - 80

Item No	Ward/Equal Opportunities	Item Not Open		Page No
9			**LEEDS TEACHING HOSPITALS NHS TRUST - FOUNDATION TRUST CONSULTATION** To consider the attached report of the Head of Scrutiny and Member Development presenting the Scrutiny Board (Health) with a range of information on the consultation being undertaken by Leeds Teaching Hospitals NHS Trust about its application to become an NHS Foundation Trust as well as seeking the views of the Board on the consultation plan and on the actual application itself.	81 - 118
10			**JOINT HEALTH SCRUTINY PROTOCOL - YORKSHIRE AND THE HUMBER** To consider the attached report of the Head of Scrutiny and Member Development presenting the Scrutiny Board with a joint health scrutiny protocol for the Yorkshire and the Humber region for members to consider and agree. The protocol would form the basis for any joint scrutiny between the constituent local authorities within the region.	119 - 128
11			**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 municipal year, for the Board to consider, amend and agree as appropriate.	129 - 158
12			**DATE AND TIME OF NEXT MEETING** To note that the next meeting of the Board will be held on 15th December 2009 at 10.00am with a pre-meeting for Board Members at 9.30am.	

SCRUTINY BOARD (HEALTH)

TUESDAY, 20TH OCTOBER, 2009

PRESENT: Councillor M Dobson in the Chair

Councillors J Chapman, D Hollingsworth, J Illingworth, M Iqbal, G Kirkland, A Lamb, P Wadsworth and L Yeadon

CO-OPTEE: E Mack

34 Declarations of Interest

Councillor Dobson declared a personal interest in respect of Agenda Item 7 'Scrutiny Inquiry: The Role of the Council and its Partners in Promoting Good Public Health (Session 1)' (Minute No. 37 refers) in his capacity as a member of Leeds Initiative – Healthy Leeds Partnership.

35 Apologies for Absence

Apologies for absence were submitted on behalf of Councillors Bentley and Congreve.

36 Minutes of the Previous Meeting

RESOLVED – That the minutes of the meeting held on 22nd September 2009 be confirmed as a correct record.

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

The Head of Scrutiny and Member Development submitted a report introducing the first session of the Scrutiny Board's inquiry to consider the role of the Council and its partners in promoting good public health.

The Chair advised that at this first session of the inquiry the Board would be considering issues associated with improving sexual health and reducing the level of teenage pregnancies. Members had been provided at Appendix 1 to the report with the Action Plan for the Improvement Priorities included in the Health and Wellbeing Partnership Plan (2009 – 2012), of which 'Reduce teenage conception and improve sexual health' was the fifth improvement priority and also with the report entitled 'Teenage pregnancy and parenthood strategy (2008-2011)' at Appendix 2.

The Chair welcomed the following officers to the meeting to address the Board and respond to any specific questions identified by Members:

- Sharon Foster, Sexual Health Lead (NHS Leeds, Public Health Team) and
- Vicky Womack, Sexual Health Lead (NHS Leeds, Public Health Team).

The officers from the Public Health Team presented the Board with a brief overview of their work and also highlighted areas of concern within the partnership working.

Members sought clarification on the delivery of various aspects of the service and also expressed their concerns on, in brief summary, the following issues:

- **Why had the Public Health Team not been given access to Party in the Park to promote sexual health and Chlamydia screening?**
  Members were advised that there had been much debate with the Council Event team as to whether it was the right type of venue as it was a family event. However the Public Health Team hoped that access would be gained in future as it was a more holistic approach that they were seeking. It was agreed that the Board would write to the organisers of Party in the Park questioning their justification for refusing attendance by the Public Health Team and requesting their support in the future.
- **Whether the targets and guidelines of reducing chlamydia and genito urinary cases were a distraction from addressing the more important work of the sexual health team:**
  Members were advised that the team were able to carry out key prevention work in schools and elsewhere.
- **Whether the distribution of contraceptives took account of certain religious groups' sensitivities:**
  Members were advised that training was given to their advisers on working with different ethnic communities, and young people could access services with complete confidentiality.
- **The work carried out with young men to prevent teenage pregnancy:**
  Members were advised that Barnardos was commissioned to work with young men, however there was generally a shortage of male front line workers.
- **Whether the targets for reducing teenage pregnancy would ever be reached and the reasons for this?**
  Members were advised that teenage pregnancy was part of the bigger picture of reducing inequalities and deprivation and therefore could not be dealt with in isolation.
- **Reducing Inequalities and narrowing the wealth and health gap:**
  Members were advised that people in deprived areas were least likely to access services. A more co-ordinated and committed long term approach was needed between the partners to raise aspirations and break moulds. These strands of work should not be working in isolation: a more holistic approach was required.
- **Whether the partnership approach was sufficiently strong and robust:**
  Members were advised that the Teenage Pregnancy and Parenthood Partnership Board brought together all the key partners: the Local Authority, Education Leeds, NHS Leeds, Leeds Teaching Hospitals Trust and the voluntary sector. Partnership working however had been hampered for instance during periods of restructuring of different agencies, for example the Youth Service. To have a shared vision was very important and officers expressed concern about the Sexual Health Strategy which was still under development.

- **Sexual Health Strategy (2009 – 2014) timescale and whether not having it signed off was hampering partnership working:**
  Members were advised that the strategy was written and it was with the Director of Public Health but might not be signed off for a few more months. Not having a formal shared vision that all the partners had signed up to, did impinge on the effectiveness of the partnership and achieving a co-ordinated approach to tackling the issues. It was explained that the Teenage Pregnancy and Parenthood Strategy 2008 - 2011 would feed into the Sexual Health Strategy (2009 – 2014).

  It was agreed that the Board would request a written response from the appropriate Council department questioning the reasons for the delay in the publication of the Sexual Health Strategy and requesting that it be signed off at the earliest opportunity as it was important for effective collaborative partnership working.

  (Note: Later in the meeting the Deputy Director – Partnerships and Organisational Effectiveness – Leeds City Council, Adult Social Services agreed to provide a written response for the reasons for the delay in the delivery of the Sexual Health Strategy and an indication of the timescale for its publication.)

Questions were also asked on the following issues:
- The percentage of young girls that make a conscious decision to get pregnant rather than getting pregnant by accident.
- Girls having several children before they were 20.

The officers from the Public Health Team were thanked for their contribution and the Chair then welcomed the following officers to the meeting:
- Paul Bollom, Priority Outcome Commissioner (Leeds City Council, Children's Services),
- Kiera Swift, Teenage Pregnancy Co-ordinator (Leeds City Council, Children's Services),
- John Freeman, Head of Service (Health Initiatives and Wellbeing Team), Education Leeds, and
- John England (Deputy Director – Partnerships and Organisational Effectiveness) – Leeds City Council, Adult Social Services.

The officers from Children's Services gave a brief summary of their role and concurred that there was room for improved working with Local Authority partners, particularly in terms of advice being offered by schools and working with housing partners.

In brief summary, Members then raised the following particular issues of concern:
- **Sex and Relationship Education (SRE) was not equal in all schools:**
  Members were advised by the Head of Service, Education Leeds, that there were barriers with certain senior managers and they were trying to raise the level of awareness amongst Governing Bodies of the importance of SRE in order to give it the priority that it deserved.

- **SRE in primary schools:**
  Members were advised that the emphasis of SRE in primary schools was more about forming long-term relationships. Outside agencies were brought in to teach this, although it was considered that schools should be trained up to do this.
- **Collection of data and targeting areas of deprivation:**
  Members were advised that data was being collected from various partners at a more local level, from which area profiles would be developed. The first meetings of Area Health and Wellbeing Partnerships had also taken place, which brought key partners together at area level. These meetings would take the lead in setting priorities at the local level and target areas of deprivation.
- **The role of health trainers on sexual health matters in Super Output Areas:**
  In response to Members' concerns, the Deputy Director – Partnerships and Organisational Effectiveness – Leeds City Council, Adult Social Services, agreed to find out whether health trainers were educating on sexual health matters in Super Output Areas and provide the Board with this information.

  During the discussions, the Priority Outcome Commissioner (Leeds City Council, Children's Services) also agreed to provide the Board with the recently published paper on young people's attendance at school and attainment.

All the officers then voiced their concerns about particular issues within the delivery of the service. These included:

- **Accessing Health Services:**
  There were concerns at the general lack of language skills and social competencies of young men in particular and how this impaired their ability to access health and other services. There was also concern that vulnerable young people, who did not spend most of their time in main stream schooling, did not have access to health education services.
- **Wellbeing and Reducing Inequalities:**
  Officers agreed that improving health standards had to be seen in the wider context of improving other social issues such as housing and low educational attainment; that issues could not be tackled in isolation – a holistic approach was vital. However these discussions were growing in momentum at for instance the Narrowing the Gap Board and the Healthy Leeds Partnership meetings and it was hoped that these ideas would be captured in the Sexual Health Strategy.
- **Partnership working and effectiveness:**
  Officers advised that partnership working could be greatly improved. The appointment of a joint Director of Public Health, as done by other local authorities, might aid this.

The Teenage Pregnancy Co-ordinator, Children's Services, informed the Board that:

- a seminar on SRE was being held that day for school governors in the Civic Hall and a toolkit would be provided.

- A pilot scheme of the Family Nurse Partnership was taking place in Leeds in the Inner East and Inner South areas which aimed to help young parents break the cycle of pregnancy. They were hopeful that this scheme would have beneficial long term effects.

Members had previously agreed that it might be beneficial for the Board to hear contributions from the voluntary sector that worked at the front line of delivering sexual health services. Various organisations were proposed. It was also suggested that it might be helpful to hear the views of Council staff working in other areas such as housing or leisure for instance, as to how much consideration was given to health and wellbeing in their work and to also hear from young people. It was agreed that further discussion would be undertaken with the Chair as to whether this could be scheduled into the work programme or if a working group would be more appropriate, taking into consideration current work commitments as defined in the work programme.

The Chair thanked the officers for attending the meeting and for their contributions.

RESOLVED –

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

(b) That the Chair, on behalf of the Board, contact the organisers of Party in the Park requesting their support for the attendance by the Public Health Team in the future, in order to assist their promotion of young people's sexual health and Chlamydia screening.

(c) That the Board request that the Sexual Health Strategy (2009 – 2014) be signed off at the earliest opportunity and accept the Deputy Director – Partnerships and Organisational Effectiveness – Leeds City Council, Adult Social Services' offer to provide a written response for the reasons for the delay in the delivery of the Sexual Health Strategy and an indication of the timescale for its publication.

(d) That consideration be given to further inquiry in the area of improving sexual health and reducing the level of teenage pregnancies by inviting various voluntary groups, young people and officers in leisure and housing to address the Board on this issue, either at a full meeting of the Board or at a working group.

(Note: Councillor Chapman joined the meeting at 10.30am during the consideration of this item.)

38 Updated Work Programme 2009/10

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.

Also included in the report was a detailed update on a number of areas – some of which had not previously been formally considered by the Board:

- Provision of renal services at Leeds General Infirmary (LGI) – this included a set of supplementary questions on issues that were still outstanding.

- Provision of dermatology services at Ward 43 LGI – notification of requests for scrutiny on the provision of dermatology services at Ward 43 LGI and the current position.
- Use of 0844 numbers at GP surgeries – the general background and current position was provided.
- Openness in the NHS - an update on information received so far.
- Children's cardiac and neurosurgery services - information on national reviews of children's cardiac and neurosurgery services.

Appended to the report was the following information:
- Renal Services: Provision at Leeds General Infirmary – Follow-up questions (Appendix 1).
- Children's heart surgery centres in England – Draft service specification standards (Appendix 2).
- Children's Neurosurgery Services Bulletin (Appendix 3).
- Minutes of the Executive Board meeting held on 17th September 2009 (Appendix 4).
- Scrutiny Board (Health) Work Programme 2009/10 – updated October 2009 (Appendix 5).

The Chair drew Members' attention to several new unscheduled items added to the work programme:
- Provision of dermatology services at Ward 43 (Leeds General Infirmary),
- Use of 0844 Numbers at GP Surgeries,
- Openness in the NHS,
- Children's Cardiac Surgery Services, and
- Children's Neurosurgery Services.

Councillor Chapman, as Chair of the Scrutiny Board (Adult Social Care), advised the Board that the working group, 'Supporting working age adults with severe and enduring mental health problems' had met on 19th October 2009 and it was agreed that the minutes of that meeting would be circulated to Members of the Scrutiny Board (Health).

RESOLVED –

(a) That the report and appendices be noted.

(b) That the Work Programme be agreed.

(c) That the minutes of the working group meeting 'Supporting working age adults with severe and enduring mental health problems' held on 19th October 2009 be circulated to Members of the Board.

39 Date and Time of Next Meeting

Noted that the next meeting of the Board would be held on Tuesday 24th November 2009 at 10.00am with a pre-meeting for Board Members at 9.30am. Mr Mack's apologies were noted for that meeting.

The meeting concluded at 11.45pm.

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 24 November 2009

Subject: Provision of Renal Services

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

1.0 Purpose of this Report

1.1 The purpose of the report is to present the Scrutiny Board (Health) with additional information to assist members to consider current proposals associated with the provision of renal services (dialysis) across the Trust, particularly in terms of provision at Leeds General Infirmary (LGI).

1.2 The report also presents the draft Yorkshire and The Humber Renal Strategy (2009 – 2014) for consideration and comment.

2.0 Background

2.1 As reported in July 2009, the Scrutiny Board was first advised of the need to close the Welcome Wing at Leeds General Infirmary (LGI) in February 2006. The decision to close the Welcome Wing included the decision to reconfigure and re-house the services elsewhere in LTHT This included the reconfiguration of renal services, which saw St. James' Hospital become the main centre for inpatient renal services.

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

2.3 Most recently, at its meeting on 28 July 2009, 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 from a 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).

2.4 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. The Scrutiny Board produced a statement to this affect, which was subsequently presented to the LTHT Board meeting.

2.5 The Scrutiny Board's statement highlighted a number of outstanding issues the Scrutiny Board wished to pursue and, at its meeting on 30 July 2009, the LTHT Board agreed to defer its decision, pending further discussions with the Scrutiny Board.

2.6 The outstanding issues the Scrutiny Board wished to pursue were confirmed by way of a set of supplementary questions (Appendix 2), issued to LTHT and other key stakeholders on 6 August 2009.

3.0 Renal Services provision – additional information

3.1 A response from LTHT has now been received and is attached at Appendix 3 for the Board's consideration.

3.2 A range of key stakeholders have been invited to attend the meeting to address any additional questions and/or areas of clarification identified by the Scrutiny Board.

Draft Yorkshire and The Humber Renal Strategy (2009 – 2014)

3.3 The response from LTHT (attached at Appendix 3) makes reference to a draft Yorkshire and The Humber Renal Strategy (2009-2014). This, along with a covering letter from the Chair of the Renal Strategy Group, is attached at Appendix 4 for the Board's consideration.

3.4 Appropriate representatives from Specialised Commissioning Group (Yorkshire and The Humber) have been invited to attend the meeting to address any questions posed by the Scrutiny Board.

4.0 Recommendation

4.1 Members of Scrutiny Board are asked to consider the information presented and determine any:

4.1.1 Specific action the Board may wish to take;

4.1.2 Recommendations the Board may wish to make;

4.1.3 Matters that require further scrutiny.

5.0 Background Papers

None

APPENDIX 1

LEEDS CITY COUNCIL

Scrutiny Board (Health)

Position Statement: Proposed Renal Services Provision at Leeds General Infirmary

Introduction

1. This position statement has been prepared to reflect the outcome of the Scrutiny Board (Health) meeting, held on 28 July 2009. It is intended to be presented to the Leeds Teaching Hospitals NHS Trust Board at its meeting on 30 July 2009, to inform its consideration on Renal Haemodialysis Satellite Unit at Leeds General Infirmary (LGI).

Background

2. The Scrutiny Board was first advised of the need to close the Wellcome Wing at Leeds General Infirmary (LGI) in February 2006. The decision to close the Wellcome Wing included the decision to reconfigure and re-house services elsewhere in Leeds Teaching Hospitals NHS Trust (LTHT).

3. In March 2006, the Scrutiny Board received an outlined of the proposals to reconfigure Renal Services in Leeds. This included St. James' Hospital becoming the main centre for inpatient renal services with an expanded satellite service, which would be delivered from Seacroft Hospital (via an 18-station dialysis unit), in addition to a new 10–station dialysis unit at the LGI.

4. At that time, the Scrutiny Board did not believe that sufficient consultation had taken place with patients around the reconfiguration proposals. On the recommendation of the Scrutiny Board, further public consultation took place between June and August 2006.

5. The outcome of the consultation and key issues agreed by NHS Leeds and LTHT were reported to the Scrutiny Board in December 2006. This included:

   - Centralisation of in-patient services at St. James's
   - Establishment of a permanent dialysis facility at Seacroft
   - Delivery of a 10-station haemodialysis unit at LGI

6. Since that time, while there have been on-going issues associated with patient transport reported and considered by the Scrutiny Board, there has been no indication or suggestion that the dialysis unit planned for LGI would not be delivered.

7. In early June 2009, via a Kidney Patient Representative, the Chair of the Scrutiny Board first became aware of proposals not to proceed with the LGI dialysis unit as planned. At its meeting on 30 June 2009, the Scrutiny Board agreed to consider these proposals in more detail at its meeting in July 2009.

Witnesses and evidence received

8. In order to gain a rounded view on the proposals, the Scrutiny Board Chair invited input and written submissions from the following organisations:

   - Leeds Teaching Hospital NHS Trust
   - NHS Leeds
   - Specialised Commissioning Group (Yorkshire and the Humber)
   - Yorkshire Ambulance Service (YAS)
   - Kidney Patients Association (LGI)
   - Kidney Patients Association (St. James')
   - National Kidney Federation

9. Each of the above organisations provided a written submission. These submissions were presented to the Scrutiny Board and are publicly available. In addition, with the exception of the National Kidney Federation, each organisation was represented at the Scrutiny Board meeting held on 28 July 2009.

10. The acting Chair of the LTHT Board did not attend the Scrutiny Board meeting, but was invited to do so.

Considerations of the Board

11. In considering the evidence presented, the Scrutiny Board also considered issues associated with NHS Trusts' duty to consult, alongside those issues associated with the substantial variation/ development of local health services.

Department of Health (DoH) Guidance

12. Each of the local NHS Trusts has a duty to consult the Scrutiny Board on any proposals it may have under consideration for substantial development or variation in the provision of local health services.

13. 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. If proposals are determined as a substantial development or variation, the NHS Trust must formally consult the Scrutiny Board. There should also be discussion with the Scrutiny Board about how consultation will be undertaken more generally.

14. The duty to consult the Scrutiny Board is in addition to the duty placed on NHS Trusts to consult and involve patients and the public as an ongoing process. Government guidance on consultations states that full consultation (involving patients, the public and the Scrutiny Board) should last for a minimum of twelve weeks.

Understanding 'substantial variation and substantial development'

15. There are no regulations that define 'substantial' variation or development. However, Appendix 1 outlines the locally agreed definitions of the reconfiguration proposals and stages of engagement/ consultation. Such definitions have previously been used by the Scrutiny Board and its working groups when considering other service change proposals.

Proposed changes to the renal haemodialysis Satellite Unit at Leeds General Infirmary (LGI)

16. In October 2008, the LTHT issued confirmation that a new renal dialysis satellite unit (on Ward 44) at LGI would open in December 2009. This in itself represented a delay in delivering the new unit, but it undoubtedly re-stated the Trust's commitment to providing this facility. 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.'*

17. Yet 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.

18. In considering the proposals not to proceed with a 10-station dialysis satellite at LGI[1], the Scrutiny Board (Health) has been mindful to consider the general impact of such a change upon patients, carers and the public who use or have the potential to use a service. Specifically, this has included:

Changes in accessibility of services.

19. The Scrutiny Board (Health) has heard contradictory arguments about the potential impact on current/ future patients in the North and North West of the City. The Scrutiny Board is not satisfied with the robustness of data presented in the Trust Board report and believes that additional work, including more informed consultation with patients, needs to be undertaken to fully assess the impact of the current proposals.

Impact of proposal on the wider community

20. The Scrutiny Board (Health) believes that the proposed changes have the potential to affect a significant number of patients receiving haemodialysis. The Board also recognises that this number of patients is predicted to increase year-on-year for the foreseeable future. Therefore, the Scrutiny Board does not feel that the wider public have been adequately involved in formulating the current proposals. Clearly, only through full involvement activity will the commissioners and the Trust be able to take a considered view as to whether the plans are in the interests of local health services.

21. While the Scrutiny Board recognises that investment in the water treatment plant at St. James' is significant and is likely to benefit a large number of kidney patients, the Board fails to understand why this necessary investment was not identified earlier. Indeed, the Scrutiny Board heard evidence to suggest that the necessary maintenance had been identified for some time. As such, the Scrutiny Board

[1] As set out in the LTHT Board report (30 July 2009)

believes that the information as presented demonstrates a distinct lack of forward planning and the replacement of the water treatment plant at St. James' should not be at the expense of the long awaited unit at LGI.

Patients affected

22. The Scrutiny Board recognises that the patients currently accessing renal dialysis services (and those patients likely to access services in the future) will need to do so for many years. As such, the Scrutiny Board does not believe that patients have been sufficiently involved in the most recent developments and formulation of the current proposals.

23. Since early 2006, renal services provision and, in particular, dialysis services across Leeds has been an area considered by the Scrutiny Board on many occasions. On a number of occasions the Board's focus has been on the provision and reliability of transport services for kidney patients. However, consideration of such matters has always been in the knowledge and belief that, in the longer-term, some of the difficulties around patient transport would be resolved by the re-provision of dialysis facilities at LGI. Comments from Yorkshire Ambulance Service reaffirmed that this would be the case for some patients – particularly those accessing services from the North and North–West of the City.

24. The Scrutiny Board considered the evidence presented by the Chief Executive of LTHT and the commissioners, which attempted to demonstrate that there was already sufficient capacity to cater for the current and projected level of demand for renal dialysis services provided by LTHT. However, the Board believes that the location of services and the impact this may have on the quality of life experienced by renal patients, are aspects that should be integrated into any considerations around the capacity of dialysis services. The Scrutiny Board (Health) does not believe that such considerations have been adequately considered in the development of the current proposals.

Methods of service delivery

25. The Scrutiny Board (Health) considered the information associated with the overall approach to renal replacement therapy (RRT). The Scrutiny Board also considered the overall desire to provide local health services closer to home – hearing how the home dialysis service could help alleviate issues around access to services. Nonetheless, the Scrutiny Board also heard how current staffing issues across renal services is having an impact on the timely delivery of home dialysis. If such services are to provide a real alternative to hospital dialysis, there needs to be sufficient evidence that such services have adequate resources and capacity to offer this alternative to a wide group of patients.

26. In addition, the Scrutiny Board believes there is insufficient evidence to demonstrate that the views of patients and carers have been collated and analysed in this regard.

Conclusion and recommendations

27. Throughout its involvement in considering the provision of renal services across Leeds, the Scrutiny Board's underlying aim has been to ensure that high quality health care services are available for all kidney patients across the City – without adding to patients' often already complicated lives. In light of the process for

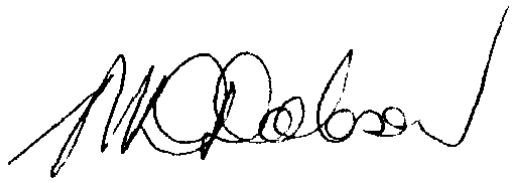
developing the current proposals, the Board does not believe that the proposals will deliver the necessary quality for all patients.

28. As such, based on the evidence presented to the Scrutiny Board and the Department of Health Guidance on Overview and Scrutiny for Health, this Board believes that the current proposed changes to renal dialysis provision represents a substantial variation to service delivery. As such, the Board feels that a statutory period of consultation is required and should take place prior to any decision of the Leeds Teaching Hospitals NHS Trust (LTHT) Board.

29. Based on the above, the Scrutiny Board recommends that the LTHT Board defer any decision on renal dialysis provision until such consultation has taken place.

30. It should also be recognised that as part of any formal consultation period, there are a number of outstanding issues that the Scrutiny Board would wish to pursue.

On behalf of the Scrutiny Board (Health)



Councillor Mark Dobson (Chair)

29 July 2009

Definitions of reconfiguration proposals and stages of engagement/consultation

Definition & examples of potential proposals	Stages of involvement, engagement, consultation			
	Informal Involvement	Engagement		Formal consultation
Substantial variation or development Major service reconfiguration – changing how/where and when large scale services are delivered. Examples: urgent care, community health centre services, introduction of a new service, arms length/move to CFT				**Category 4** Formal consultation required (minimum twelve weeks) **(RED)**
Significant variation or development Change in demand for specific services or modernisation of service. Examples: changing provider of existing services, pathway redesign when the service could be needed by wide range of people			**Category 3** Formal mechanisms established to ensure that patients/service users/ carers and the public are engaged in planning and decision making **(ORANGE)**	
Minor change Need for modernisation of service. Examples: Review of Health Visiting and District Nursing (Moving Forward Project), patient diaries		**Category 2** More formalised structures in place to ensure that patients/ service users/ carers and patient groups views on the issue and potential solutions are sought **(YELLOW)**		
Ongoing development Proposals made as a result of routine patient/service user feedback. Examples: proposal to extend or reduce opening hours	**Category 1** Informal discussions with individual patients/ service users/ carers and patient groups on potential need for changes to services and solutions **(GREEN)**			

OSC involved

OSC may be involved

Information & evidence base

Information & evidence base

Information & evidence base

Note: based on guidance within the Centre for Public Scrutiny *Substantial variations and developments of health services, a guide*

APPENDIX 2

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

LEEDS TEACHING HOSPITALS NHS TRUST

Response to Scrutiny Board Health follow up questions on Renal Services provision at Leeds General Infirmary

Strategy

Question 1
Please explain the rationale (including the clinical need) that informed the decision concerning the provision of a 10 station haemodialysis unit at the Leeds General Infirmary (LGI) in 2006 and outline what has subsequently changed.

The provision of a 10 station dialysis unit at LGI was not always part of the longer term plan for the provision of renal services following the decision to close Wellcome Wing.

During the early part of 2005, deficiencies in the infrastructure of Wellcome Wing gave rise to an uncertain future for the building.

In July 2005, the Leeds Renal Service issued to all services in Leeds Teaching Hospitals NHS Trust (LTHT) and to the 2 Kidney Patients' Associations (KPA) a document entitled 'The Reconfiguration of the Leeds Renal Service. 1st Draft Proposals - Position at 22 July 2005.

There was no proposal in that document to provide a chronic haemodialysis facility at the LGI.

The comments received by the requested timescale of early September 2005, did not indicate any clinical need for a chronic haemodialysis facility at the LGI. Neither KPA responded to the draft proposals.

By November 2005, LTHT had distilled its planning to 2 options, for discussion with staff, patients and the KPAs:

- Reprovide the services at SJUH and Seacroft Hospital
- Upgrade Wellcome Wing, to a minimum standard to meet the immediate health and safety requirements.

LTHT conducted 2 open meetings with patients and their carers on 11 December 2005 and 8 January 2006. At these meetings there was a considerable amount of concern expressed from users at the thought of losing any of the services at LGI and it was in response to this that the Trust proposed the 10 station unit.

There remains no clinical need for such a facility at LGI. Access to nephrology opinion and acute renal failure services at the LGI has been provided since October 2006 to the present day, by a small team of renal nurses and doctors.

Question 2

- *Please provide an outline and details of how and when the Renal Replacement Strategy was developed.*

  The Yorkshire & Humber Specialised Commissioning Group (SCG) agreed, towards the end of 2008, to develop a Yorkshire & Humber-wide strategy for Renal Services, supported by a Regional Strategy Group and Sub-Regional Local Implementation Groups, based around clinical networks for Renal Services.

The new Renal Strategy document currently exists in draft format and, subject to the approval and recommendation of the Renal Strategy Group at its meeting on Monday 28th September, will be circulated widely, for further consultation. The final document is due for publication early in the New Year.

The draft document focuses on the following priorities:

i. Prevention of the occurrence of renal disease, through systematic identification of at-risk groups, and reduction of risk factors.
ii. To slow the progress of renal disease, through ensuring high coverage of disease management interventions across primary and secondary care.
iii. Ensuring early identification and referral of patients likely to need Renal Replacement Therapy, and adequate preparation and choice of treatment type.
iv. To ensure timely availability of Renal Replacement Therapy for those likely to benefit, in designated Renal Units (or associated satellite units), transplant centres, or home-based therapies.

- *Please provide confirmation of the Renal Centres across Yorkshire & the Humber, including the services/treatment provided, the population/geographical areas each centre serves and the current number of patients accessing haemodialysis.*

There are six Renal Centres in the Yorkshire & Humber region, based within the following NHS organisations:

- Bradford Teaching Hospitals NHS Foundation Trust
- Doncaster & Bassetlaw Hospitals NHS Foundation Trust
- Hull & East Yorkshire Hospitals NHS Trust
- Leeds Teaching Hospitals NHS Trust*
- Sheffield Teaching Hospitals NHS Foundation Trust*
- York Hospitals NHS Foundation Trust

Renal services for patients with chronic kidney disease are largely delivered by renal specialists working in the specialist renal centre itself, and on an outreach basis to surrounding local hospitals. Specialist renal centres also treat patients with acute kidney injury. Specialist renal centre services include:

- Nephrology (Renal) out-patient clinics within the organisation and available as an outreach service to local hospitals.
- Haemodialysis services within the organisation.
- Satellite haemodialysis services.
- Support to patients on peritoneal dialysis and home haemodialysis.
- Anaemia management and specialist renal dietetic support.
- Conservative management programmes for established renal failure.
- Out-patient and in-patient services for acute kidney injury.
- *Transplantation services – provided at Leeds & Sheffield.

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

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

Nephrology out-patient clinics in local hospitals are provided on an outreach basis by medical and nursing staff from the specialist renal centre and will include general nephrology clinics and specialist clinics such as pre-dialysis clinics and anaemia clinics.

In-patient nephrology services are provided at the specialist renal centre. These are used for investigation and treatment of renal diseases including kidney biopsies, management of fluid and electrolyte disorders, initiation of immunosuppression and treatment of hypertension. Nephrological conditions covered include all forms of glomerulonephritis, kidney disease associated with systemic diseases such as diabetes mellitus, systemic lupus erythematosis and vasculitis and other causes of chronic kidney disease. In-patient services are also used for the management of patients with acute kidney injury, complications in patients on dialysis and the investigation and treatment of patients with functioning renal transplants.

The kidney transplant service includes:

Activities taking place at <u>all</u> specialist renal centres:

- Assessment of patient need and suitability for transplantation.
- Organising tissue typing and testing for antibodies.
- Registration of appropriate patients with NHS Blood & Transplant.
- Live donor screening.
- Live donor work-up.
- Post-transplant follow-up (for life).
- Post-transplant immunosuppressant drug therapy (for life).

Activities <u>only</u> taking place at the renal transplant centres:

- Donor organ (cadaver) retrieval.
- Live donor organ retrieval.
- Cadaveric kidney transplant.
- Non heart-beating kidney transplant.
- Live donor kidney transplant.
- Desensitisation of potential transplant recipients who have high panel reactivity.

The six Renal Centres serve a total Yorkshire & the Humber population of 5.278 million (ONS sub-regional population projections), and the SCG commissions specialised renal services on behalf of this population. There are no geographical restrictions on where patients can access renal services, (with the exception of renal transplant, which can only be undertaken at the Leeds and Sheffield centres). The SCG is committed, however, through its planning processes, to ensuring that as many patients as possible can access services as close to home as possible, wherever this is an expressed preference and is clinically appropriate.

The current number of patients accessing haemodialysis across the region is as follows:

Bradford Teaching Hospitals:	**No. of Haemodialysis**

	Patients
St. Luke's Hospital, Bradford	156
Skipton Satellite	36
Total	**192**
Doncaster & Bassetlaw Hospitals:	**No. of Haemodialysis Patients**
Doncaster Royal Infirmary	90
Bassetlaw Satellite Unit (Worksop)	28
Total	**118**
Hull & East Yorkshire Hospitals:	**No. of Haemodialysis Patients**
Hull Royal Infirmary	157
Bridlington Satellite	26
Grimsby Satellite	63
Scarborough Satellite	30
Scunthorpe Satellite	47
Total	**323**
Leeds Teaching Hospitals:	**No. of Haemodialysis Patients**
St. James's University Hospital (Wards 55/53)	83
Beeston Satellite	40
Halifax Satellite	40
Huddersfield Satellite	40
Seacroft B Ward Satellite	40
Seacroft R&S Ward	119
Dewsbury Satellite	48
Wakefield Satellite	46
Total	**456**
Sheffield Teaching Hospitals:	**No. of Haemodialysis Patients**
Sheffield Teaching Hospital (Renal F & G Wards)	285
Barnsley Satellite Unit	65
Chesterfield Satellite Unit	62
Sheffield Satellite Unit (Heeley)	80
Rotherham Satellite Unit	80
Total	**572**
York Hospitals:	**No. of Haemodialysis Patients**
York Renal Unit	66
Easingwold Satellite Unit	26
Harrogate Dialysis Unit	40
Total	**132**
Y&H Regional Total	**1,793**

- *Please provide: confirmation of the current number of kidney transplants per annum (regionally and locally).*

The Sheffield Centre carried out 56 kidney transplants during the year 2008/09, exactly in line with plan. This figure excludes transplants carried out on children, who are generally referred to the Nottingham Centre from South Yorkshire. The 2009/10 plan is for 56 transplants. Additional transplant activity will be funded, should the opportunity arise.

The Leeds Centre carried out 163 kidney transplants during the year 2008/09, 19 more than planned. This figure includes transplants carried out on children.
The Leeds centre also carried out 42 organ retrievals from live donors. The 2009/10 plan is for 190 transplants and 55 live donor organ retrievals. Additional transplant activity will be funded, should the opportunity arise.

During 2008/09, an additional £697k was invested in kidney transplantation in Leeds, taking total investment in transplantation for the year to well over £4.5m. As indicated above, further additional investment is being made for 2009/10.

- *Please provide: confirmation of the current number of patients using home dialysis (regionally and locally).*

  During 2008/09, there were 57 patients across the region receiving home haemodialysis. A further 384 patients were receiving peritoneal dialysis.

- *Please provide: 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.*

  In January 2008, UK Health Ministers accepted the 14 recommendations of the Organ Donation Taskforce to improve organ donor rates. The expectation is a 50% increase in organ donation rates in the UK within five years – resulting in an additional 1200 organs a year and significant clinical and cost effectiveness benefits.

  The Taskforce recommendations focus on the need to invest significantly in the infrastructure of organ donation. They include the need for a UK-wide organ donor organisation established as part of NHS Blood and Transplant; a strengthened network of dedicated Organ Retrieval Teams working with critical care teams in hospital to procure organs for transplant; a doubling of the number of front line donor coordinators – about an extra 100 donor transplant coordinators – and the need to make organ donation a usual rather than an unusual event supported by additional staff training and a monitoring of donation activity in all Trusts. Additional national funding of £11m was made available for 2008/09, with further funding agreed for subsequent years.

  The implementation of the Taskforce recommendations is being overseen by Professor Sir Bruce Keogh, the NHS Medical Director, and Mr Chris Rudge, Medical and Transplant Director of NHS Blood and Transplant, has joined the Department of Health to lead day-to day implementation.

  It has been acknowledged that some changes can be made quite rapidly, but full implementation may take up to three years.
  Yorkshire and Humber has also made significant progress already, in increasing the number of live donor kidney transplants.

The SCG is currently developing plans, consistent with the aims of NHS Kidney Care, and the National Clinical Director for Kidney Care, as part of its new strategy for Renal Services across the region, to increase the number of patients on home haemodialysis.

The Leeds Renal Centre is already committed to providing home haemodialysis for all suitable patients, although there have been some delays in carrying out the necessary training due to nurse staff absence as a result of a 10 year peak in maternity levels.
It should, however, be noted that the majority of patients are not clinically suitable for home therapies, and that even where patients are clinically suitable, not all have a carer who could assist them. Exceptionally, patients can self-dialyse at home unaided, but this is very rare. Equally, in some cases where home haemodialysis might otherwise be an option, not all patients have space for a machine to be installed in their property, or by means of an extension.

Previously agreed plans

Question 3
The statement is one attributable to the NHS Leeds Trust Board: it is not a statement from LTHT. At the time LTHT provided NHS Leeds with the information - as reported in October 2008, this being that; discussions were ongoing with KPA representatives, a Project Team was in place and design work for a dialysis unit on ward 44 was taking place. Design work was not stopped until 1st June 2009.

The statement from NHS Leeds regarding 18 stations at Seacroft refers to an options paper produced on 2nd February 2006. Subsequently events moved on (see section 4 for further details).

- *Please explain when discussions about proposals not to proceed with the dialysis unit at LGI first take place within LTHT and who was involved.*

  Discussions began in the context of developing the capital programme for 2009/10 and were held with members of the Capital Planning Group within LTHT. The first discussion on the overall capital programme was on 28th January 2009.

  Members of the Capital Planning Group included the Director of Finance, the Director of Estates & Facilities, the Head of Planning, the Head of Estates and a Divisional General Manager.

- *What, if any, considerations were given to involving other interested parties in these discussions, i.e. commissioners, patients and carers (i.e. KPA) and the Scrutiny Board.*

  No discussions were held with commissioners or patients and carers about any of the options that were under consideration at this time. Each clinical area potentially within the capital programme was discussed. As the options themselves affected many hundreds of patients potentially in many different specialties it was therefore not practicable until the options had been agreed in principle to have any discussions outwith the Capital Planning Group which had been given the mandate to recommend the capital programme for 2009/10 to the Senior Management Team.

- *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?*

  A parallel process was in evidence during the early part of 2009 with the KPA still involved in discussions around delivery of the unit at LGI because the decision was still to deliver the unit at this time, pending any future Trust Board decision. In the spirit of openness, the Trust Medical Director and the Head of Planning met with Mrs Black to discuss with her the likely recommendation to the Board that the dialysis at LGI would not go ahead.

- *When did NHS Leeds and SCG first become aware of LTHT's proposals not to proceed with the dialysis unit at LGI?*

  NHS Leeds and SCG first became aware of LTHT's proposals after 2nd June 2009. This was because the Trust took a decision to talk to representatives of users and carers via the KPA before any other group.

- *Does this signify a breakdown in communication between LTHT and NHS Leeds as commissioners?*

  We do not feel that there has been a breakdown in communication between LTHT and NHS Leeds but recognise that improvements regarding communication channels can be made. Whilst the position regarding dialysis is of course the top priority for the patients using the service, out of the 1,000,000+ attendances at Trust hospitals (inpatients, day cases, outpatients, A&E) and the many specialties delivered by the Trust, change is occurring all the time and discussions are occurring all the time.

- *What does this situation say about the general relation between local NHS bodies?*

  This question is addressed in response to question 14

Question 4
Please explain the provision of 34 stations on R&S Ward at Seacroft Hospital.

The discussion within the Trust has always been about finding the right footprints within which the haemodialysis units could be established. We did not feel it would be a particular concern that we were able to accommodate more units than were required at this time.

24 stations were originally in LGI Wellcome Wing, running 6 days a week, with additional twilight sessions.

The timescale for vacating Wellcome Wing was such that the permanent unit could not be created in time, so it was agreed that there would be a temporary unit built in the former T&U wards at Seacroft Hospital, replicating the 24 stations in Wellcome Wing. There would also be 4 additional stations to decompress SJUH. In October 2006 the temporary unit opened with 28 stations. The former LGI twilight patients moved to the St James's twilight sessions.

The work on the permanent unit in R&S wards was continuing concurrently. At this point a decision had to be made around the number of stations to be installed.

In March 2007, the Yorkshire and Humber Commissioning Group approved, on the recommendation of the Regional Renal Services Strategy Group, an LTHT bid for 8 additional dialysis stations to service West Yorkshire (2 stations in Wakefield and 6 in Leeds).

The LTHT case of need had cited a lack of progress in developing local satellite facilities in the mid Yorkshire district. The longer term location of the additional capacity would be the subject of a strategic dialogue with the Yorkshire & Humber SCG and the Regional Renal Strategy Group.

As the planning of the permanent unit in R&S wards demonstrated the footprint was large enough to take 34 stations without significant additional cost, 34 stations remained in the brief. This constituted the original 28 stations plus 6 additional stations as recommended by the Regional Renal Services Strategy Group.

As stated earlier there was never any suggestion that having more stations than at first identified was going to be a problem.

At this point there was no suggestion internally that we would not be going ahead with the dialysis unit at LGI and there was no consultation apparently required. The Trust would not normally advise the Scrutiny Board when it was creating additional capacity.

The proposal not to have haemodialysis stations at LGI has only come about as the Trust has further carefully scrutinised clinical need, capacity and cost.

Question 5
Please explain at what point did the planned unit at LGI involve the level transfer of stations from Seacroft

The planned unit at LGI always involved the transfer of stations from Seacroft and was articulated to the early user group consultation meetings when the suggestion of a dialysis unit at LGI was suggested by the Trust in 2006.

Demand and capacity

Question 6
Please complete the summary table at Appendix 1, for LTHT Renal Centre.

Appendix 1 is attached and is accurate as at September 2009. The column headed 'projected demand (2013/14)' has not been completed for the reasons explained below, under Question 7 - the methodology that predicts local demand.

Question 7
Please explain the methodology used that predicts local demand to rise by less than an average of 2% over 5 years.

For the purposes of clarity, the summary table presented at Appendix A to the Scrutiny Board's follow-up questions, shows a projected increase in demand of over 13% over 5 years, with an average annual increase of 2.7%, and not less than 2% as indicated.

However, it has been 2 years since detailed modelling work has been undertaken on the likely future numbers of end stage renal failure patients in the Yorkshire & the Humber region. Since then, the Renal Strategy Group has actively engaged with the Department of Health, who have developed new modelling software, designed to give consistent methodology for the whole country. This new "MORRIS" Model is auto populated with routinely available data (from the National Renal Registry & the Office for National Statistics), and is as accurate as it can be without bespoke data collection.

The input parameters are as follows:

- Initial Renal Replacement Therapy Population.
- Transplant Supply.
- Renal Centre Distribution.
- Take On Rates.
- Mortality Rates.
- Modality Split – Dialysis.
- Graft Failure Rates.
- Population Projections.

The user is able to modify any/all of the input parameters to estimate the impact of a wide variety of potential scenarios. The results of this 'what if' scenario planning can be easily exported from the model.

Output from the model is given by PCT, by Renal Centre and by Local Authority. A Strategic Health Authority summary is also available. Output (projected need) is split into dialysis (with sub modalities) and transplant. Both are expressed with ranges of uncertainty (confidence intervals, largely reflecting uncertainties in how input parameters will change over time).

Further work is needed to develop confidence that MORRIS will be able to provide accurate and robust predictions of future need. Initial analysis, undertaken very recently, has concluded it is a complex, comprehensive modelling tool, and preliminary results indicate a higher level of predicted future demand for some areas of the region, than have been predicted previously. It is important to stress however, that the model is still in draft form at this time.

Question 8

Please confirm the number of patients (both regionally and locally) awaiting pre-dialysis education.

Locally, in August 2009, a total of 404 patients were in the Leeds Renal Centre's pre-dialysis service, derived from the centre's total West Yorkshire catchment area (ie 4 PCTs - Leeds, Wakefield, Kirklees and Calderdale).

Of these 404 patients, 248 had received education regarding their treatment options, which include haemodialysis (in renal haemodialysis units), peritoneal dialysis (patients self care) or conservative care.

132 patients were awaiting education. Professional consensus suggests that optimal time to prepare a patient and their carers for renal replacement therapy is around 1 year before dialysis is expected to be necessary.

The remaining 24 patients will be referred back to the Renal service following clinical review.

In August 2009 no other patients, whether in the pre-dialysis service or arriving at the renal service acutely, were awaiting access to chronic haemodialysis treatment.

Question 9
Please comment on the suggestion that some patients are receiving a reduced level of haemodialysis

In August 2009, 10 patients were receiving dialysis twice per week rather than the standard 3 times per week. 3 of these patients were new patients for whom twice weekly dialysis was indicated. The other 7 patients dialysed twice per week either by personal choice or because their blood test results indicated this to be appropriate.

Question 10
Please provide evidence that the home haemodialysis service has adequate resources and capacity to offer the service to a wide group of patients in the short, medium and longer term.

In April 2003, the Regional Renal Services Strategy Group agreed to a proposal from LTHT to increase the number of patients on home haemodialysis from 3 to 23 ie a net increase of 20 patients. By November 2006, the number had risen to 10 and by August 2009 to 15. The rate of conversion is dictated primarily by the willingness of patients and their carers and the many other criteria (e.g. medical, social, psychological, practical, etc) that make a conversion to home care feasible.

Since May 2009, 8 patients have expressed an interest in converting to home haemodialysis. One patient started training in September. The seven other patients were found to be unsuitable for conversion, either for medical reasons or required re-housing.

Patient Survey

Question 11
Please provide a full summary of the survey that stated '…in a recent patient survey only 11 patients expressed a preference to dialyse at LGI…' and confirm when the survey was carried out, etc.

At the joint KPAs/LTHT liaison meeting on 17 March 2009, it was discussed that NHS Wakefield and LTHT, in partnership, were to survey the patients at the Wakefield and Leeds haemodialysis units to ascertain how many patients with a Wakefield postcode would prefer to dialyse in Wakefield itself or Pontefract, or in fact any other nurse led renal haemodialysis unit. Later in March, NHS Wakefield interviewed all the patients at the satellite haemodialysis unit at Clayton Hospital, Wakefield.
Also in March, LTHT constructed a survey letter and reply form, signed by the Renal Clinical Director and Renal Matron, intended solely for haemodialysis patients with a Wakefield postcode. That letter was issued to the relevant patients at B ward at Seacroft

Hospital and at ward 55, SJUH. Unfortunately and in error, the letter was sent to all the patients on R&S Ward.

11 of the 87 patients on R&S ward who replied marked a preference to dialyse at LGI.

The letter and survey form were in the same format as the one used a year previously and endorsed by the KPAs.

Patient Transport

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

Please see Appendix 2 and its 4 sheets:
Sheet 2.1 - Numbers of patients by all dialysis treatment modes and unit
Sheet 2.2 - Numbers of patients, by haemodialysis unit and non-Leeds postcode
Sheet 2.3 - Numbers of patients, by haemodialysis unit and Leeds postcode
Sheet 2.4 - Numbers of patients, by haemodialysis unit and grouped postcodes.

The data in Appendix 2 dates from April/May 2009, hence the minor differences in patient numbers from those quoted in Question 2 and Appendix 1 in Question 6, both of which are accurate at September 2009.

The most striking figures are the disparity between demand and capacity for haemodialysis in Wakefield (133 against 96); Huddersfield (66 against 40) and Halifax (50 against 40).
Appendix 1 has shown the excess of capacity in Leeds against demand.

Using these data, along with the potential capacity illustrated in Appendix 1 and the new Department of Health 'MORRIS' model on future demand, LTHT is in close dialogue with the Yorkshire & Humber SCG Regional Renal Strategy Group and local NHS provider Trusts to establish how best, strategically, to meet the current, local shortfalls and the future demands.

Question 13
What are the travelling times for patients from the North/North West of the city, who haemodialyse Seacroft?

Please see Appendix 3.

The 2 sheets present the number of journeys undertaken from April 2009 to the end of July (ie the date the data was presented by YAS to Scrutiny Board), based on patient journey times to and from both the Seacroft dialysis units, involving patients travelling to and from the Leeds postcodes LS16, 17, 18, 19, 20, and 21.

Role of the Scrutiny Board

Question 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?*

The length of this document and the depth of its content demonstrate that Leeds Teaching Hospitals place great emphasis on the role of the Scrutiny Board and shows where, why and how Scrutiny and service users have been engaged. The Trust is anxious to work closely with Scrutiny now and in the future and to this end a number of discussions have been held between the Chair of Scrutiny and the Chief Executive of Leeds Teaching Hospitals to explore ways of working better together so that each body can appropriately carry out its role. We understand that the Health Proposals working group is being reinstated so that there is a forum for very early discussion of possible change and the Trust is organising a special presentation to members of Scrutiny in November 2009.

In relation to the Specialised Commissioning Group;

The Establishment Agreement of the Yorkshire & the Humber Specialised Commissioning Group (SCG), Section 2, Functions of the Specialised Commissioning Group, Paragraph 2.3, states that:

The SCG will undertake the following functions……., including:
To maintain close links with PCT's and providers, and other statutory authorities, including Local Authorities and Criminal Justice System agencies, in the SCG area……..

The Establishment Agreement of the Yorkshire & the Humber Specialised Commissioning Group (SCG), Section 6, Accountability of the SCG, Paragraph 6.1.4, also states that:

In order to ensure that time is allowed for consultation with the constituent PCT's and with other stakeholders wherever possible, adequate notice will be given of proposals to change commissioning policies, commit resources and/or enter into service agreements and contracts.

The Yorkshire & the Humber Specialised Commissioning Group (SCG) also has a Strategy for Involving and Engaging Patients and the Public in Specialised Commissioning.

This strategy sets out the aims and objectives of the Yorkshire & the Humber Specialised Commissioning Group in order to involve the public and patients in the commissioning of specialised services. The strategy makes clear the role of NHS Barnsley as the host of the SCG, the Specialised Commissioning Team and individual PCT's.

Section 5, Stakeholders to Public and Patient Engagement, states that:

There are a number of stakeholders in Public and Patient Engagement – each of which may have a different perspective. It is important to be clear that the SCG must engage with all stakeholders.

Patients, carers, parents or families of patients care most about the quality of their everyday interactions with professionals rather than about how the service is organised. Citizens often care passionately about perceived threats to services more broadly; about how resources are allocated and about health risks.

There are a range of other stakeholders that represent the views of both patients and the public. These include local councillors (particularly those involved in Overview and Scrutiny Committees where substantial changes are proposed) and a range of Voluntary and Community Sector agencies that may be patient advocacy groups or deliver services to specific groups. There is a particular need to ensure that 'seldom heard' groups are involved in commissioning decisions.

Service providers are important stakeholders; both as organisational units and clinicians working within them. The establishment of feedback from patients using services into commissioning decisions is an important priority here. The involvement of groups that traditionally have little voice in service planning is particularly important.

Section 6, Aim and Objectives of the Yorkshire & the Humber Patient & Public Engagement Strategy, states that:

This strategy is a three year strategy, covering the period from April 2009 to March 2012. The strategy sits within the SCG work plan, will be reviewed annually, and specific objectives set within a work programme. An annual report will be made to the SCG (more frequently be exception).

As the host of the SCG, this work also sits within the NHS Barnsley approach to Improving Patient Experience. There are also other links between this strategy and Patient and Public Engagement in other region-wide health agencies, and a region-wide approach to Overview and Scrutiny.

Section 6.1, Aim,

To involve patients and the public so that their views are taken into consideration during the planning, improvement, monitoring and evaluation of all specialised services in Yorkshire & the Humber for which the Yorkshire and the Humber Specialised Commissioning Group has responsibility.

Section 6.2, Specific Objectives – April 2009 to March 2010, sets out a more detailed proposed work programme setting out specific activities that will be initially undertaken, including:

Section 6.2.5: Develop an on-going positive relationship with Overview and Scrutiny Committees in Yorkshire & the Humber, both individually and through the Yorkshire & the Humber Health Scrutiny Network.

A senior member of the Specialised Commissioning Team is due to attend the October meeting of the Yorkshire & the Humber Overview and Scrutiny Officers meeting, with specific reference to Section 6.2.5 above.

By way of practical example, the SCG consulted widely with Yorkshire and the Humber Overview and Scrutiny Committees on national and regional plans for the reconfiguration of Specialised Burn Care Services.

Responses to additional questions raised by Mrs Lillian Black (Kidney Patient Association)

Transport - addressed in response to question 12 above

It should also be noted that of the 118 patients at R&S ward at Seacroft, 41 (35%) live outside Leeds.

Similarly, of the 81 patients on ward 55 at SJUH, 41 (50%) live outside Leeds.

Prior to the unit at Beeston opening in 2005, the 24 patients who had been dialysing in a temporary unit at Cookridge Hospital were given the option of moving to other units, including Ward 50 at the LGI. 23 patients moved to Beeston; one moved to 'B' ward at Seacroft and none chose LGI.

Renal clinical standards - I can confirm that LTHT and the Renal service are aware of the various national guidance around haemodialysis services and utilises this guidance within its service plans

"The current Renal Association Guidelines & the draft future guidelines quote the following:

Guideline 1.3 – HD: Haemodialysis Facilities
"We recommend that, except in remote geographical areas the travel time to a haemodialysis facility should be less than 30 minutes or a haemodialysis facility should be located within 25 miles of the patient's home. In inner city areas travel times over short distances may exceed 30 minutes at peak traffic flow periods during the day".

The 28 patients who dialyse on the twilight shift at SJUH do so at their own request.

Patient survey 2008 **-** addressed in response to question 11 above

Capacity - the need for continued skilled and committed staff within the renal service is recognised and staffing levels within all the haemodialysis units remain under regular review by the Matron and Divisional Nurse.

The Seacroft Unit offers a haemodialysis service to patients. This allows many patients within the renal satellite service to be treated in a Nurse-led environment. The Seacroft Unit also benefits from dedicated medical cover between the hours of 09:00 to 17:00 Monday to Friday.

Due to the nature of the work carried out at the Seacroft Unit the requirement for fully trained nurses in dealing with a medical emergency is paramount. All nurses at Seacroft undertake annual mandatory basic Life Support training. To date all staff at Seacroft has undertaken this training with competence achieved at the required level. Many of the nurses at Seacroft have also participated in further training to a higher level (Intermediate Life Support ILS).

In relation to nurse staffing, the Renal Service is currently experiencing its highest rate of maternity leave in more than 10 years, with 10% of the nursing workforce currently on, or planning to be on maternity leave. This has clearly placed additional pressures on the Renal service; however additional posts have been approved and are being recruited to ensure the continued provision of the Renal service.

The availability of trained haemodialysis staff, nurses in particular, is a concern being expressed by all the renal units across Yorkshire & Humber. The newly formed Yorkshire & Humber Regional Renal Network has recognised this as an early priority.

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LTHT RENAL CENTRE - Haemodialysis Units - Current Capacity and Demand (September 2009) **APPENDIX 1**

Unit	No. of dialysis stations	Maximum capacity (2 sessions/day)	Current demand (09/2009)	Current utilisation/ occupancy[1]	Maximum capacity (3 sessions/day)	Projected demand (2013/14)	Comment
Beeston	10	40	40	100%	60		
Halifax	10	40	40	100%	60		
Huddersfield	10	40	40	100%	60		
Seacroft (B ward)	10	40	40	100%	60		
Dewsbury	12	48	48	100%	72		
Wakefield	12	48	46	96%	72		
Seacroft (R&S ward)	34	136	119	87.5%	204		+ 2 training rooms for home haemodialysis
SJUH (Wards 55/53)	23	92	83*	90.2%	138		Includes 5 isolation stations (ward 53) *Includes 28 patients on the twilight shift (ward 55)
TOTALS	**121**	**484**	**456**	**94%**	**726**	See letter Q7	

[1] Demand divided by capacity

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LTHT Renal Centre - Number of patients by all dialysis treatment modes and units

Unit	No of Patients
Haemodialysis	
Ward 55, SJUH	**81**
R&S Ward, Seacroft Hospital	**118**
B Ward, Seacroft Hospital	**36**
Beeston, South Leeds	**38**
Wakefield, Clayton Hospital	**48**
Huddersfield, St Luke's Hospital	**40**
Halifax, Calder Royal Hospital	**40**
Dewsbury District Hospital	**46**
Sub Total	**447**
Home Haemodialysis	**15**
Sub Total	**15**
Peritoneal Dialysis	
Automated Peritoneal Dialysis)	**71**
Continuous Ambulatory Peritoneal Dialysis	**33**
Sub Total	**104**
Total	**566**

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By Haemodialysis Unit and Individual Non Leeds Postcode

	POSTCODE	HG5	YO2	YO12	YO18	BD4	BD6	BD7	BD8	BD9	BD10	BD11	BD16	BD19	BD23	WF1	WF2	WF3	WF4	WF5	WF6	WF7	WF8	WF9	WF10	WF11	WF12	WF13
UNIT		Harrogate		York		Bradford										Wakefield												
Ward 55, SJUH		0	0	0	0	1	1	0	0	1	0	1	0	1	0	21	0	0	0	0	0	0	0	0	0	0	0	0
Beeston		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
B, Seacroft		1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0	0	0
Huddersfield		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dewsbury		0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	3	3	0	0	0	0	0	0	6	10
R&S, Seacroft		0	0	0	0	0	1	0	0	0	1	0	0	0	0	1	1	0	2	0	0	0	2	3	6	0	2	1
Wakefield		0	0	0	0	0	0	0	0	0	0	0	0	0	0	6	11	1	5	1	4	3	2	5	7	1	1	
Halifax		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0
Totals		1	0	0	0	1	2	0	0	1	1	2	0	2	0	28	12	2	10	4	4	3	4	9	14	1	9	11

By Haemodialysis

	WF14	WF15	WF16	WF17	DN32	DN37	HD1	HD2	HD3	HD4	HD5	HD6	HD7	HD8	HD9	S71	S75	OL14	HX1	HX2	HX3	HX4	HX5	HX6	HX7	Totals
UNIT					Grimsby		Huddersfield									Barnsley		Todmorden	Halifax							
Ward 55, SJUH	0	0	0	0	0	0	1	3	0	1	2	0	0	0	1	1	0	0	0	2	3	0	0	1	0	41
Beeston	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
B, Seacroft	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Huddersfield	0	0	0	0	0	0	10	4	2	9	5	1	5	1	2	0	0	0	0	1	0	0	0	0	0	40
Dewsbury	4	3	2	11	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	46
R&S, Seacroft	1	0	0	1	0	0	3	5	1	2	0	0	0	0	1	0	0	0	2	0	3	1	0	1	0	41
Wakefield	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	48
Halifax	0	0	0	0	0	0	0	2	1	0	0	1	0	0	0	0	0	0	7	11	8	2	1	5	2	40
Totals	5	3	2	12	0	0	14	14	4	12	9	2	5	2	4	1	0	0	9	14	14	3	1	7	2	260

By Haemodialysis Unit and Individual Leeds Postcode

	POSTCODE	LS1	LS5	LS6	LS7	LS8	LS9	LS10	LS11	LS12	LS13	LS14	LS15	LS16	LS17	LS18
UNIT		Leeds														
Ward 55, SJUH		5	0	1	4	4	0	0	3	4	1	3	2	3	0	0
Beeston		0	0	0	0	0	0	2	9	6	3	0	0	2	0	0
B, Seacroft		0	1	5	2	1	2	1	1	1	1	5	3	1	3	0
Huddersfield		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Dewsbury		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
R&S, Seacroft		0	0	0	9	8	4	4	3	3	4	3	7	7	5	1
Wakefield		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Halifax		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals		5	1	6	15	13	6	7	16	14	9	11	12	13	8	1

LS19	LS20	LS21	LS22	LS23	LS25	LS26	LS27	LS28	LS29	Totals
1	0	1	0	1	3	1	1	2	0	40
1	1	1	0	0	0	3	6	3	1	38
0	0	0	0	0	3	2	0	0	0	32
0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	0
7	0	4	1	0	0	1	0	3	3	77
0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	0
9	1	6	1	1	6	7	7	8	4	187

By Haemodialysis Unit and Grouped Postcode

	POSTCODE	HG	YO	BD	WF	DN	HD	S	OL	HX	LS	Totals
UNIT		Harrogate	York	Bradford	Wakefield	Grimsby	Huddersfield	Barnsley	Todmorden	Halifax	Leeds	
Ward 55, SJUH		0	0	5	21	0	8	1	0	6	40	81
Beeston		0	0	0	0	0	0	0	0	0	38	38
B, Seacroft		1	0	0	3	0	0	0	0	0	32	36
Huddersfield		0	0	0	0	0	39	0	0	1	0	40
Dewsbury		0	0	2	42	0	2	0	0	0	0	46
R&S, Seacroft		0	0	2	20	0	12	0	0	7	77	118
Wakefield		0	0	0	47	0	1	0	0	0	0	48
Halifax		0	0	0	0	0	4	0	0	36	0	40
Totals		1	0	9	133	0	66	1	0	50	187	447

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	Time on Vehicle																			
Postcode	**0 - 10**	**11 - 20**	**21 - 30**	**31 - 40**	**41 - 50**	**51 - 60**	**61 - 70**	**71 - 80**	**81 - 90**	**91 - 100**	**101 - 110**	**111 - 120**	**121 - 130**	**131 - 140**	**141 - 150**	**151 - 160**	**161 - 170**	**171 - 180**	**181 +**	**Total**
LS16	15	30	124	120	40	16	7	4	0	2	0	0	0	0	0	0	0	0	1	359
LS17	7	19	70	46	48	16	4	0	2	1	0	0	0	0	0	0	0	0	0	213
LS18	1	1	11	8	20	7	2	1	0	0	0	0	0	0	0	0	0	0	0	51
LS19	6	1	7	44	114	94	29	5	0	5	0	1	0	0	0	0	0	0	3	309
LS20	3	0	2	14	29	21	12	8	4	0	0	0	0	0	0	0	0	0	0	93
LS21	7	1	4	29	21	17	13	3	2	0	1	2	1	0	0	0	0	0	0	101
Total	39	52	218	261	272	171	67	21	8	8	1	3	1	0	0	0	0	0	4	1126

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	Time on Vehicle																			
Postcode	**0 - 10**	**11 - 20**	**21 - 30**	**31 - 40**	**41 - 50**	**51 - 60**	**61 - 70**	**71 - 80**	**81 - 90**	**91 - 100**	**101 - 110**	**111 - 120**	**121 - 130**	**131 - 140**	**141 - 150**	**151 - 160**	**161 - 170**	**171 - 180**	**181 +**	**Total**
LS16	22	29	169	74	23	12	4	2	3	0	0	0	1	0	0	0	0	0	0	339
LS17	5	16	72	33	12	6	2	1	1	1	0	0	0	0	0	0	0	0	0	149
LS18	6	0	9	12	9	3	2	0	1	0	0	0	0	0	0	0	0	0	0	42
LS19	13	4	9	67	82	29	3	1	1	0	0	0	0	0	0	0	0	0	0	209
LS20	5	1	1	23	22	19	5	4	2	0	0	0	0	0	0	0	0	0	0	82
LS21	7	0	3	15	20	21	13	3	1	0	1	0	1	0	0	0	0	0	0	85
Total	58	50	263	224	168	90	29	11	9	1	1	0	2	0	0	0	0	0	0	906

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APPENDIX 4

NHS
East Riding of Yorkshire

09 November 2009

To: PCTs, Providers, GPs, Patient Groups, Y&H SCG, Y&H SHA, Scrutiny Boards, NHS Kidney Care, Networks, Renal Strategy Group, Local Implementation Groups

Chief Executive's Office
East Riding of Yorkshire Primary Care Trust
Health House
Grange Park Lane
Willerby
East Yorkshire
HU10 6DT

Telephone: (01482) 672038
Fax: (01482) 672079

E-mail: ivan.ellul@erypct.nhs.uk
Website: www.erypct.nhs.uk

Dear Colleague

RE: DRAFT YORKSHIRE AND THE HUMBER RENAL STRATEGY 2009-14

Please find enclosed a copy of the Draft Yorkshire and the Humber Renal Strategy 2009-14.

A number of specialised services are commissioned collaboratively by PCTs across the Yorkshire and Humber region by the Specialised Commissioning Group (SCG). The Renal Strategy Group was established within the SCG to take forward the commissioning of a range of renal services. Membership of the Strategy Group is made up largely of clinicians from across the region, and also representation from patient groups and management

The Yorkshire and the Humber Renal Network Strategy sets out a five-year plan and outlines the following aims:

1. To prevent the occurrence of renal disease, through systematic identification of at risk groups, and reduction of risk factors.
2. To slow the progress of renal disease, through ensuring high coverage of disease management interventions across primary and secondary care.
3. To ensure early identification and referral of patients likely to need Renal Replacement Therapy, and adequate preparation and choice of treatment type.
4. To ensure timely availability of Renal Replacement Therapy for those likely to benefit from treatment by haemodialysis in designated renal units (or associated satellite units), by receiving a renal transplant, peritoneal dialysis or home haemodialysis.

This strategy is intended to provide the context for a consistent approach to planning services and moving towards equity of provision, in line with the implementation of the National Service Framework. The Yorkshire and the Humber Renal Strategy Group will be responsible for the implementation of the strategy and have agreed a five year work plan (included as appendix 1 of the strategy). Please note figure 1 will follow as an addendum.

I would be grateful if you could review the document and wherever possible provide early feedback. Comments should be forwarded to Rebecca Campbell, Renal Network Manager, at Rebecca.Campbell@barnsleypct.nhs.uk by no later than Thursday 31st December 2009.

Yours sincerely

Ivan Ellul
Chief Executive

Dr Chas Newstead
Clinical Lead

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NHS

Yorkshire and the Humber
Specialised Commissioning Group

Yorkshire and the Humber Renal Network Strategy for Renal Services

2009 – 2014

Draft Version
Version 8.3
9th November 2009

Yorkshire and the Humber Renal Network Strategy for Renal Services 2009 - 2014

Contents

Yorkshire and the Humber Renal Network Strategy for Renal Services 2009 - 2014

1 Background.

Chronic Kidney Disease (CKD) is a long-term condition and is defined as either kidney damage (proteinuria, haematuria or anatomical abnormality) or GFR <60 ml/min/1.73m^2 present on at least 2 occasions for more than or equal to 3 months [1]. It is an umbrella term for all types of kidney disease that can slowly damage the kidneys over months or years.

CKD may be progressive and its prevalence increases with age, male sex, and South Asian and African Caribbean ethnicity. People of South Asian origin are particularly at risk of CKD-linked diabetes. Diabetes is more common in this community than in the population overall. People of African and African Caribbean origin have an increased risk of CKD linked to hypertension. It is therefore important to understand the needs of the local population.

Acute kidney injury (AKI), formerly known as acute renal failure, is both a prevalent and serious problem amongst hospitalised patients. Clinically, AKI should be easily recognised by the onset of oliguria, anuria and/or deteriorating biochemistry. However, if unrecognised and allowed to deteriorate, AKI will result in uraemia, acidosis, hyperkalaemia and ultimately death. Strategies to reduce the risk of AKI are well known; they include identifying relevant risk factors, appropriate monitoring of blood biochemistry, rapid remedial action when AKI occurs, and appropriate referral of patients to specialist services. However, it is unknown if these strategies are being implemented and many factors around patients with AKI, both amongst those admitted to and already within UK hospitals remain unclear [2].

1.1 National Context

The Renal National Service Framework [3] (NSF), published in 2004 and 2005, set out a 10 year plan for the improvement of renal services and included comprehensive quality markers across the pathway of renal disease. The NSF thus represents the benchmark against which the Yorkshire and the Humber Renal Network will develop services.

In addition, there is a range of associated guidance and quality standards the Network will aim to meet. These include relevant National Institute of Clinical Excellence (NICE) guidance [4], Quality and Outcomes Framework [5] (QOF) standards, Putting Prevention First [6], the Organ Donation Taskforce recommendations [7] and the End of Life Care in Advanced Kidney Disease Framework [8].

Treating patients with Acute Kidney Injury (AKI) especially those with disease so severe as to require dialysis support is a key service offered by specialist renal units. The recently published results of a National Confidential Enquiry into Patient Outcome and Death (NCEPOD) [2] review of the care of patients who DIED in hospital with a primary diagnosis of AKI indicated that only 50% of patients were deemed to have received an overall standard of care that was considered good. This was particularly striking for those who developed AKI post admission where only one third received good care.

1.2 The Strategy

The Yorkshire and the Humber Renal Network Strategy outlines the aims of the Network and sets out a 5-year work plan. This strategy will be reviewed on an annual basis. The Network is supported by three Local Implementation Groups, based around the clinical networks for renal services.

Figure 1: Map of region with location of main units / satellites / stations & inpatient beds and capacity and including the configuration of Local Implementation Groups to be inserted here.

2 Commissioning Framework and Governance.

Most patients with CKD will be managed within the primary care sector. For those patients who require it, it is important that there are clearly identified clinical and commissioning pathways in place to ensure a smooth transition from primary to secondary and tertiary care, with appropriate referral and patient choice mechanisms in place. The commissioning of renal care should reflect the role of Practice Based Commissioning and individual PCTs.

The Renal Network is responsible for providing clinical advice to commissioning, and setting the overall service development and quality framework for all renal services in the region. Clinical networks (Local Implementation Groups) are principally responsible for ensuring implementation of the Renal NSF locally; for developing proposals for service developments and improvements and for ensuring a link into primary care. Individual PCTs may also wish to integrate renal services into the local Vascular and Diabetic Programme.

3 Health Need

3.1 Chronic Dialysis

There are approximately 4.9 million people living in Yorkshire and Humber. It is estimated that there are approximately 359,000 adults (18+) with Chronic Kidney Disease (CKD) (stages 3-5) in Yorkshire and the Humber. 167,000 have been diagnosed (QOF 07 08), this indicates a significant undiagnosed population with CKD.

Approximately 550 new patients start Renal Replacement Therapy (RRT) every year. The majority would be treated initially by dialysis, with a small number receiving a “pre-emptive” renal transplant. Bradford and Kirklees have a higher than expected (taking into account age and gender characteristics) rate of CKD5 (End Stage Renal Failure) who are treated by dialysis / transplantation. Although the data are less reliable it is thought that these two districts have a higher rate of CKD 3-4. In contrast, Doncaster and East Riding have a lower than expected rate of CKD5 (End Stage Renal Failure) who are treated by dialysis / transplantation.

In total there are 4,313 patients receiving RRT across the region in 2009. Of these approximately 48% are transplant patients and there are 2,258 dialysis patients in the region. Further data regarding the current and projected positions are detailed in the table below.

Figure 2: Current and Projected Position

	Current position
Estimated Number of patients 18+ with CKD	**359,000 (2007-08)**
Number of patients 18+ diagnosed with CKD	**167,000 (QOF 06-07)**
Number of Renal Centres	**6**
Number of Satellite Units	**19**

	Current position 2009 / 10	Projected 2014 / 15
Total number of dialysis patients	**2,258**	**2,495**
Total number of haemodialysis patients	1806	2062
Total number of peritoneal dialysis patients	389	430
Total number of transplant patients	**2,055**	**2,334**
TOTAL (on RRT)	**4,309**	**4,819**

3.2 Home-Based Therapies

NICE has recommended that all patients who are suitable for home haemodialysis (HD) should be offered the choice of having haemodialysis in the home or in a renal unit [9]. Patients currently treated in hospital that are potentially suitable for home haemodialysis on clinical grounds, but who have not previously been offered a choice, should be reassessed and informed about their dialysis options. The absolute number of patients receiving home haemodialysis in Yorkshire and the Humber is low but the proportion is slightly higher than the UK average which is 2%.

The UK Renal Registry data for 2008 [10] indicates that the percentage of dialysis patients receiving home HD varied from 0% in 20 centres in the UK, to greater than 5% of all dialysis activity in the following 6 centres, Sheffield (5.2%), London Guys (5.1%), Brighton (5.5%), Bangor (5.1%), Bristol (5.5%) and Manchester Royal Infirmary (8.6%).

NICE guidance indicates potential scope for expansion of home HD, and that this is a cost effective option which delivers better outcomes and quality of life for patients. The number of patients who would preferentially opt for home HD rather than peritoneal dialysis (at home) and who are unlikely to receive a transplant in the near future AND are clinically suitable for it is unknown. The proportions vary across the region (see figure 3 for total number), a Health Technology Appraisal by NICE indicated that there is the potential to explore a significant increase in numbers with this option, with them setting a target minimum of 15%.

Figure 3: Current position regarding Home Haemodialysis (HD)

	Current position (2009 / 10)
Total number of patients on haemodialysis	**1865**
Total Number of patients on home HD	**57**
% of patients on home HD	**3%**

3.3 Acute dialysis

Although no definitive studies have been undertaken in the UK the prevalence amongst hospitalised patients in the US is 4.9%[11] and associated mortality rates have been wide ranging[12].

In all the specialist renal units in the region facilities to manage haemodialysis patients with AKI are shared with some facilities to treat patients with established renal failure. In the last few months pressure on these facilities has resulted in renal centres declining referrals for the management of AKI from their traditional referral hospitals for a period of several weeks.

The Yorkshire and the Humber Network will undertake further work to pilot the incorporation of the acute renal care bed base across the region into the new Clinical Management System "Live" Bed Management West Yorkshire Critical Care Network Pilot, in order to more effectively manage acute admissions.

3.4 Transplantation

Renal transplantation for suitable patients offers a very significant improvement in quality of life, and patients are a third less likely to die one year post successful transplantation compared to those who stay on dialysis (but are deemed suitable for a transplant). Each transplant saves approximately £250K of health care costs over a patient's lifetime.

The Leeds and Sheffield Centres provide transplant services for Yorkshire and the Humber. The majority of renal donors are from individuals who have died due to "brain stem death", and kidneys from these donors are allocated by a nationally agreed set of rules. Recent changes to these rules mean that predicted transplants from this source will decrease in Leeds for the next two years, and then increase, and in Sheffield will increase somewhat steadily. Kidneys are also retrieved from donors who have died following "cardiac death", and Leeds has a reasonably well established programme for retrieval that in Sheffield is yet to be firmly established. Investment in this donor source would be appropriate. The third source of kidneys and the best results are obtained from living donors. The Specialised Commissioning Group has invested significantly in this activity and the Renal Network will performance manage the expected steady growth in this area.

Leeds has recently made a preliminary application to secure funding from the National Specialised Commissioning Advisory Group in order to develop combined pancreas/renal transplantation. The nearest units currently offering this service are Manchester and Newcastle.

3.5 Predicted Future Demand

Current Department of Health models predict that over the next 9 years (up to 2018) the region will have an additional 430 patients in the prevalent population requiring dialysis. It should be noted that the figures stated in this section are subject to review and may change. Further work is being done on future demand modelling currently. The detail of this should not delay planning for increasing the capacity in dialysis services, particularly haemodialysis.

Although chronic haemodialysis capacity has improved over the last few years the projected increase in demand requires significant capital investment. In addition to this growth in expected need, there are concerns regarding

existing estates and facilities with a number of units operating in outdated premises. Furthermore, there are units operating out of leased premises which will need to be relocated in the near future. It is anticipated that the new national tariff for haemodialysis may not provide enough funds to allow step wise construction of new satellite units nor the replacement of unfit estate.

Options for expansion of dialysis capacity that require smaller capital investment include:

- A higher proportion of patients to opt for home based therapies (peritoneal dialysis or home haemodialysis).
- An increase in the number of shifts that current units are staffed for.
- To secure capacity from independent sector providers therefore paying out of revenue. *There has been significant independent sector provision in the South of the region and more recently in Humberside. The latter was "pump primed" by central government in a way that is unlikely to occur again in the immediate future.*

There is a requirement for continuity of funding, skilled capacity management and planning across Yorkshire and the Humber. Urgent consideration therefore needs to be given to the provision of capital funding over the next five years for the replacement and refurbishment of existing facilities and the development of new satellite haemodialysis facilities.

4 Strategic Aims.

The aims of the Yorkshire and the Humber Renal Network are:

1. To prevent the occurrence of renal disease, through systematic identification of at risk groups, and reduction of risk factors.
2. To slow the progress of renal disease, through ensuring high coverage of disease management interventions across primary and secondary care.
3. To ensure early identification and referral of patients likely to need Renal Replacement Therapy, and adequate preparation and choice of treatment type.
4. To ensure timely availability of Renal Replacement Therapy for those likely to benefit from treatment by haemodialysis in designated renal units (or associated satellite units), by receiving a renal transplant, peritoneal dialysis or home haemodialysis.

5 Implementation and Interfaces.

The Yorkshire and the Humber Renal Network is responsible for the implementation of this strategy. A component of this work is the establishment of a single commissioning framework (including performance management and quality) for Renal Services in the region.

An early task is to provide an assessment of progress towards implementing NSF; to include a review of capacity, clinical policies and pathways for dialysis, transplant and primary care management of CKD across Yorkshire and Humber.

The interface between this renal strategy and prevention of renal disease, primary care management of renal disease, pathways into secondary and tertiary care for all types of renal disease, renal input into end of life care, renal input into critical care networks where appropriate, and the role and

capacity of the independent sector in the region all fall within the scope of this strategy.

A regional approach to planning is not about imposing a single model of care, but about ensuring there is a consistent approach to planning of services and moving towards equity of provision – whatever the actual model of delivery at the front line.

Important outputs of the Network will be agreed and include prioritised service development / improvement plans, provision of consistently high standard and equitable services across the region (through care pathway development and other quality improvement measures), with a clear mechanism for clinicians and patients to influence directly the commissioning arrangements for renal care.

The Yorkshire and the Humber Renal Network has agreed a 5 year work plan (see appendix 1). The work plan sets out a comprehensive set of actions to improve the care for renal patients in the region and is appended. It will be regularly reviewed to ensure it reflects current and future planning priorities.

Together with patients, local communities and all other stakeholders the Renal Network is committed to transforming renal care across the region.

6 References

1. National Kidney Foundation. K/DOQ1 clinical practice guidelines for chronic kidney disease: evaluation, classification and stratification. American Journal of Kidney Disease, 2002, 39: S1-266.
2. Adding Insult to Injury: A review of the care of patients who died in hospital with a primary diagnosis of acute kidney injury (acute kidney failure). NCEPOD. June 2009. http://www.ncepod.org.uk/2009aki.htm
3. The National Service Framework for Renal Services – Part One: Dialysis and Transplantation. Department of Health. January 2004 and - Part Two: Chronic Kidney Disease, Acute Renal Failure and End of Life Care. Department of Health. February 2005. http://www.dh.gov.uk/en/Healthcare/Renal/DH_4102636
4. National Institute of Clinical Excellence (NICE) http://www.nice.org.uk/
5. The NHS Information Centre for Health & Social Care. The Quality and Outcomes Framework. http://www.ic.nhs.uk/qof
6. Putting Prevention First. Vascular Checks: Risk assessment and management. Department of Health. April 2008. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083822
7. Organs for transplants. A report from the Organ Donations Taskforce. Department of Health. January 2008. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082122
8. End of Life Care in Advanced Kidney Disease: A framework for implementation. NHS Kidney Care. June 2009. http://www.kidneycare.nhs.uk/i/assets/EoLC_Jun09.pdf
9. TA48 Renal Failure: Home verses Hospital Haemodialysis: Guidance. October 2002 (http://guidance.nice.org.uk/TA48/Guidance/pdf/English)
10. UK Renal Registry: The Eleventh Annual Report. Renal Association. December 2008. http://www.renalreg.com/Reports/2008.html
11. Naikar SS, Liu KD, Chertow GM. The incidence and prognostic signifi cance of acute kidney injury. Cherow 2007. Current Opinion in Nephrology and Hypertension; 16:227-236.
12. Hoste EA, Clermont G, Kersten A, et al. RIFLE criteria for acute kidney injury are associated with hospital mortality in critically ill patients: a cohort analysis. 2006. Critical Care. 10(3):R73.

7 Appendices

Appendix 1
Work Plan of YH Renal Strategy: 2009/10 – 2013/14

Priorities 2009-10	Objective	Action
1. Pandemic Flu	To ensure that services for patients requiring renal replacement therapy have robust business and service continuity plans in place.	• Network to seek formal assurance from all providers that robust (and tested) contingency plans are in place in hospital and independent sector units **Lead: Chas Newstead/Greg Fell**
2. Haemodialysis Capacity and Health Needs Assessment	To undertake a comprehensive assessment of haemodialysis capacity currently available in all units.	• Analysis of QOF achievement at practice level, outpatient utilisation trends • Re run Demand Model (existing and MORRIS model) • Match this against actual and expected need • Identify service pressures/gaps • Reinforce policy that patients that are clinically suitable should be dialysed as close to home as possible • Identify and address any specific current issues • Identify medium term planning needs • Identify scope for growth in home haemodialysis programmes • Use routinely available data to provide quality overview of current services • Identify investment that may be required to meet future need. **Lead : Greg Fell**
3. Future capacity planning	To use information on health need, and a wide range of other information, to make prioritised service development proposals to SCG and other commissioning bodies.	• Network to establish concrete proposals to increase dialysis (and related) capacity to meet future need. • Review the role and capacity of the independent sector in the region **Lead : Jackie Parr/Greg Fell**
4. Acute Kidney Injury and Critical Care	To ensure that provider trusts have robust plans to manage acute admissions in addition to chronic care.	• The Network is working in partnership with the West Yorkshire Critical Care Network (WYCCN) and planning for more effective management of acute admissions • This should be linked to a systematic approach across the region, so that both provider trusts and PCTs are clear how best to manage occasional crises. • This should include within its scope critical care capacity, pathways and protocols and link to nursing workforce

		shortages. • Consistent approach to renal input into critical care networks where appropriate (for example Acute Kidney Injury and acute post transplant care) **Lead: Jackie Parr (as member of the WYCCN group)**
5. Transplant Capacity	To undertake a local review of the recommendations of the Organ Donation Taskforce Review and identify gaps in local provision and areas for service growth.	• Local review of the consistency of transplant pathway in Leeds/Sheffield (and feeder trusts) • Identify the process for implementing the recommendations of the Organ Donation Taskforce • Identify the specific interventions (health care system, clinical, public health, other) that might be undertaken in Yorkshire & the Humber • Further investment will/may be required. Priority for next planning round **Lead: Chas. Newstead**
Ongoing work 2010-14	**Objective**	**Action**
6. Patient & Public Engagement & Involvement	To ensure patient input into commissioning, performance management and service improvement arrangements.	• Develop an ongoing programme of patient involvement and consultation. • Ensure that there is patient representation and a patient voice, at all relevant SCG/LIG meetings • Develop an information pack and programme of support for patient representatives • Ensure that the Network is available to attend patient groups • This will include consistent access and availability of appropriate information to facilitate an informed and planned care pathway. **Lead: Dennis Crane/Rebecca Campbell**
7. Workforce Planning	To understand the scope and nature of the current issues in the workforce, including nursing, medical and ancillary clinical and support services. To identify the workforce models that exist in the region and how this fits in with recommended best practice. To identify the high impact actions that can be taken to address current shortages in the renal nursing	• To scope out the nature and extent of the issues • Workforce issues to be discussed with the Workforce Planning Lead at the Strategic Health Authority • Develop workforce plan **Lead: Elaine Harrison**

	workforce.	
8. Transport	To review current arrangements for transport services for RRT patients in light of the national audit. To ensure the recommendations of the national audit are implemented To continue to develop the pilot arrangements for Personalised Health Budgets for Renal Transport	• Review findings of national audit. • Review current arrangements across the region, Consideration of value for money in current local arrangements • Identify and share best practice. • Highlight planning gaps locally. • Highlight any specific issues that need to be addressed by PCTs locally **Lead: Chas Newstead/Elaine Harrison/ Rebecca Campbell**
9. NSF milestones	To assess progress against the National Service Framework (NSF) milestones and identify gaps and areas for development	• Review of progress towards implementing NSF milestones • Template for this established by Regional Group, Local Implementation Groups to undertake the review and identify gaps and issues that should be addressed **Lead: Rebecca Campbell**
10. Equity	To review existing service pathways and commissioning policies across the renal pathway.	• Review existing pathways for dialysis and transplant and develop consistent care pathways for renal care, thus improving equity of care across the region • Develop commissioning policies (and associated service specifications) to support ongoing service development and reduce variation in the level and availability of services. • This may focus on home HD, conservative care and renal input into end of life care, AAPD, new primary care services (shared care arrangements; EPO / Anaemia Management and pre dialysis year). • Interface between children's and adult services **Lead: Jackie Parr**
11. Primary Care capacity, quality and expertise	To make assessment of current expertise in primary care	• Assess current expertise in primary care for the identification & management of renal disease • This will be informed by a practice level analysis of performance against the QOF standards. • Identify training needs • Consider the establishment of a central web based renal resource for the region. Such a resource might serve to harness creative thinking from primary care around service redevelopment • Ensure consistent and appropriate links between renal care and prevention of renal disease (a consistent approach across the region, linked to the vascular programme work)

		• Establish referral pathways into secondary for all types of renal disease **Lead: Michael Gordon**
12. Pre Dialysis Year	To review current practice in pre dialysis care across the renal units in the region.	• Small group to review current practice across the renal units in the region in collaboration with GPs • Identification of best practice • Develop a commissioning framework to implement what is identified/agreed to be best practice • Ensure implementation at a local level **Lead: Chas Newstead**
13. Anaemia Management	To undertake a review of current arrangements for Anaemia Management across primary care in the region.	• Small group to be established across Yorkshire & the Humber to better understand best practice and share widely • Implementation of best practice is a Local Implementation Group or individual PCT issue, requiring close liaison between renal units and local GPs • This work should include EPO, Shared care arrangements, Prescribing protocols, Locally Enhanced Services (LES) arrangements **Lead: Michael Gordon**
14. Conservative Care	To Develop a Palliative/Conservative Care Strategy/ Commissioning Framework for the region. This should be based on the End of Life Care in Advanced Kidney Disease Framework	• Jackie Parr to link up with regional Darzi work-stream • Develop a YH commissioning policy for conservative care and renal input into end of life care **Lead: Jackie Parr**
15. Commissioning standards	To advise SCG on standards against which to commission renal services in YH.	Renal Network to develop a set of recommended minimum standards against which RRT services should be commissioned These standards may include: • The configuration of clinical networks for renal services (main renal units, satellite units – independent sector and NHS, and links to primary care) • RRT programme size and capacity • Links between transplant and renal dialysis unit • Consistency of clinical policies, protocols and care pathways • Multi-disciplinary team discussion about new and existing patients, and care planning for all patients, coordination of different disciplines • On-call arrangements • Links between RRT services and inpatient beds

		• Staffing models; technical, IT, and surgical support • Governance arrangements between main and satellite units • Contribution to surveillance and monitoring of QOF and Renal Registry • Minimum set of quality [i] and performance standards for RRT services. Within this, agree indicators of high and low quality care • To consider the development of a single tariff and costing framework for the region, dependent on national developments in this area • Costing arrangements should reflect different types of RRT (including transplant, and transplant work up – donor and recipients); conservative care, pre dialysis care, electronic and phone advice to non renal physicians, delivery of training and education **Lead: Jackie Parr**

[i] A number of suggestions have already been put forward:

Quality markers for RRT

Good Fistula v line access for dialysis / Timely listing of patients on the cadaver transplant list. / Rate of pre emptive live donor transplants, rate of live donor transplants, rate of non heart beating donor transplants. Absolute number of transplants / 3 or greater times per week dialysis / unit rank order in RR datasets for BP, dialysis adequacy – URR, Phosphate control etc.

Poor - High rate of acute inpatient stay with LOS of >12 – 16w / Dialysis twice (or less) per week

Quality Markers for CKD - QOF performance (and exception rate) for CKD3 and CKD4

Quality markers for Conservative Care- Gold Standard Framework adoption and implementation

Appendix 2
Yorkshire and the Humber Renal Strategy Group Members

Ivan Ellul	**Chair of Yorkshire & the Humber Renal Strategy Group** **Chief Executive of NHS East Riding of Yorkshire**
Rebecca Campbell	**Renal Network Manager**
Dr Chas Newstead	**Clinical Lead**
Dr Michael Gordon	**GP Lead**
Elaine Harrison	**Nurse Lead**
Greg Fell	**Public Health Lead**
Dennis Crane	**Patient Representative**
Jackie Parr	**Senior Commissioning Manager** **Yorkshire & the Humber Specialised Commissioning Group**
Matt Neligan	**Chair of West Yorkshire & York Local Implementation Group** **Director of Commissioning, NHS Bradford & Airedale**
Gary Lusty	**Chair of North & East Yorkshire and North Lincolnshire Local Implementation Group** **Assistant Director of Planning, NHS East Riding of Yorkshire**
To Be Appointed	**Chair of South Yorkshire / North Trent Local Implementation Group**
Dr Russell Roberts	**Consultant Nephrologist** **Bradford Teaching Hospitals NHS Foundation Trust**
Dr Ian Stott	**Consultant Nephrologist** **Doncaster & Bassetlaw Hospitals NHS Foundation Trust**
Dr Helen Collinson	**Consultant Nephrologist** **Hull & East Yorkshire Hospitals NHS Trust**
Dr Mark Wright	**Consultant Nephrologist** **Leeds Teaching Hospitals NHS Trust**
Dr William McKane	**Consultant Nephrologist** **Sheffield Teaching Hospitals NHS Foundation Trust**
Dr Paul Laboi	**Consultant Nephrologist** **York Hospitals NHS Foundation Trust**

Appendix 3
Summary of National Service Framework standards, quality requirements and markers of good practice

These standards apply to all patients. In some cases, for example children and young people and some older people, they will also apply in varying degrees to families, guardians or carers.

Part One of the NSF:

STANDARD ONE: All children, young people and adults with chronic kidney disease are to have access to information that enables them with their carers to make informed decisions and encourages partnership in decision-making, with an agreed care plan that supports them in managing their condition to achieve the best possible quality of life.

Markers of good practice
• Provision of high quality, culturally appropriate and comprehensive information and education programmes.
• Education programmes tailored to the needs of the individual.
• Individual care plans, regularly audited, evaluated and reviewed.
• Access to a multi-skilled renal team whose members have the appropriate training, experience and skills.
• For children and young people, meeting the standards of *Getting the right start: National Service Framework for Children, Young People and Maternity Services.*

STANDARD TWO: All children, young people and adults approaching established renal failure are to receive timely preparation for renal replacement therapy so the complications and progression of their disease are minimised, and their choice of clinically appropriate treatment options is maximised.

Markers of good practice
• Referral to a multi-skilled renal team, where possible at least one year before the anticipated start of dialysis treatment, for appropriate clinical and psychological preparation. This principle should also be followed for people with a failing transplant.
• Accelerated process with intensive input from the renal team for those who present late to renal units or as acute uraemic emergencies.
• People with ERF given information about all forms of treatment so that an informed choice can be made.
• Patients put on the national transplant list within six months of their anticipated dialysis start date if clinically appropriate.
• Anaemia treated to maintain an adequate haemoglobin level.
• Management of cardiovascular risk factors and diabetes according to the National Service Frameworks for Coronary Heart Disease and for Diabetes.

STANDARD THREE: All children, young people and adults with established renal failure are to have timely and appropriate surgery for permanent vascular or peritoneal dialysis access, which is monitored and maintained to achieve its maximum longevity.

Markers of good practice
• Early referral for assessment and investigation for the best means of access, and timely surgery (current best practice being six months before haemodialysis, four weeks before peritoneal dialysis) which enables patients to begin dialysis with their vascular or peritoneal dialysis access established and functioning.
• Monitoring and early intervention to minimise complications of the access.
• Recording and regular auditing of the type of access in use at the start of dialysis, time from referral to surgery, and complication rates for each procedure. Temporary access replaced by permanent access as early as possible.
• Proper training for patients, carers and members of the renal team in the care of the access.
• For children and young people: Dialysis access surgery to follow the principles set out in *Getting the right start: the National Service Framework for Children, Young People and Maternity Services – Standard for Hospital Services.*

STANDARD FOUR: Renal services are to ensure the delivery of high quality clinically appropriate forms of dialysis which are designed around individual needs and preferences and are available to patients of all ages throughout their lives.

Markers of good practice
• All dialysis methods available interchangeably for patients, including home haemodialysis and automated peritoneal dialysis.
• Patients receive an adequate and effective dialysis dose.
• Peritonitis rates to be less than one per 18 patient months for adults undergoing peritoneal dialysis, one per 14 patient months for children.
• Patients have their nutritional status monitored and appropriate nutritional support in place.
• Efficient patient transport services available.
• Specialist renal staff, equipment and care available throughout admission, whatever the setting, for patients with established renal failure admitted to hospital.

STANDARD FIVE: All children, young people and adults likely to benefit from a kidney transplant are to receive a high quality service which supports them in managing their transplant and enables them to achieve the best possible quality of life.

Markers of good practice
• Early provision of culturally appropriate information; discussion with and counselling of patients, relatives and carers about the risks and benefits of transplantation with a clear explanation of tests, procedures and results.
• Application of a national matching scheme using criteria agreed through UK Transplant to optimise blood group and tissue matching for kidneys from deceased donors.
• Effective preventive therapy to control infections.
• Timely operating theatre availability to ensure optimal cold ischemia times.
• Appropriate immunosuppression and anti-rejection treatment in accordance with forthcoming NICE guidance and effective monitoring and treatment to minimise the risks of adverse effects of immunosuppressive treatment.
• Clear explanation for patients of tests, procedures and results, and especially information and education about anti-rejection therapy.
• Specialist advice from the transplant team available for patients with a renal transplant admitted to hospital, whatever the setting.
• Organ procurement and transplantation to follow the principles set out in *Saving Lives, Valuing Donors: A Transplant Framework for England.*

Part two of the NSF:

QUALITY REQUIREMENT ONE: People at increased risk of developing or having undiagnosed chronic kidney disease, especially people with diabetes or hypertension, are identified, assessed and their condition managed to preserve their kidney function.

Markers of good practice
• All people at increased risk of CKD are identified, and given appropriate advice, treatment and support (which is sensitive to the differing needs of culturally diverse groups) to preserve their kidney function.
• People identified as having an increased risk of CKD have their kidney function assessed and appropriately monitored, using estimated GFR.
• Implementation of the NICE clinical guideline on the management of Type 1 diabetes.
• Implementation of the NICE clinical guidelines on the management of Type 2 diabetes: renal disease; blood glucose; blood pressure and blood lipids.
• Implementation of the NICE clinical guideline on the management of hypertension in adults in primary care.
• For children and young people with potential urinary tract infection, accurate diagnosis and prompt antibiotic treatment, and investigation sufficient to identify structural renal defects and to prevent renal scarring.
• For children and young people with bladder dysfunction, planned investigation and follow-up, with access to urology services with paediatric expertise.

QUALITY REQUIREMENT TWO: People with a diagnosis of chronic kidney disease receive timely, appropriate and effective investigation, treatment and follow-up to reduce the risk of progression and complications.

Markers of good practice
• All people diagnosed with CKD have access to care which is sensitive to the differing needs of culturally diverse groups, to maximise the benefits of treatment and minimise the effects of the disease; and have a care plan.
• Use of the best available evidence to inform the management of blood pressure, cardiovascular disease and cardiovascular risk, and urinary tract obstructions and infections in people with CKD.
• In people with diabetes and CKD, interventions to reduce microvascular complications, in accordance with the *National Service Framework for Diabetes*.
• Implementation of the forthcoming NICE guideline on the treatment of anaemia in CKD.
• Referral from primary care to the specialist renal service at an appropriate stage to optimise outcomes.

QUALITY REQUIREMENT THREE: People at risk of, or suffering from, acute renal failure are identified promptly, with hospital services delivering high quality, clinically appropriate care in partnership with specialised renal teams.

Markers of good practice
• Timely identification and referral to renal and critical care services for specialist, culturally appropriate advice and assessment.
• Appropriate pre-operative testing and interventions, in accordance with the NICE guideline on pre-operative testing.
• Involvement of local critical care networks in planning, commissioning and monitoring the delivery of critical care services to acutely ill renal patients.
• Liaison with specialist renal services to facilitate optimal management of people with ARF in the most clinically appropriate setting.
• For children and young people: Treatment and care in accordance with *Getting the right start: National Service Framework for Children, Young People and Maternity Services*.

QUALITY REQUIREMENT FOUR: People with established renal failure receive timely evaluation of their prognosis, information about the choices available to them, and for those near the end of life a jointly agreed palliative care plan, built around their individual needs and preferences.

Markers of good practice
• The renal multi-skilled team has access to expertise in the discussion of end of life issues including those of culturally diverse groups and varied age groups, the principles of shared decision making, and training in symptom relief relevant to advanced non-dialysed ERF.
• Prognostic assessment based on available data offered to all patients with stage 4 CKD as part of the preparation for RRT described in standard two of part one of this NSF.
• People receive timely information about the choices available to them, such as ending RRT and commencing non-dialytic therapy, and have a jointly agreed care plan built around individual needs and preferences in line with palliative care principles.
• People who are treated without dialysis receive continuing medical care including all appropriate non-dialytic aspects of CKD, and wherever possible are involved in decisions about medication options.
• Individuals are supported to die with dignity, and their wishes met wherever practicable regarding where they die, their religious and cultural beliefs, and the presence of the people closest to them.
• The care plan includes culturally appropriate bereavement support for family, partners, carers and staff.

Appendix 4
Glossary of terms

Primary Care Trust (PCT) is a type of NHS Trust responsible for commissioning primary, community and secondary care services from providers. Many PCTs are now calling themselves NHS and then the name of their geographical area to make it easier for local people to understand how the NHS is managed locally. Collectively PCTs are responsible for spending around 80% of the total NHS budget. PCTs have their own budgets and set their own priorities, within the overriding priorities and budgets set by the relevant Strategic Health Authority (SHA) they belong to, and the Department of Health (DH).

Strategic Health Authorities (SHA) are responsible for enacting the directives and implementing policy as dictated by the Department of Health (DH) at a regional level. In turn each SHA area contains various NHS Trusts which take responsibility for running or commissioning local NHS services. The SHA is responsible for strategic supervision of these services.

Commissioning is the strategic activity of assessing needs, resources and current services, and developing a strategy to make best use of available resources to meet identified needs. Commissioning involves the determination of priorities, the purchasing of appropriate services and their evaluation.

Specialised Commissioning is the commissioning of a specific set of services which are classified as 'specialised'. These services, which include renal services, are defined as those that need to be planned across a bigger area and require specialist (more complex) clinical input. The commissioning of these services is the responsibility of the **Specialised Commissioning Group (SCG)** which is a permanent Joint Committee of, and acts on behalf of all the Primary Care Trusts (PCTs) in the Strategic Health Authority (SHA). In Yorkshire and the Humber the Yorkshire and the Humber Specialised Commissioning Group (Y&H SCG) covers 14 PCTs.

Practice-Based Commissioning (PBC) is a Department of Health (DH) policy designed to give general practitioners (GPs), nurses and other primary care professionals the power to decide how NHS money is spent in their local area. Whilst Primary care trusts (PCTs) have overall accountability for healthcare commissioning.

National Tariff is a standardised price list for operations and procedures applied nationally.

The **Yorkshire and the Humber (Y&H) Renal Network** has been established to lead on the modernisation and development of Renal Services across the region. The strategic planning and commissioning of renal services across Yorkshire and the Humber, in accordance with the National Service Framework (NSF) for Renal Services and National Institute for Health and Clinical Excellence Guidance (NICE) is delivered through the Renal Strategy Group (RSG), which is supported by three Renal Local Implementation Groups (LIG). These reflect and support local commissioning, provider and patient population groups and relationships within the region.

Renal Replacement Therapy (RRT) is the term used for life-supporting treatments for kidney disease. It includes haemodialysis, peritoneal dialysis and transplantation. In practice dialysis only provides about 5% and a renal transplant about 40% of "normal" kidney function.

Haemodialysis (HD) is a form of Renal Replacement Therapy (RRT) in which the blood is purified outside the body by passing it through a filter called a dialyser. The filter is connected to a machine which pumps the blood through the filter and controls

the entire process. For patients with established renal disease each dialysis session normally lasts from 3-5 hours and the sessions are almost always needed three times a week. Haemodialysis can either be carried out at home (HHD), or in a satellite or main renal unit.

Peritoneal Dialysis (PD) is a form of Renal Replacement Therapy (RRT) in which blood purification takes place using the patient's own peritoneum as the membrane. Bags of dialysis fluid containing glucose and various other substances are drained in and out of the abdominal cavity via a PD catheter.. It is a home-based treatment usually performed by patients themselves.

This may be in the form of Continuous Ambulatory Peritoneal Dialysis (CAPD) performed manually, usually 4 times throughout the day, or Automated Peritoneal Dialysis (APD) which uses a machine to perform the exchange of fluid overnight whilst the patient sleeps. Assisted APD (aAPD) provides support to patients who may not be able to perform all components of the dialysis by themselves.

Transplantation is the replacement of an organ in the body by another person's organ. About 40% of patients with established renal failure are suitable for transplantation. As well as offering much the best quality of rehabilitation, there is an improved survival for patients who receive a renal transplant. Pancreatic transplants will treat diabetes which may be the cause of renal failure. By performing a simultaneous kidney and pancreas transplant both the diabetes and the renal disease will be treated.

Pre-emptive Transplant is carried out before dialysis is required and is considered to be the optimum form of treatment.

Living donors are those where the kidneys for transplantation are donated by a member of the recipient's family (**live related**) or by an individual who is not blood related (**live non-related**). The results from transplantation from a live donor source are better than when the donor has deceased.

Cadaveric donors are those where a kidney is donated from an anonymous individual who has recently died. The majority of renal donors are from individuals who have died due to **brain stem death**.

Kidneys are also retrieved from donors who have died following **cardiac death** which refers to natural death from cardiac causes, heralded by abrupt loss of consciousness within one hour of the onset of acute symptoms.

Estimated Glomerular Filtration Rate (eGFR) is a measure of the level at which the kidneys are working based on a calculation of the Glomerular Filtration Rate (GFR) most commonly from the patient's serum Creatinine, age, sex and ethnicity.

Proteinuria is the presence of an excess of serum proteins in the urine and is almost always a sign of renal damage. Since serum proteins are readily reabsorbed from urine, the presence of excess protein indicates either an insufficiency of absorption or impaired filtration. The most common cause of proteinuria is diabetes.

Haematuria is the appearance of blood in the urine. Any part of the urinary tract from the kidneys to the bladder and urethra may be a cause of haematuria. This may be due to diseases that cause renal failure or inflammation but renal tract cancer is another important cause of haematuria.

Oliguria is the decreased production of urine.

Anuria means passage of almost no urine and is practically defined as passage of less than 50 milliliters of urine in a day. Anuria is the inability to urinate due to failure

in the function of kidneys or more commonly because of obstruction from prostatic disease, kidney stones or tumours. Anuria is also sometimes called anuresis.

Uraemia is a term used to describe the illness accompanying renal failure, in particular the syndrome due to accumulation of nitrogenous waste products associated with the failure of the kidneys.

Acidosis is an increased acidity. Metabolic acidosis is an increased production of metabolic acids, usually resulting from disturbances in the ability to excrete acid via the kidneys. Renal acidosis is associated with an accumulation of urea and creatinine as well as metabolic acid residues of protein catabolism.

Hyperkalaemia is an elevated blood level of the electrolyte potassium.

Stages of Chronic Kidney Disease (CKD)
To help improve the quality of care for people with kidney disease, the National Kidney Foundation (NKF) created a guideline to help non specialist doctors identify each level of kidney disease. The NKF divided kidney disease into five stages.

Stage 1 Chronic Kidney Disease (CKD1) A person with Stage 1 CKD has kidney damage with a GFR at a normal or high level greater than 90 ml/min. There are usually no symptoms to indicate the kidneys are damaged.

Stage 2 Chronic Kidney Disease (CKD2) A person with Stage 2 CKD has kidney damage with a mild decrease in their GFR of 60-89 ml/min. There are usually no symptoms to indicate the kidneys are damaged.

Stage 3 Chronic Kidney Disease (CKD3). A person with Stage 3 CKD has kidney damage with a moderate decrease in the GFR of 30-59 ml/min.

Stage 4 Chronic Kidney Disease (CKD4). A person with Stage 4 CKD has advanced kidney damage with a severe decrease in the GFR to 15-30 ml/min. It is likely someone with Stage 4 CKD will need dialysis or a kidney transplant in the near future.

In stages 3 and 4, as kidney function declines waste products can build up in the blood causing uraemia and a person is more likely to develop complications of kidney disease such as high blood pressure, anaemia (a shortage of red blood cells) and/or early bone disease.

Stage 5 Chronic Kidney Disease (**CKD5).** A person with Stage 5 CKD has end stage renal disease (ESRD) with a GFR of 15 ml/min or less. At this advanced stage of kidney disease the kidneys have lost nearly all their ability to do their job effectively, and eventually dialysis or a kidney transplant is needed to live.

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Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 24 November 2009

Subject: Provision of Dermatology Services

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

1.0 Purpose of this Report

1.1 The purpose of the report is to present the Scrutiny Board (Health) with a range of information to assist members to consider current developments associated with the provision of dermatology services, particularly in terms of inpatient provision on ward 43 at Leeds General Infirmary (LGI).

2.0 Background

2.1 The proposed changes to dermatology services are a result of the broader Clinical Services Reconfiguration (CSR), which will see the centralisation of children's in-patient services at LGI. This will also result in the centralisation of Older People's Medicine and Acute Medicine for Adults at St. James' University Hospital.

2.2 The Scrutiny Board (Health) has been broadly aware of proposals associated with CSR, but has not previously been made aware of any specific proposals associated with dermatology services, including any changes relating to inpatient capacity.

2.3 In early October, members of the Scrutiny Board became aware of potential changes in the provision of dermatology services, particularly in terms of inpatient provision on ward 43 at Leeds General Infirmary (LGI). Concurrently, two separate requests for the proposals to be examined in more detail were received. These, independent, requests came from patients and the British Association of Dermatologists (BAD).

2.4 At its previous meeting, 21 October 2009, the Scrutiny Board was advised that initially, given the timing of the publicity and the requests for scrutiny, the Chair of the Scrutiny Board took this issue forward on behalf of the Board by:

- Issuing a letter to the Chief Executive of LTHT (copied to NHS Leeds) seeking a moratorium on any further action until the Scrutiny Board 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.

2.5 The Scrutiny Board (Health) was also advised that, at that time, a formal response from LTHT had not been received.

3.0 Dermatology Services – proposed changes

3.1 In the letter to LTHT, the Chair of the Scrutiny Board requested information and sought clarification on the following matters:

- Services (and associated arrangements) currently provided on Ward 43;
- Catchment area for which LTHT is the nearest centre providing both in-patient and out patient dermatology services;
- The detailed outline of proposals to vary the services currently provided (i.e. which services will be affected and how will the delivery change), including the rationale and an outline of the benefits to patients;
- Current / planned engagement and involvement of all key stakeholders; and,
- Proposed timescales.

3.2 A response from LTHT has now been received and is attached at Appendix 1 for the Board's consideration.

3.3 Since the public reporting of the developments / changes associated with the provision of dermatology services, LTHT has received communication from a range of stakeholders, including patients, the British Association of Dermatologists (BAD), local Members of Parliament and other dermatology service areas for which LTHT provide a tertiary referral service. Examples of these communications are provided at Appendix 2 and Appendix 3.

3.4 A range of interested parties have been invited to attend the Board meeting to help members consider the proposed changes and any associated impacts.

4.0 Recommendation

4.1 Members of Scrutiny Board are asked to consider the information presented and determine any:

4.1.1 Specific action the Board may wish to take;

4.1.2 Recommendations the Board may wish to make;

4.1.3 Matters that require further scrutiny.

5.0 Background Papers

None

APPENDIX 1

The Leeds Teaching Hospitals NHS
NHS Trust

13 November 2009

Dear Councillor Dobson

Thank you for your letters of 8 and 29 October regarding the Dermatology service at Leeds Teaching Hospitals Trust. I am sorry this reply has taken some time to prepare but as I am sure you will understand I am keen that it reflects the most up to date position and there is ongoing discussion about this issue.

You may wish to know that the Trust is replying separately to the Skin Care Campaign and the British Association of Dermatologists whose Clinical Vice President has also contacted us on the same subject.

I would like to preface my detailed response by stating that the Dermatology service is held in high regard within the Trust and the service that Dermatology staff provide to patients is greatly valued.

It is clear that there is widespread concern about the future of the service. Much confusion and anxiety seems to have been caused by media coverage which does not necessarily give a full or completely informed account of the Trust's plans. This letter provides the most accurate information that is currently available.

As part of a wider programme of changes across the two main hospital sites in Leeds, plans are being developed to change the use of the current Dermatology ward at Leeds General Infirmary and to reprovide the patient beds in a suitable alternative location in the Trust.

I must emphasise that we fully intend to maintain the inpatient Dermatology service with dedicated beds and specialist staff, however the precise location of these beds is yet to be agreed. For that reason it is not possible to give you a detailed set of proposals as we are working with the clinical team to develop them. However, as background, it might be helpful for me to explain why we are considering changes to the service.

Catchment area

The Dermatology department based at Leeds General Infirmary provides a secondary referral service for the Leeds area and a tertiary referral centre for the Yorkshire region. Nine consultants provide general dermatology services and tertiary referral services for subspecialties including connective tissue disease, cutaneous oncology, photobiology, contact allergy, dermatological surgery, laser therapy and paediatric dermatology.

Dermatology is principally an out-patient specialty and the department has comprehensive day treatment facilities including 3 theatres. The present inpatient Dermatology ward (Ward 43) at Leeds General Infirmary is a 14-bed ward with a notional allocation of 10 Dermatology beds and 4 acute Rheumatology beds.

Reasons for change

Clinicians in the Rheumatology service have expressed a wish to relocate the 4 acute inpatient beds to St James's University Hospital so that they can be located with Acute Medicine. The main Rheumatology inpatient service will remain at Chapel Allerton hospital. This move is one of the key factors in our proposed change.

Although we originally planned to locate the children's outpatients department into ward 43 this was not the reason for the move and because of the delay we are trying to identify another location so that work to centralise children's inpatient services can move ahead.

In relation to Dermatology, medical cover out of hours will potentially be more difficult following changes in the Elderly Medicine department.

We believe it is important to meet the responsibility we have to achieve the greatest benefit to all patients. By making the best use of clinical resources and expertise, especially by bringing together smaller wards into larger shared ward areas, we aim to use public money effectively and efficiently. In this case it means providing dedicated beds in a larger ward. It is our aim that new accommodation will be at least as good as the existing accommodation, although it may not replicate facilities exactly as they exist. I would like to emphasise it is **not** our intention to treat patients who currently use the service in unidentified beds around the Trust.

Specialist staff

The inpatient service will continue with specialist Dermatology staff caring for patients in their new location. This will be achieved by nursing staff who currently work on Ward 43 relocating to the designated ward for Dermatology inpatients. The consultants and support staff who currently care for Dermatology patients will also continue to do so in the new location.

Patient safety

We are discussing with consultants, nursing staff and the rest of the specialist team, requirements of the inpatient service to ensure the reprovided beds are suitable for safe and effective care

In addition, we are taking expert advice on infection control issues from our microbiology service and from the specialist nursing team. Although the accommodation on the current ward is provided in single rooms for all patients, this is not a clinical requirement for all Dermatology patients. Nursing some patients in bays or open ward areas is a safe and appropriate way of providing care. Many other Trusts do exactly this without putting either Dermatology or other patients at any additional risk.

Efficiency

The Trust is seeking to accommodate the service in up to10 beds within a 22 or 24-bed ward. It is clear that we need to consider changes in the way the service is provided to bring it in line with services offered by other Trusts who provide a specialist service.

We know that our average length of stay is longer than that for similar Trusts, and we feel there are further opportunities to improve the service offered to Dermatology patients, for example by potentially increasing the number of patients treated on a day case basis.

I confirm that the both the day case and outpatient services will continue and we anticipate developing them in the future. In fact, for the 5 months April to August 2009 day case activity has increased by 22% over the same period last year.

Consultation

It is our intention to engage with Dermatology patients about proposals for new accommodation as soon as we have identified appropriate options based on criteria specified by the clinical team. We expect this to be during November. No changes will be made until we have talked to staff and patients about them but we would aim to make any changes without undue delay. Of course, if the resulting proposal involves a move to a different hospital we will regard this as a significant variation in service and consult more widely, including with the Scrutiny Board as well as other stakeholders.

Up to this point we have not proposed moving off the LGI site and for that reason I do not believe we have failed to meet our statutory obligations to consult, although discussions might have been managed more effectively. We considered it important to ask clinical staff to get involved in identifying options for a new location specifically to ensure that the quality of patient care is not reduced. Unfortunately before having had the chance work through this process properly, we were faced with speculative claims that we would no longer provide inpatient Dermatology care at LTHT and also requests to provide information that we do not, as yet, have available.

I would like to reassure you that the quality of the service and the experience of patients are absolutely central to our thinking. At the moment we are working with clinicians to identify a suitable new location with access to appropriate beds and facilities. We have asked clinicians to let us know about their priorities and, based on their experience of providing care, about the aspects that are important for patients using this service. We know that dedicated beds and nursing expertise are important. We also know that access to the right kind of facilities to maintain a safe service that protects the privacy and dignity of patients is crucial.

Please be assured that the requirement for quality patient care in an appropriate environment is essential to any decisions made about the future of Dermatology services in our hospitals.

I trust that this response addresses your concerns, however please do not hesitate to contact me if you require further information at this time.

Yours Sincerely

Maggie Boyle (Miss)
Chief Executive

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Dr Peter Belfield
Acting Medical Director
St. James's University Hospital
Beckett Street,
Leeds
LS9 7TF

2 October 2009

Dear Dr Belfield

It has recently come to our attention that it is proposed to move the inpatients Dermatology Ward at Leeds General Infirmary in order to accommodate additional space for paediatric out-patients as per the article published in the Yorkshire Evening Post on the 2 October 2009.

While this in itself seems a reasonable course of action, there has been no discussion and reassurance from the Trust that the existing dermatology inpatient bed numbers will be retained and indeed the service itself relocated.

As I am sure the local consultants will inform you, although the current trend for dermatology is moving Care Closer to Home, this is only appropriate for those patients with mild to moderate skin disease. There still remain approximately 5% of patients with more severe skin disease who require the expert services of consultants in secondary care departments and access to inpatient services throughout their lifetime.

Typically a small proportion of patients with severe eczema and psoriasis, patients with other severe inflammatory dermatoses, patients with acute immunobullous disorders and all patients with toxic epidermal necrolysis etc will require inpatient care. The BAD suggest 2 beds per 100,000 population to meet this serious need. High quality dermatology inpatient care also requires the input of trained dermatology nurses and it has been found repeatedly around the country that the same level of care is not forthcoming when dermatology patients are admitted to general wards. It is, therefore, of concern to know that the Trust's number of dermatology nurses has already been reduced, with a resulting reduction of the number of day-care patients treated. The need for these inpatient and day-care services will not in any way be reduced by any alteration in the pattern of service provision that might result from any 'modernisation' agenda.

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In addition, as I am sure you will be aware, Leeds is held as a centre of excellence for dermatological surgery, lasers and connective tissue diseases. With regards to the latter, such patients can often be medically very unwell and, not infrequently, such patients require expert inpatient dermatological care. In addition, many are treated with the new biological therapies, one of which requires intravenous infusion and would therefore require the availability of inpatient or day case services.

I write, therefore, to clarify the facts presented to the BAD and to ensure local consultants are consulted in line with any proposed service changes. In the interest of high quality patient outcomes, the BAD also seeks your reassurance that no closure of the inpatient facility will ensue until suitable alternative facilities are in place.

Further to this we would also seek clarification on how your proposed plans highlighted in the Yorkshire Evening Post provide short and longer term financial savings to the public purse if vital services for patients are to be preserved.

I look forward to your early reply.

Yours sincerely

Stephen Jones
Clinical Vice-President
British Association of Dermatologists

cc:

Maggie Boyle, Chief Executive, St James University Hospital

Kevin Howells, Acting Chief Executive, Leeds PCT
Jill Copeland, Director of Partnerships and Development, Leeds PCT
Philomena Corrigan, Acting Director of Commissioning and Nurse Director, Leeds PCT

Dr Ian Cameron, Director of Public Health, NHS Leeds

Steven Courtney, Scrutiny Board (Health), Leeds City Council

APPENDIX 3

The Mid Yorkshire Hospitals NHS
NHS Trust
Dewsbury & District Hospital
Medical Directorate
Halifax Road
DEWSBURY
West Yorkshire
WF13 4HS

Tel: 01924 816137
Fax: 01924 816286

DEPARTMENT OF DERMATOLOGY
Dr Gayle Taylor BSc (Hons) MB ChB FRCP (Lond)
Dr Gordon P Ford BSc (Hons) MB ChB FRCP (Edin)
Dr Manu Shah MD FRCP (Lond)

Awarded for excellence

Enquiries to: Dr Taylor's Secretary

GT/KLK

Dear Dr Bellfield

I have become aware of plans to shut the Dermatology Ward in the Brotherton Wing at Leeds General Infirmary via the articles in the Yorkshire Evening Post.

I am a Consultant in Dermatology at a District General Hospital (Dewsbury). We do not have any access within our own hospital to specialist dermatology beds. We can use beds on a general medical ward but this is often highly unsatisfactory for patients who have disfiguring skin disorders and who are at increased risk of either getting infections from other patients or indeed shedding Staph aureus which may be a risk to other patients.

Whilst all dermatologists will manage the majority of their patients as out-patients, there are times when it is absolutely essential to have access to specialist dermatology beds and particularly to the dermatology nursing expertise. This facility has been lost in DGHs and it would be a great disservice to dermatology patients if it were lost at your hospital which is our tertiary referral centre.

I hope that you will be able to maintain this essential service for dermatology patients.

Yours sincerely

Gayle Taylor
Consultant Dermatologist

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Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 24 November 2009

Subject: Leeds Teaching Hospitals NHS Trust – Foundation Trust Consultation

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

1.0 Purpose of this Report

1.1 The purpose of the report is to:

- Present the Scrutiny Board (Health) with a range of information on the consultation being undertaken by Leeds Teaching Hospitals NHS Trust (LTHT) about its application to become an NHS Foundation Trust.
- Seek the views of the Scrutiny Board (Health) on the consultation plan presented; and,
- Seek the views of the Scrutiny Board (Health) on the Trust's application to become an NHS Foundation Trust.

2.0 Background

2.1 NHS Foundation Trusts are a new type of organisation, they are not-for-profit, public benefit corporations. They are part of the NHS and must meet national healthcare standards. They continue to provide services to patients on the basis of need and not ability to pay.

2.2 LTHT in the process of developing its application for this important change and the consultation is a way of getting stakeholder views about how the organisation will be run in the future. LTHT is required by section 35(5) of the National Health Service Act 2006 to undertake formal consultation with the staff, patients, the public and stakeholder bodies.

3.0 Foundation Trust – consultation

3.1 The full consultation document (attached at Appendix 1) sets out the full range of issues involved in the Trust's application. The main issues are those proposed in the consultation document and these will inform the Trust's drafting of its new constitution. Monitor, the independent Foundation Trust Regulator, publishes a model core constitution. The Trust's draft constitution, based on this model core, will set out the legal framework for Foundation Trust status, including provisions for:

- Membership
- Constituencies
- Board of Governors
- Board of Directors
- Elections

3.2 The Foundation Trust process LTHT is working through is an extended one, with three stages overseen by Yorkshire & Humber Strategic Health Authority, the Department of Health, and Monitor.

3.3 The exact timescale for the change will vary depending on how quickly approval is given at different parts of the process: Nonetheless, the table below provides an indicative timetable.

Oct - Dec 2009	12 week formal public consultation on governance proposals
Spring 2010	Trust publishes its response to feedback given during the 12-week consultation
October 2010	Formal application submitted to the Department of Health
Spring 2011	Earliest date when the Trust could be authorised to become a Foundation Trust

Consultation

3.4 Consultation on the proposals is a key element of the Foundation Trust process. An outline of the Trust's consultation plan is presented at Appendix 2, with more detailed information relating to specific events presented at Appendix 3.

3.5 This paper forms part of the overall member consultation, with LTHT presenting similar information to local Area Committee meetings. LTHT has also undertaken to provide speakers and presentations to other local groups such as neighbourhood forums and parish or town council meetings.

3.6 Representatives from LTHT have been invited to attend the meeting to address any questions and/or areas of clarification.

Membership

3.7 A specific matter which may be of interest to members of the Scrutiny Board relates to membership of an NHS Foundation Trust.

3.8 Section 9(4) of the National Health Service Act 2006 requires the aspirant Foundation Trust to appoint one or more Governors from qualifying local authorities (local authority for an area which includes the whole or part of an area specified by the Trust as the area for its public constituency). In this case, the City of Leeds is a qualifying authority as it includes 9 public constituencies.

4.0 Recommendation

4.1 Members of Scrutiny Board are asked to consider the information presented and:

4.1.1 Comment on the robustness of the consultation plan presented by LTHT;

4.1.2 Identify and agree and specific matters, by way of a response on the proposals presented and determine any specific action the Board may wish to take; and,

4.1.3 Identify and agree any other matters that may require further scrutiny.

5.0 Background Papers

None

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your hospitals your say

The Leeds Teaching Hospitals NHS
NHS Trust

foundation trust consultation document

October 2009

St James's University Hospital

Leeds General Infirmary (LGI)

Chapel Allerton Hospital

Terms used in this leaflet

NHS Trust The name for an NHS organisation that manages one or more hospitals

NHS Foundation Trust The name for an NHS organisation that manages one or more hospitals as not-for-profit public benefit corporation with Members (like the Co-op)

Board of Directors The members of the Trust Board who lead an NHS organisation and who take collective responsibility for achieving the organisation's aims; the Board is made up of Non-Executive and Executive Directors.

Non-Executive Directors Directors who have expertise, not necessarily within the NHS but who bring a beneficial perspective from their outside experience. They are drawn from the catchment area served by an NHS Trust and sit on the Board of Directors. Their role is to ensure the Trust is performing well by providing an internal challenge.

Chairman The senior Non-Executive post in the organisation, who leads the organisation's Board in setting the strategic direction. The Chairman makes sure the Board takes proper decisions to achieve the Trust's aims.

Executive Directors The most senior managers in an NHS organisation. They have special responsibility for areas such as finance, medical and nursing staff, but they also have collective responsibility to work together as members of the Board with Non-Executives across all areas of the Trust.

Chief Executive The senior Executive Director who is responsible for all aspects of the work of the Trust, including leadership, management of resources and performance management of objectives. The Chief Executive has personal responsibility for the quality and safety of services.

Governors Members of an NHS Foundation Trust who are elected to represent the interests of Foundation Trust Members, patients and the public.

Members People who choose to join because they have an interest in the Foundation Trust; they elect Governors.

Primary Care Trusts The NHS bodies who use money allocated by The Government to buy health services such as hospital care, mental health services and GP services for their local community. They are also responsible for improving public health in the area.

Monitor The independent regulatory body created by Parliament to hold Foundation Trusts accountable for delivering efficient and effective health care.

This consultation document can be downloaded from www.leedsth.nhs.uk . It can be made available in Braille, large print and minority ethnic languages on request.

Seacroft Hospital

Wharfedale Hospital, Otley

Leeds Dental Institute

contents

"The staff's patience, care and attention means I can go home a more confident mum"

Bianca Mason (mum) babies Freya and Annabelle with Jayne Wagstaff (midwife)

section 1 introduction

Thank you for taking time to consider Leeds Teaching Hospitals plans to become an NHS Foundation Trust. This document explains the reasons why we would like to take this step and asks for your feedback on some important questions that need to be answered during this consultation.

NHS Foundation Trusts are a new type of organisation. They are not-for-profit, public benefit corporations. They are part of the NHS and must meet national healthcare standards. They continue to provide services to patients on the basis of need and not ability to pay. However, they are more independent of Government than NHS Trusts so that they can more effectively become part of the local community.

At the moment we are directly accountable to the Secretary of State for Health. In future, if we become a Foundation Trust, we would be regulated by Monitor, the independent body created by Parliament to oversee Foundation Trusts. We will also be run differently and will be more accountable to local people who can become Members and Governors of the Foundation Trust.

We are in the process of developing our application for this important change and our consultation is a way of getting your views about how the organisation will be run in the future.

The questions in this document are about key aspects of these changes and we would like your views so that we can make decisions properly informed by your feedback. Staff from our hospitals will be out and about talking to local groups and answering as many questions as possible during a 12-week consultation period beginning on 1 October 2009 and running until 24 December 2009.

Your views are very important to us as the main benefit from becoming a Foundation Trust is to ensure the Board of Directors is better connected to the community we serve. Please take the opportunity to respond to the consultation using the form provided or by writing or e-mailing us to say what you think.

We want to use the new arrangements that come about as a result of being a Foundation Trust to plan our future in partnership with you. This is an exciting time to be part of our hospitals. We are aiming to use the opportunity presented by Foundation Trust status to make sure that improvements and changes we make are well understood and supported by the people who use our services.

We look forward to hearing from you with feedback on our ideas, on the questions set out in this document and on any other aspect of our proposals. We will consider all the responses sent to us, analyse them and make decisions based on them and the other information available to us. We will publish our conclusions before the end of March 2010.

Maggie Boyle, Chief Executive

Mike Collier CBE , Chairman

why are we applying to become a foundation trust

section 2

In summary, as a Foundation Trust we will have greater freedom to develop services to suit the needs of our local community. We would be operating under different arrangements that encourage and reward improved performance.

We will be more accountable to the local community and less to Whitehall. One way in which this will happen is by the setting up of a Council of Governors to work with the Board of Directors. Governors will be elected by local Members to represent their views and those of other people in Leeds and the region beyond.

As a Membership organisation, we will also actively seek the views of our Members who will mostly be drawn from local people, patients and staff. We believe that this will help us to become more responsive to local needs and wishes.

We will be able to invest any surplus money we make, either by working more efficiently or by disposing of unused assets, into improving services. We can also borrow money within the private sector to invest in new services or facilities.

The Government would like all NHS Trusts to be on their way to becoming Foundation Trusts by the end of 2010. Although they are not required to follow directions from the Secretary of State for Health, Foundation Trusts still follow the same ethos as all NHS Trusts – to provide and develop services for NHS patients according to NHS values, principles and standards and with the same NHS systems of inspection in place to ensure quality.

As a Foundation Trust we will be able to design and plan our services differently. This means we can tailor local services to the needs of local people.

We would be known as Leeds Teaching Hospitals NHS Foundation Trust. Our Members will play a crucial role in electing representatives (called Governors) to work closely with our Board of Directors in ensuring our hospitals provide the best health care and represent the views of Members

Do you think the proposed name properly represents the organisation?

The Board of Directors and the Governors will work together to make sure we perform well, ensure we fulfil our statutory duties as an organisation and ensure our Members' views are represented. It will be the Board's role to manage the hospitals and the Governors' role to hold them to account. The Board of Directors and the Council of Governors will report back to Members about achievements, improvements and any problems.

section 3 our plans for the future

We plan to use the changes involved in being a Foundation Trust to help us achieve our vision for success. Health care is changing to meet the expectations of the people who use it. It is also clear that efficiency will be increasingly important as the NHS faces up to the same challenges as other sectors of the economy.

We will rise to the challenge set by consumers who want ever higher quality services which are also good value for public money. We aim to bring local people into the network of knowledge and experience that drives change and improvement.

Our strategic goals are:

- **Achieve excellent clinical outcomes**
- **Improve the way we manage our business**
- **Become the hospital of choice for patients and staff**

Excellent health services - we will use the views of patients and carers, as well as health professionals to develop our services and drive up quality. There is lots of evidence to show that as a result we will improve clinical outcomes and reduce costs. We will maintain and extend the wide range of health care we provide, from regular hospital services to very skilled and specialist services available regionally and nationally.

Expert staff - we already have a professional and expert workforce, dedicated people who work together in multidisciplinary teams providing very specialist care. We will become more efficient by developing our staff to work in new ways and improving our systems, for example the better use of information technology between health agencies.

Teaching, research and development - we plan to make the most of the excellent partnerships we have with higher education to provide teaching for healthcare professionals and to inspire world-class research and development projects.

Local partnerships for change - hospital care is only part of the mix of health services required to meet people's expectations of the NHS. We will work positively with NHS Leeds - the organisation that plans and funds health services in Leeds - to ensure we do the best we can for the city and beyond. The direction for the NHS is clearly set out in national policy. We will try to be at the leading edge of this change by collaborating with NHS Leeds to provide high quality care in settings that are closer to people's homes and communities.

Health care environment - when people come into hospital we want to care for them in exceptional clinical facilities. As we move forward we aim to have the best possible accommodation so that we can move out of older buildings which are expensive to maintain and are less fit for purpose.

In summary, we know that improving quality is the highest priority and that we can do this best by engaging properly with the people who can influence this - NHS staff, patients, carers and the organisations who work with us. Achieving Foundation Trust status is an important step in this process because it will give us the right structures and relationships.

Do you have any suggestions you think we should take into account as part of our vision and goals?

benefits of being a foundation trust

section 4

We believe that NHS Foundation Trust status will help us deliver the highest quality health care to people who use our services. We continuously strive to improve patient care, but we know we need to do this even more effectively and faster.

As an NHS Foundation Trust we are still part of the NHS, but will have more freedom to run our own affairs at a local level. For example, although we must comply with national standards, we can decide how we do that, by developing new ways of working and to reflect local needs and priorities.

NHS Foundation Trusts are controlled locally so they are able to respond more readily to the needs of patients and the local community. We will have more flexibility in how resources are used and greater opportunities to get investment in new and improved facilities and equipment which will really make a difference to patients and staff.

As a Foundation Trust we will:

- **ask the views** of our members to help us design and plan services
- **tailor our services** to make them more responsive to local people's needs by making them more accessible, more convenient and more appropriate for the communities we serve
- **support patient choice** more effectively by using patient views to shape how, when and where we provide services
- **involve local communities** and other partners in the overall governance of the organisation and its development
- **seek different sources of income** and have greater freedom to decide how we spend it
- **retain financial surpluses** at the end of each financial year which we can reinvest in patient services
- **strengthen our contractual arrangements** with other organisations (including other NHS organisations) to ensure these are legally binding, bringing greater security and ensuring continuity of services
- **use our research** more effectively for the benefit of local patients and clinicians
- **work more closely** with other bodies such as social care organisations, local businesses and other health care partners

Overall, it puts us in a stronger position to improve services at our hospitals and ensure they are designed around the needs of local patients and the public.

"Achievement of foundation status means more freedom and independence for the Trust"

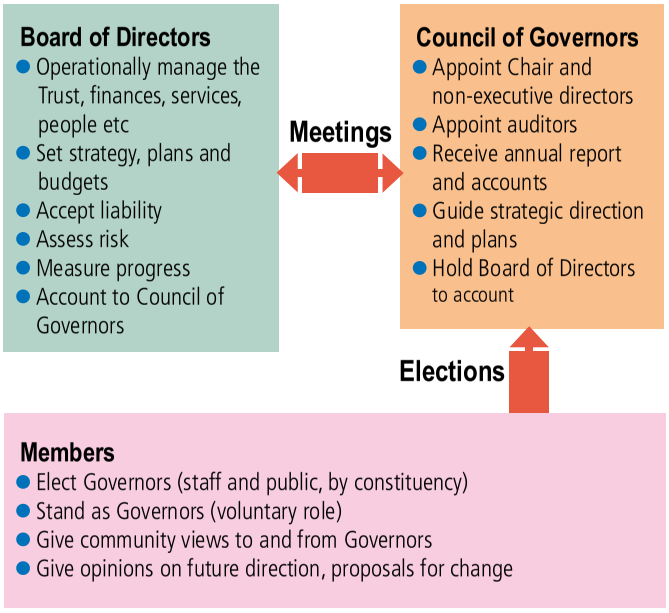
Ramnath Subramaniam (Consultant Paediatric Urologist)

section 5 what the changes will mean

Foundation Trusts have different structures to existing NHS Trusts. The new arrangements focus on relationships between three main groups:

- **Members**
- **Council of Governors**
- **Board of Directors**

The diagram shows how they relate to each other and outlines their main roles:



Membership

Foundation Trusts are public benefit organisations which are run in a similar way to co-operative or mutual organisations. All Foundation Trusts have to recruit Members who help the Trust plan its future. Any patient, carer or member of the public, is welcome to join.

We believe most of our staff will want to join as Members automatically, but they can opt out if they want.

Do you support the proposal that staff Members automatically become Members unless they choose to opt out?

The role of Members

After we are approved as a Foundation Trust, our Members will have a number of important opportunities or responsibilities including:

- **voting in elections** to appoint Governors representing Members and the public
- **acting as an ambassador** of the Trust
- potentially (by choice) **standing for election** to the Council of Governors
- **participating in events**, surveys, focus groups etc
- **engaging in consultations** and discussions about significant or key issues
- **giving feedback** on services, long term plans and ideas
- **helping to recruit** more Members

The benefits of Membership

Membership is free of charge and you are under no obligation to join. You will not receive better or faster treatment as a member but there are many benefits. If you do join, you can give as much or as little time as you like.

As a member you will receive

- **A free members' newsletter.** It will contain health information and advice direct from our doctors and nurses, as well as valuable information about the hospitals and what's going on in the NHS
- **Invitations to exclusive members' events.** These could include health fairs where you can come and get your blood pressure checked to open evenings with some of our health experts
- **A chance to have your say** by taking part in surveys about our hospitals or letting the Governors who represent you and other Members know your views
- **The opportunity to vote in elections** to the Council of Governors – or stand for election yourself if you would like to become a Governor

It's up to you how involved you want to be. We value any of your input. We're proud of our hospitals but we know they can be even better with your help. All you need to do is to take the step of joining us as a Member.

Although we are not yet a Foundation Trust we can still begin to recruit people who are interested in becoming Members. They will act in a 'shadow' capacity until we are approved as a Foundation Trust. During this time, we will still keep people up to date and ask for views about key developments.

Who can be a member?

Membership of our Trust will be open to the people who fall into one of the following two groups and who have an interest in its development and well being:

- People aged over 16 who live locally, and people who have used or who may need to use our services
- People who are employed by us

We are proposing that the minimum age for Membership is 16; however we know that young people take a keen interest in health matters and we aim to develop a way of involving younger people through schools and other activities.

Do you agree with the minimum age of 16 for Members?

The area that we serve includes the city of Leeds (see map on page 10) and because we are a Trust providing many specialist services our area extends to much of Yorkshire and the Humber region. Anyone in these areas can join as a member. In addition, people who live further away but who might use specialist services provided by the Trust can also become Members.

Mark Morrell (Porter)

Jon Pickett (Portering Supervisor)

section 5 what the changes will mean

"The hospital is great, spacious and relaxing"

Enid Dring with Faye Sweeney (Radiographer)

Membership and representation

We will recruit Members who represent the diversity of the populations and patient groups served by our hospitals. Members will be represented within the Trust by Governors. In order to do this practically, Members will be grouped into geographical constituencies to elect local Governors who can be in regular touch.

Even breaking down the city-wide area and beyond into constituencies does not guarantee effective liaison with all groups. We know there are some which, for a variety of reasons, are seldom heard because they do not find it easy to make links with formal organisations.

Please let us know if you have any suggestions for groups that meet this description and if you have any ideas for effective ways to communicate with them.

We will try to make sure our Membership fairly represents different groups and health interests. We will do this by recruiting for Members in populations or areas that may be under-represented or through channels such as specific health groups.

Governors

Foundation Trusts have a Council of Governors to represent the views of Members and work closely with the Board of Directors. The Council will comprise of a number of Governors who are either **elected** or **appointed.** We are asking for your views about our proposed structure.

Composition of the Council of Governors

We are proposing that the Council of Governors will consist of a Chair and 35 Governors. At least 51% of the Council of Governors must be drawn from and elected by public Members. The rest of the Council will be drawn from staff Members and Governors appointed in agreement with local organisations that we work with.

Do you think this is the right number of Governors? Are there too few or too many?

Once elected, Governors will normally hold office for up to three years (although they can resign at any time) and they will be able to run for re-election.

Is this the right term of office for Governors? Please let us know if you think there are parts of the local community or partner organisations that are not represented?.

The Council of Governors will meet regularly in public and in support of these meetings there will be good two way communications between Members, Governors and the Board of Directors.

The Council of Governors are required to act in the best interests of the Trust. They have some statutory duties including:

- **Receiving** the Trust's annual reports and accounts
- **Appointing** (and if necessary, removing) the Chair and Non-Executive Directors
- **Deciding** the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive directors
- **Approving** the appointment of the Chief Executive
- **Appointing** and, if appropriate, removing the auditor
- **In addition**, in preparing the NHS Foundation Trust's "forward plan", the Board of Directors must have regard to the views of the Council of Governors.

Louise Allott (Staff Nurse) left
Jo Jackson (Ward Clerk) centre
Sharna Matthew (Sudent Nurse) right

what the changes will mean

section 5

We are proposing they will also:

- Act as advocates for the Trust
- Act as a link between the Members and the Trust, represent Members' views during discussions about the development of the organisation and its services
- Represent the views of the Trust back to Members
- Give feedback to the Board of Directors on business and financial plans
- Recruit new Members, induct and train them and devise a Membership strategy
- Support the Trust's public consultation process for service changes
- Participate in visits and the inspection of Trust services

Do you think these Governor roles will help us to deliver health care effectively?

Elections will be run in the latter stages of the Foundation Trust authorisation process by an external organisation to ensure they are democratic and fair. The governing body will run in shadow form at first and will officially take up its role once the Trust is approved as a Foundation Trust.

Elected Governors

Governors who represent Members of the public, patients and staff will be elected from the Membership by other Members. Anyone who wants to become a Governor can nominate themselves if they are a Member of the Trust.

Hospital staff

There will be dedicated staff Governors who will represent the interest of our staff. Staff Governors will be elected from four groups (or constituencies):

- **Medical and dental staff electing 1 governor**
- **Nursing and midwifery staff electing 2 governors**
- **Other clinical staff electing 1 governor**
- **Non-clinical staff electing 1 governor**

Staff Governors will assist the Trust in developing its services and to ensure representation from those who have immediate responsibility for patients, their care and the hospital environment.

Do you think these are the right groups for staff constituencies?

We are also interested in your views about whether in elections people who volunteer regularly at any of our hospitals should be treated as Members of staff, electing a staff governor, or whether they should be treated as Members of the public electing public Governors.

Should volunteers be regarded as Members of staff?

section 5 what the changes will mean

Patients and Members of the public

Public Governors will form the largest group on the Council of Governors – this will be written into our constitution to ensure patients and local people always have the majority. Public Governors will be elected from groups (or constituencies) formed by more than one local authority ward.

There will be 9 constituencies in Leeds each electing 2 Governors.

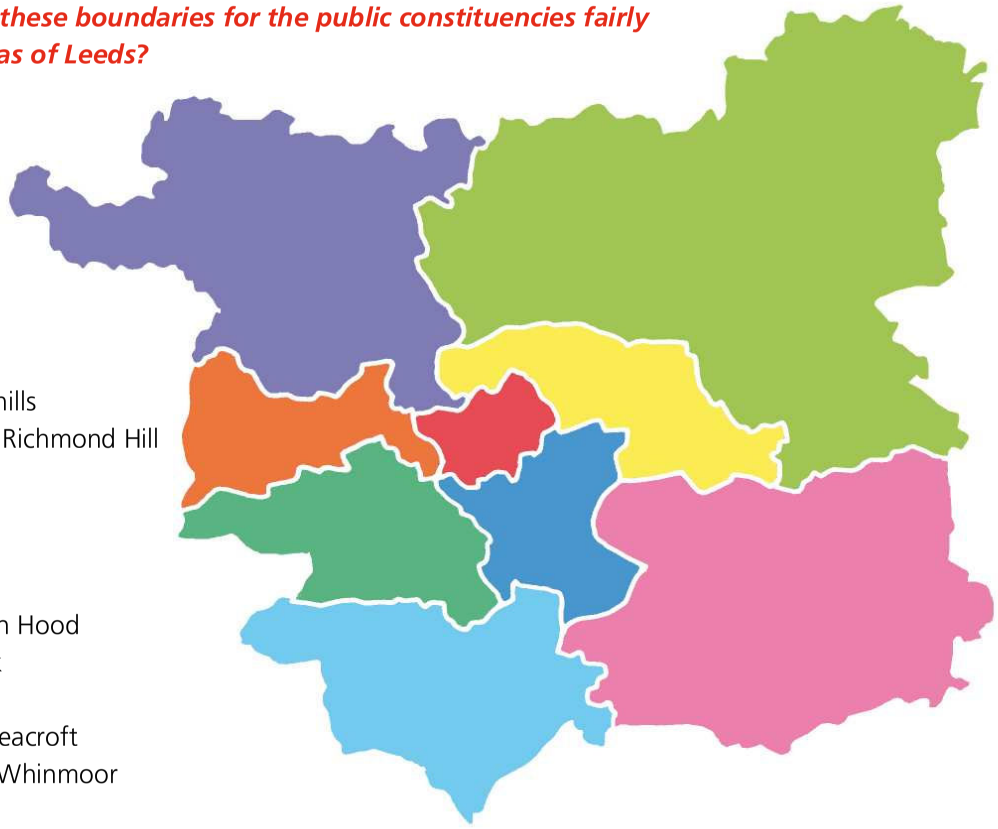
Public Governors from Leeds will represent around 70% of our patients and the public who live in the immediate area served by the Trust for whom we are the local general hospital as well as a specialist hospital.

The map shows the way the constituency boundaries are drawn (they follow local authority electoral ward boundaries but include more than one ward in each constituency). Our constituencies will be made up of the following wards:

J. R. Butterfiield

Laura Sokocyk (Student Nurse)

Do you think these boundaries for the public constituencies fairly represent areas of Leeds?



Gipton & Harehills
Burmantofts & Richmond Hill
City & Hunslet

Morley North
Morley South
Ardsley & Robin Hood
Middleton Park

Killingbeck & Seacroft
Cross Gates & Whinmoor
Roundhay
Moortown

Temple Newsam
Garforth & Swillington
Rothwell
Kippax & Methley

Chapel Allerton
Headingley
Hyde Park & Woodhouse

Alwoodley
Harewood
Wetherby

Weetwood
Kirkstall
Bramley & Stanningley
Calverley & Farsley

Horsforth
Adel & Wharfedale
Otley & Yeadon
Guiseley & Rawdon

Armley
Beeston & Holbeck
Farnley & Wortley
Pudsey

There will also be constituencies outside Leeds as we are a major Trust with regional and national specialties:

- **1 constituency** covering people outside Leeds in the wider Yorkshire and Humber area, electing 2 Governors
- **1 constituency** covering the rest of England electing 1 governor

Public Governors from outside Leeds will represent some 30 % of our patients who come from outside the immediate area for which the Trust provides specialist services

Do you think this is the right number of public constituencies and Governors? Do you think there are parts of the local community or partner organisations that are not represented?

Do you think we should have separate groups specifically representing patients? If so, how might we break them down into smaller groups?

Appointed Governors

Some Governors will be appointed to the Council and will not have to stand for election. Appointed Governors will represent our partners:

- **NHS Leeds (Leeds Primary Care Trust)** - 1 appointed governor to represent the organisation that is our main health community partner
- **Leeds City Council** - to represent our main non-NHS local health community partners
- **Leeds University Medical and Dental Schools** - to represent teaching and research interests

We are required to have representatives from these bodies. In addition we may also appoint other Governors. We are proposing to appoint Governors representing:

- **Leeds Metropolitan University**, as one of our partners in the education sector
- **Leeds Partnerships NHS Foundation Trust**, as health partners providing services for people with mental health and learning disabilities
- **Leeds Chamber of Commerce** - 1 appointed governor to bring additional expertise from the strong commercial sector in Leeds and to foster links with the business community
- **Voluntary sector representation** - 1 appointed governor to represent voluntary groups in the city
- **Yorkshire Forward** - the regional development agency - 1 appointed governor to represent the interests of the organisation leading wider economic and social development in the region
- **The hospitals' Staff Side Council** - 1 appointed governor to (the Chair) to represent

Do you think these proposals for appointed Governors are right?

Margaret Lumby and Brenda Foster

section 5 what the changes will mean

In summary, the structure of Governors we are proposing is below:

Elected Public Governors (Public)

18 public Governors from 9 constituencies representing Leeds residents and patients who use our general hospital services as well as some specialist services; constituencies will be made up of groups of neighbouring local authority electoral wards

2 public Governors from the Yorkshire and the Humber region representing residents and patients outside Leeds who may need to use our specialist regional services

1 public Governor from the rest of England representing residents and patients who may need to use our specialist national services

Appointed Governors

9 appointed Governors one Governor representing each of the following organisations:

NHS Leeds (Leeds Primary Care Trust)
Leeds City Council
Leeds University
Leeds Metropolitan University
Leeds Partnerships NHS Foundation Trust
Leeds Chamber of Commerce
Voluntary sector organisations in the city
Regional Development Agency
Staff Side Council (Chair)

Elected Staff Governors

1 governor representing medical and dental staff

2 governors representing nursing and mid-wifery staff

1 governor representing other clinical staff

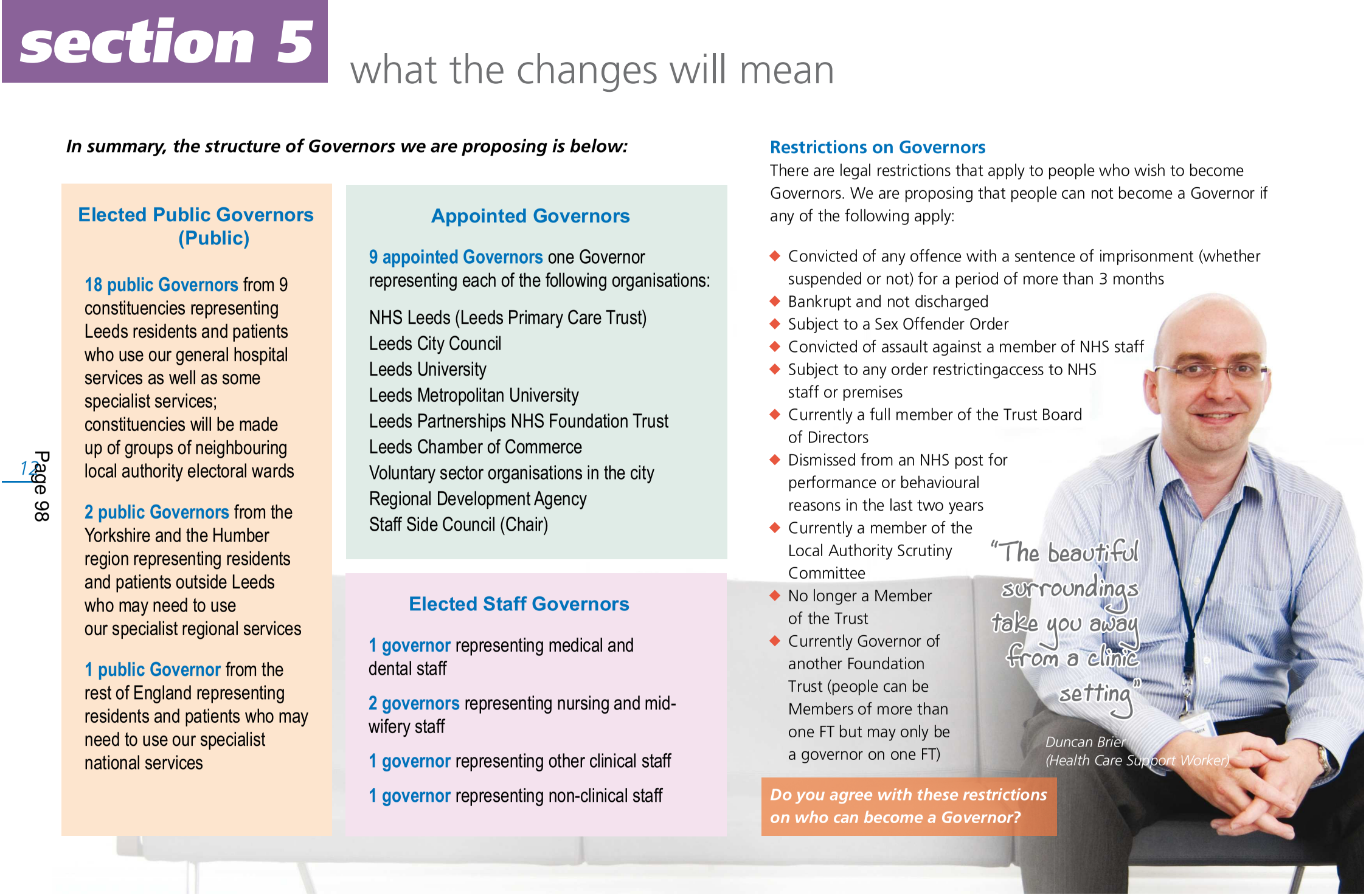
1 governor representing non-clinical staff

Restrictions on Governors

There are legal restrictions that apply to people who wish to become Governors. We are proposing that people can not become a Governor if any of the following apply:

- Convicted of any offence with a sentence of imprisonment (whether suspended or not) for a period of more than 3 months
- Bankrupt and not discharged
- Subject to a Sex Offender Order
- Convicted of assault against a member of NHS staff
- Subject to any order restrictingaccess to NHS staff or premises
- Currently a full member of the Trust Board of Directors
- Dismissed from an NHS post for performance or behavioural reasons in the last two years
- Currently a member of the Local Authority Scrutiny Committee
- No longer a Member of the Trust
- Currently Governor of another Foundation Trust (people can be Members of more than one FT but may only be a governor on one FT)

Do you agree with these restrictions on who can become a Governor?



Board of Directors

The Board of Directors will be made up of Non-Executive Directors and Executive Directors and will include a Chairman and a Chief Executive. Non-Executive Directors will be in the majority. The current Chair and Non-Executive Directors will continue in their current posts when we are approved as a Foundation Trust. Once their term of office ends, future appointments will be made by the Council of Governors.

The role of the Trust Board of Directors will be similar to its current role which is to take overall responsibility for plans and actions intended to deliver our goals. Its main duties are:

- Set the organisation's strategic aims, ensure the necessary financial and human resources are in place
- Set and maintain the organisation's values and standards, ensure obligations to patients, the local community and the Secretary of State are met
- Take collective responsibility for adding value to the organisation by directing and supervising work to achieve the organisation's aims
- Provide leadership within a framework of prudent and effective controls which enable risk to be assessed and managed
- Review management performance

Do you agree with our proposals for the Board of Directors?

Role of Chairman

The Trust Chairman will lead both the Board of Directors and the Council of Governors. This important role will link the two bodies. The Chairman's role is to provide overall leadership and direction ensuring the complementary roles of Directors and Governors support the Trust's strategic aims.

Transitional Arrangements

We want to ensure there is no disruption to services when we transfer from one set of management arrangements to another. We propose the transitional arrangements that best ensure a smooth transfer are:

- Current chair and Non-Executive directors will be appointed to the Foundation Trust Board of Directors for a minimum period of 12 months and until the end of their period of appointment as a maximum – (in accordance with legislation)
- The current Chief Executive and Executive Directors will be appointed to the Board of the Foundation Trust (in accordance with legislation)
- Elections for a Shadow Council of Governors will happen in 2010 to be supervised by a fully independent and accredited organisation.

Do you agree with our proposed transitional arrangements?

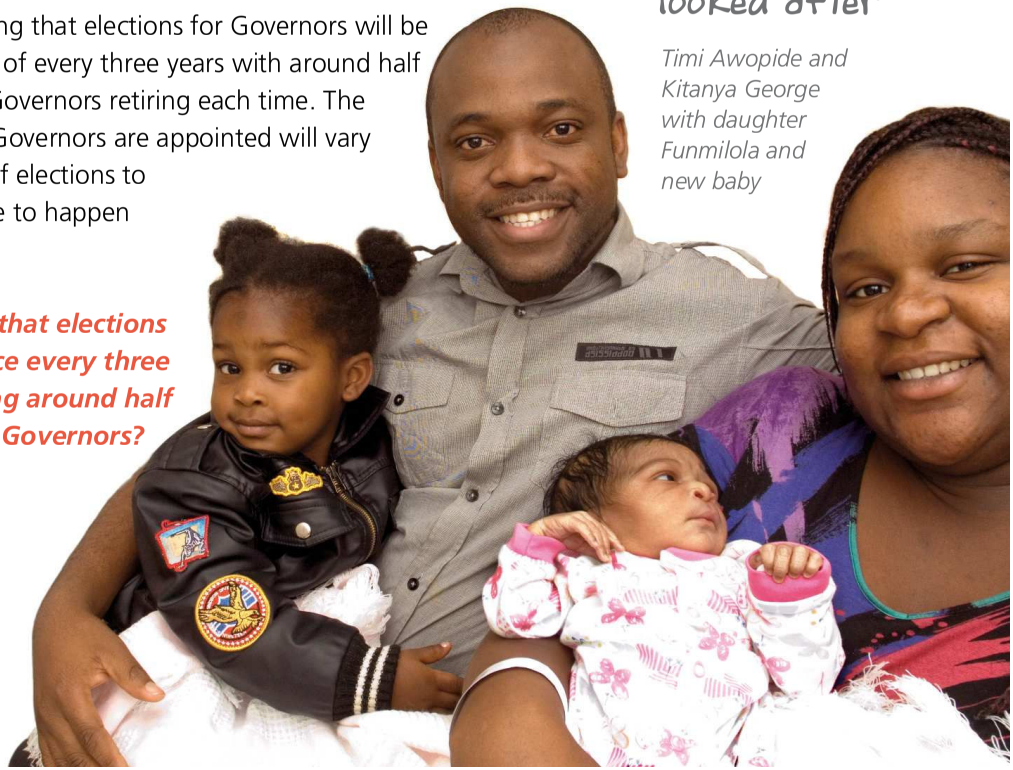
Elections

We are proposing that elections for Governors will be held in two out of every three years with around half of the elected Governors retiring each time. The length of time Governors are appointed will vary at the first set of elections to enable this cycle to happen in future years.

Do you agree that elections should be twice every three years, involving around half of the elected Governors?

"We were well looked after"

Timi Awopide and Kitanya George with daughter Funmilola and new baby



section 6 your say

There will be many ways to find out more about our plans to become a Foundation Trust, including this consultation document and other information leaflets.

We will hold public open meetings and various other events - look out for details on our website and in the local media.

We will attend as many meetings of organised groups as we can manage during the three month consultation period. If you are involved with a group and would like to invite us to attend to explain our proposals, please contact the Communications Team by e-mail public.relations@leedsth.nhs.uk or by telephone on **0113 2064098**, or write to:

Communications Team
Leeds Teaching Hospitals
1st Floor Trust Headquarters
St James's University Hospitals
Beckett Street
Leeds LS9 7TF

The answers to questions we are asking in this consultation document will feed into our new rules (Foundation Trust constitution) so that we take full account of local opinions as we become a Foundation Trust.

Please use the response form to say what you think about the specific questions highlighted on the pages you have just read. If you want to make any other comments you can also use the form opposite to do so.

If you would prefer to do this online please use the following link:
www.leedsth.nhs.uk/consultation

The exact timescale for the change will vary depending on how quickly approval is given at different parts of the process. ***The table below shows the approximate time frames:***

Oct - Dec 2009	**12 week formal public consultation on governance proposals**
Spring 2010	**Trust publishes its response to feedback given during the 12-week consultation**
October 2010	**Formal application submitted to the Department of Health**
Spring 2011	**Earliest date when the Trust could be authorised to become a Foundation**

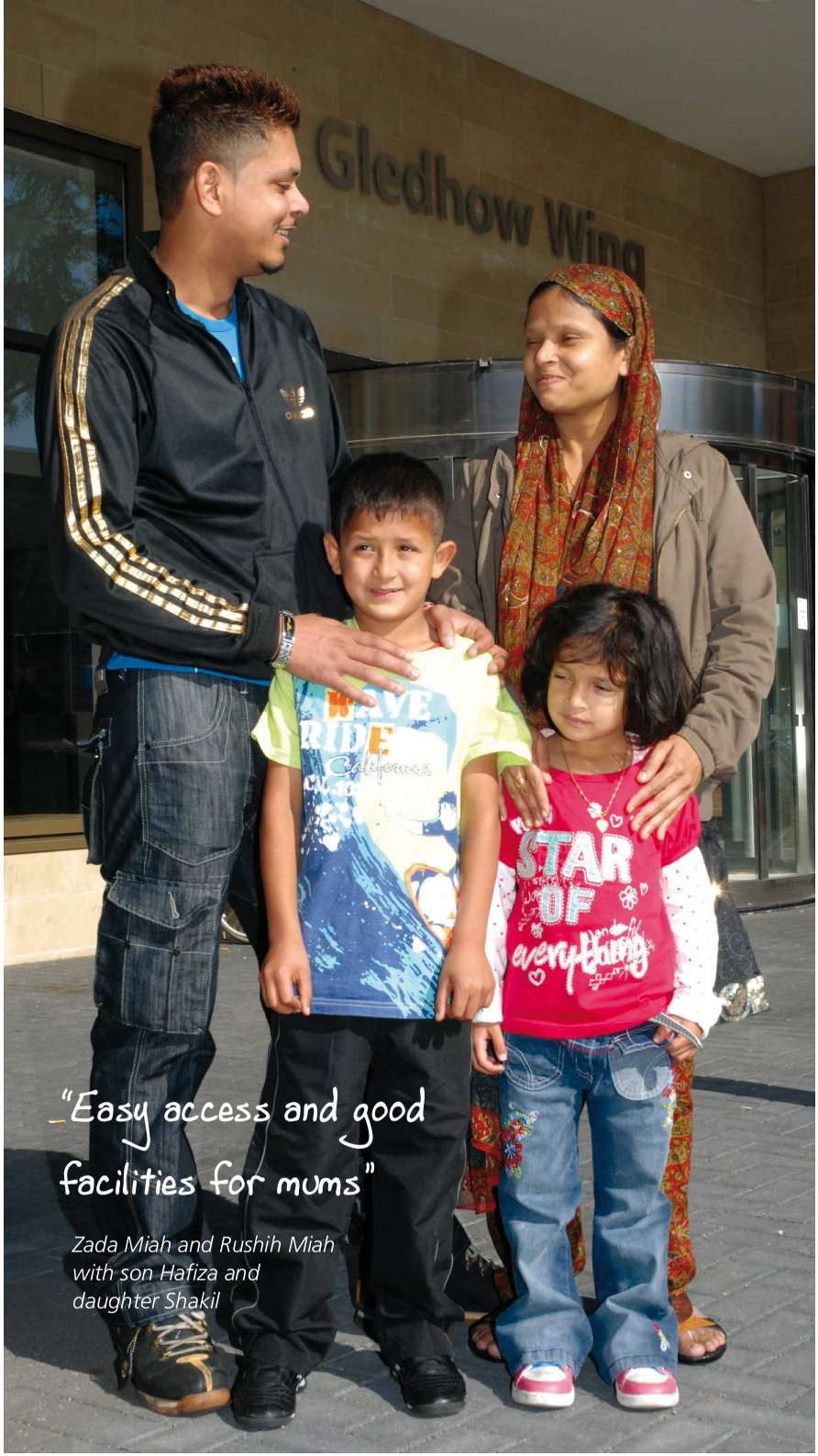
Becoming a member

Use the form on our web site:
www.leedsth.nhs.uk/Membership or complete and post the attached Membership form using the reply paid envelope enclosed with this leaflet, otherwise send to:

Patient and Public Support Services
Trust Headquarters
St James's University Hospital
Beckett Street
Leeds LS9 7TF

Or send an email to public.relations@leedsth.nhs.uk with your full name, title, postal address, date of birth and details of your ethnicity, these are not essential but will help us to ensure our Membership is representative. We'll reply to you to complete the registration.

To receive a hard copy of our application form call **0113 206 6785** and we'll send a form out to you.



Response form *Please tick*

Overall, do you support our plans to become a Foundation Trust?
Yes ☐ **No** ☐ Any comment (please write on a separate sheet if you need to):

Do you think the proposed name properly says what we are about? [page 3]
Yes ☐ **No** ☐ Any comment:

Do you have any suggestions you think we should take into account as part of our vision? [page 4]
Yes ☐ **No** ☐ Any comment:

Do you support the proposal that staff Members automatically become Members unless they choose to opt out? [page6]
Yes ☐ **No** ☐ Any comment:

Do you agree with the minimum age of 16 for Members? [page7]
Yes ☐ **No** ☐ Any comment:

Please let us know if you know of any 'seldom heard' (or hard to reach) groups and tell us about any effective ways to communicate with them. [page 8]
Yes ☐ **No** ☐ Any comment:

Do you think we have the right number of Governors? Please let us know if you think there are parts of the local community or partner organisations that are not represented? [page 8]
Yes ☐ **No** ☐ Any comment:

Is 3 years the right term of office for Governors? [page 8]
Yes ☐ **No** ☐ Any comment:

Do you think our proposals for Governor roles will help us to deliver health care? [page 9]
Yes ☐ **No** ☐ Any comment:

Do you think these are the right groups for staff constituencies? [page 9]
Yes ☐ **No** ☐ Any comment:

Should volunteers be regarded as Members of staff? [page 9]
Yes ☐ **No** ☐ Any comment:

Do you think these boundaries for the public constituencies fairly represent areas of Leeds? [page 10]
Yes ☐ **No** ☐ Any comment:

Is this the right number of public constituencies? [page 11]
Yes ☐ **No** ☐ Any comment:

Do you think we should have separate groups specifically representing patients? If so, how might we should break them down into smaller groups? [page 11]
Yes ☐ **No** ☐ Any comment:

Do you think our proposals for appointed Governors are right? [page 11]
Yes ☐ **No** ☐ Any comment:

Do you agree with these restrictions on who can become a Governor? [page 12]
Yes ☐ **No** ☐ Any comment:

Do you agree with our proposals for the Board of Directors? [page 13]
Yes ☐ **No** ☐ Any comment:

Do you agree with our proposed transitional arrangements? [page 13]
Yes ☐ **No** ☐ Any comment:

Do you agree that elections should be twice every three years, involving around half of the elected Governors? [page 13]
Yes ☐ **No** ☐ Any comment:

cut here

section 6 your say

Application to become a Foundation Trust Member

If you would prefer to do this online you can do so at: www.leedsth.nhs.uk/Membership

Title:.....

First Name:.....

Surname:.....

Full address:.....

.....

.....Postcode:.....

Date of Birth	DD	MM	YYYY

Age (years).....

Gender M ☐ F ☐

Home telephone number:.....

Mobile telephone number:.....

e-mail address **(this is the most effective way for us to contact you):**.....

Any special information requirements, e.g. other languages, Braille, etc

Your ethnicity

A White

- ☐ British
- ☐ Irish
- ☐ Any other white background

B Mixed

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other mixed background

C Chinese or other ethnic group

- ☐ Chinese
- ☐ Any other ethnic group

D Black or Black British

- ☐ Caribbean
- ☐ African
- ☐ Any other Black background

E Asian or Asian British

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Kashmiri
- ☐ Any other Asian background

Have you selected 'Any other … background'? Please give us more details so that we can better understand your needs:

.....

Membership Interests (please tick any that apply)

- ☐ Open meetings and open days
- ☐ Surveys, Workshops and Focus Groups
- ☐ Volunteering
- ☐ Fundraising
- ☐ Consider standing for Membership of the
- ☐ Council of Governors
- ☐ Help develop better information for patients and carers
- ☐ Help to recruit more Members
- ☐ Be consulted on any changes to the constitution
- ☐ Help develop patient information
- ☐ Be consulted on any changes to the constitution
- ☐ Help develop patient information

Other (please give details):

.....

.....

Health interests (please tick any areas in which you have a particular interest)

- ☐ Cancer
- ☐ Heart disease
- ☐ Children's health
- ☐ Men's Health
- ☐ Women's Health
- ☐ Older People's health and care
- ☐ Diabetes
- ☐ Surgical services
- ☐ Renal medicine
- ☐ Respiratory medicine

Other (please give details)

.....

.....

In compliance with current UK Data Protection legislation, any information you provide here will be kept secure, treated confidentially and used by the Trust only for the purpose of establishing and developing Foundation Trust status.

- ☐ Please tick here if you do not want to be enrolled automatically as a supporter or Member of the Trust when it changes to an NHS Foundation Trust

- ☐ Please tick here if you would like to receive more copies of this form

- ☐ NHS Foundation Trusts are required to publish a publicly available register of members. Please tick here if you do not want your name to appear on

If there is a reply paid envelope with this leaflet please use it to return the consultation response form and / or the Membership application form. If there is no reply paid envelope please contact us on 0113 206 6785 or use a stamp to send it to Patient and Public Support Services at the address shown above (on the inside back cover). Thank you.

"Caring for the people of Leeds and beyond past, present and future"

Matrons - Sue Dodman, (left) Helen Christodoulides (centre) and Kath Oddy (right)

If you would like more copies of this leaflet or a less detailed summary version, or if you would like more copies of the membership application form please contact:

Patient and Public Support Services
Trust Headquarters
St James's University Hospital
Beckett Street
Leeds
LS9 7TF

or send an email to
public.relations@leedsth.nhs.uk

or call **0113 206 6785**

Leeds Teaching Hospitals NHS Trust
Consultation Document
October 2009

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APPENDIX 2

The Leeds Teaching Hospitals NHS
NHS Trust

Foundation Trust consultation and membership activity

	CURRENT STATUS	TARGET / REQUIREMENT	COMMENTS / ACTIONS
PUBLIC CONSULTATION	• Full consultation document published, summary document also available • Launch meeting and Health Fair 30.9.09 • 21 public meetings (neighbourhood forum meetings) attended to date - approx 500 members of public • Consultation documents sent to all Leeds GP surgeries and public libraries	• Robust public consultation • Representative Membership developed • Staff and stakeholder involvement in development of IBP • Continued commitment to FT culture change	• 40 public meetings scheduled • Feedback and questions logged for each meeting attended so far • 7 stakeholder / public open consultation workshops scheduled mid Nov - early December
STAFF CONSULTATION	• Full consultation document published, summary document also available • 7 staff meetings held - approx 200 staff	• Opportunity to play an active part in the dialogue and deliberations around FT application	• 7 staff road shows scheduled • TCNC meeting 1 December • SMSC meeting tbc
STAKEHOLDER CONSULTATION	• 2000 letter to stakeholder groups notifying consultation • Further 2000 letters sent to stakeholder groups enclosing consultation document • Letters to 150 GP practices notifying consultation • Further letter to 150 GP practices enclosing consultation documents • Appointed Governor organisations notified	• Requirement to be able to list and describe the key areas of interest of main stakeholder organisations	• 7 stakeholder / public open consultation workshops scheduled mid Nov - early December • Second stage contact with stakeholder organisations to report public engagement activity and request feedback from stakeholder organisations

The Leeds Teaching Hospitals NHS
NHS Trust

	CURRENT STATUS	TARGET / REQUIREMENT	COMMENTS / ACTIONS
MEMBERSHIP	• 900 letters sent to volunteers enclosing consultation document and inviting membership applications - 2 face to face meetings with volunteers to discuss membership	• 11,000 public members • 14,000 staff members	• Membership letters included in all in / out patient letters due to begin Nov - • Developing outline database management project

Communications & Corporate Affairs
November 2009

APPENDIX 3

Leeds Consultation Events - Committee, Forum, Parish , Town Council and Other Meetings by date order

Date	Area	Meeting & Location	Contact	Notes	Attending
23rd September at 7.30 pm	West Outer	Tyersal forum at Tyersal Club	Rebecca M Boon Project Officer West North West Leeds Area Management Team, Regeneration Section. Leeds City Council 3rd Floor, Pudsey Town Hall, Lowtown, Leeds LS28 7BL Tel 395 1970 Fax 395 0997 I am not in the office on Fridays	Confirmed	Ross Langford
30th September 2009, 3.30 - 6.00	East Inner	Harehills Consultation event Harehills Primary School, Darfield Road, Leeds LS8 5DQ	Anna Turner - 0113 214 5872 Anna.turner@leeds.gov.uk Or Melanie Bratton- 2145895		Elizabeth Alarcon
5th October 2009, 4 - 7 pm	North East Inner	Chapel Allerton Consultation, Venue: Space@Hillcrest Hillcrest School on Cowper Street in Chapeltown (LS7 4DR)	Main contact: Kate Parry Area Assistant Kate.Parry@leeds.gov.uk Tel: 214 5871 Mob: 07545604339 Fax: 2145870 Sharon Hughes Area Management Officer Tel: 214 5898 Mobile: 07891 275581 Fax: 214 5870 sharon.hughes@leeds.gov.uk AMT offices, 2nd Floor, Leeds Media	22.9.09 Kate said we can have a stall and maybe a slot for a presentation - she's to get back to me They will be there from 3pm and suggest we are there from 3.30 pm. They're providing a table for the display Said; We will be having an interactive quiz for residents and alongside this partners will have stalls with displays which promote their services. Residents will have	Ross Langford

			Centre, 21 Savile Mount, Leeds, LS7 3HZ	the opportunity to discuss their concerns with you. I would be grateful if can record specific concerns raised by residents as all comments will be used to influence our area delivery plan next year.	
5th October 2009, 6 pm until 9.15 or 9.30 pm	East Inner	Richmond Hill Consultation event at Richmond Hill Primary School, Clarke Crescent, off Pontefract Lane, LS9 8QF	Renew - tel 3833920 or Anna Turner - 0113 214 5872 Anna.turner@leeds.gov.uk	Confirmed	Ross Langford
6th October 2009, 7.00 pm - 9.00 pm	East Inner	Burmantofts Consultation event St Agnes Church Hall, behind St Agnes Church, Stoney Rock Lane, Burmantofts	Renew - tel 3833920 or Geoff Hollerand on 07932 552853 Anna Turner - 0113 214 5872 Anna.turner@leeds.gov.uk	confirmed	Ruth Holt
7th October 2009 at 7pm	North West Outer	Guiseley & Rawdon forum is on 7th October at Greenacre Community Hall, New Road Side, Rawdon, LS19 6AS	Kate.Sibson@leeds.gov.uk	Confirmed	Ross Langford
13th October 2009 at 6.50 pm	North East Outer	Wetherby Town Council	Barbara.Ball	Confirmed PRESENTATION	Ross Langford/ Ruth Holt
16th October 2009 at 2pm	West Outer	Leeds West Outer Committee at Pudsey Civic hall in the Woodhall room.	Sam Woodhead sam.woodhead@leeds.gov.uk	Confirmed. PRESENTATION Report needs to go to Sam Woodhead by the 24th Sept at the latest. 10 mins are allowed for presentations From Sam: Happy for you to bring leaflets along on the day and distribute them to who attends, very few people don't turn up who say they will.	Ross Langford

				Don't have a newsletter at the mo, working on a website but won't have this live until the New Year. PRESENTATION	
19th October 2009, 5 - 7 pm	North East Outer	Alwoodley Consultation, Open House, 78 -81 Lingfield Drive, LS17 7HF	Kate Parry Area Assistant Kate.Parry@leeds.gov.uk Tel: 214 5871 Mob: 07545604339 Fax: 2145870	Confirmed STAND Can set up from 4.30 pm Table and chairs will be provided	Andrew banister / Suzanne Breen
22nd October 2009, 4 - 6 pm	North East Inner	Moortown Consultation Meeting, Allerton Grange School, LS17 6SF (access via Lidgett Lane)	Main contact: Kate Parry Area Assistant Kate.Parry@leeds.gov.uk Tel: 214 5871 Mob: 07545604339 Fax: 2145870 Sharon Hughes Area Management Officer Tel: 214 5898 Mobile: 07891 275581 Fax: 214 5870 sharon.hughes@leeds.gov.uk AMT offices, 2nd Floor, Leeds Media Centre, 21 Savile Mount, Leeds, LS7 3HZ	Confirmed STAND Can set up from 3.30 pm Table and chairs will be provided	Dawn Marshall & Jo Bewley
22nd October 2009, 6-8 pm	North East Inner	Roundhay Consultation, Allerton Grange School, LS17 6SF (access via Lidgett Lane)	Main contact: Kate Parry Area Assistant Kate.Parry@leeds.gov.uk Tel: 214 5871 Mob: 07545604339 Fax: 2145870 Sharon Hughes	Confirmed. STAND Date changed from 14th October Table and chairs will be provided Can set up half an hour beforehand	Jo Bewley & Dawn Marshall

			Area Management Officer Tel: 214 5898 Mobile: 07891 275581 Fax: 214 5870 sharon.hughes@leeds.gov.uk AMT offices, 2nd Floor, Leeds Media Centre, 21 Savile Mount, Leeds, LS7 3HZ		
26th October 2009 11.00 am - 4.00 pm	NHS Choices Roadshow	Leeds Central Library , Tiled Hall	Ann Day Neighbourhood Renewal Manager Leeds Library and Information Service Tel 0113 395 2340 Mob 07891276861 ann.day@leeds.gov.uk	Confirmed. STAND The libraries are promoting libraries and health and the NHS are promoting NHS Choices	Elizabeth Alarcon
27th October 2009, 4pm	East Outer	Area committee meeting at Civic Hall	1. Janet Pritchard Governance Officer Governance Services Section 4th Floor West The Civic Hall LEEDS LS1 1UR Tel: (0113) 2474327 Fax: (0113) 3951599 (Please note my usual working days are all day Mondays and Tuesdays and Wednesday mornings) 2. Martin Hackett Area Management Officer South East Leeds Area Management Leeds City Council Tel: 0113 3950705 Fax: 0113 2474851 martin.hackett@leeds.gov.uk	E-mailed to confirm, PRESENTATION	Graham Johnson Consultant Emergency Medicine Divisional Medical Manager - Medicine graham.johnson@leedsth.nhs.uk gjohnson@doctors.org.uk
4th November 2009, 3.30 -	East Inner	Gipton consultation event Gipton Working Men's club	Anna Turner - 0113 214 5872	Confirmed.	Ross Langford

6.30 pm		Coldcotes circus	Anna.turner@leeds.gov.uk Or Melanie Bratton- 2145895	STAND	
9th November 2009 at 2pm	North West Outer	Area Committee at Civic Hall	Jane Pattison Area Management Officer West North West Area Management Team Leeds City Council 3rd Floor Pudsey Town Hall Leeds LS28 7BL Tel 395 2832 Mobile 07891 272108 Fax 0113 395 0997 jane.pattison@leeds.gov.uk	Confirmed PRESENTATION	Ross Langford
9th November 7.30 at Swinnow Community centre	West Outer	Pudsey & Swinnow Forum at Swinnow Community Centre	Clare Wiggins Area Management Officer - Outer West 0113 395 1973 clare.wiggins@leeds.gov.uk or Gavin Forster Gavin.Forster@leeds.gov.uk	Confirmed PRESENTATION Can e-mail info after meeting. They don't have a newsletter	Ross Langford
10th November 2009 10.00 am	North East Outer	Scholes Community Forum at Scholes Manor House, LS15 4AA	Angela Stocks angelastocks@uwclub.net>	Confirmed. Meeting is at Scholes Manor House which is a sheltered housing complex - will have electrical sockets but no other equipment for presentation Have sent article for newsletter PRESENTATION	Graham Johnson Consultant Emergency Medicine Divisional Medical Manager - Medicine graham.johnson@leedsth.nhs.uk gjohnson@doctors.org.uk
11th November	East Inner	Killingbeck and Seacroft	Anna Turner - 0113 214 5872	Confirmed	Ross Langford

2009, 3.30 - 6.30		consultation event Probably to take place at the Working Men's Club on Ironwood Approach - but is to be confirmed	Anna.turner@leeds.gov.uk Or Melanie Bratton- 2145895	STAND	
11th November 2009 6.30 pm	South Inner	Inner south area committee At Belle Isle Family Centre, Belle Isle Rd LS10 3PG	Sheila Fletcher Area Management Officer Area Management South East 0113 3951652 07891 276853 Sheila.Fletcher@leeds.gov.uk	Confirmed PRESENTATION	Clare Linley and Jill Asbury
12rh November 4pm	North East Oouter	Wetherby Town Hall	Barbara Ball	STAND - public awareness and membership sign-up	Ross Langford and Elizabeth Alarcon-Rhodes
12th November 2009 at 7pm	West Outer	Farnley Wortley Forum - St John's Church Dixon Lane Road (off of Dixon Lane) Lower Wortley	Sam Woodhead Area Management Officer Environments and Neighbourhoods 0113 3950655 sam.woodhead@leeds.gov.uk	Confirmed PRESENTATION From Sam Woodhead: You can distribute leaflets at this meeting with pleasure to those who attend. Unfortunately, we won't be able to pass leaflets onto those on our mailing list who don't attend for resource reasons. However, the Councillors who attend often offer to take some leaflets (from people who bring them) to distribute in community venues.	
16th November 2009 at 7.30 pm	South Outer	Drighlington Parish Council in the meeting hall, Moorland Road, Drighlington, BD11 1JZ.	Arthur Thornton Arthur@thornton4620.freeserve.co.uk	Confirmed Arthur Thornton said: As we have a full agenda I would ask that the presentation including Q&A is kept to 15 - 25 mins maximum. He suggested we bring 25 - 30 booklets to distribute on the night	Helen Barker

				PRESENTATION	
16th November 5.00 - 6.00 pm		Thorner Parish Centre	Originally contacted: Steven Wood Clerk to Thorner Parish Council 5 Camp Square Thorner Leeds LS14 3BX Tel: 2893121 thornerclerk@btinernet Steven Wood is advertising the meeting for us Room has been booked with Catherine Clements thornerpc@googlemail.com Tel 2892578. Best phoning after 7pm as will be at work during the day	Confirmed PRESENTATION Room holds up to 100 people. Need to bring laptop, projector and screen. There is a kitchen with hot water boiler, & cups & saucers but need to bring our own tea, coffee etc. Need to wash up after. I've been told not to use the dishwasher as we haven't been 'trained' to us it. Room booked 4.30 - 6.40 to allow time to set up and clear up	
17th November 2009 at 7pm	West Outer	Armley Forum at Armley One Stop Centre, Stock Hill, Armley	Sohail Effendi West North West, Area Management 3rd Floor, Pudsey Town Robin Lane Leeds LS28 7BL Tel: (0113) 39 52833 Fax:(0113) 39 50997 E-mail: sohail.effendi@leeds.gov.uk	Councillor Harper, the Chair of Armley Forum, is fine someone attending the November Armley Forum, and asks that he tries to keep his presentation to a minimum of 15 minutes to allow time for questions thereafter. Sohail asked that we let him know who's attending. PRESENTATION	Ruth and Darryn
26th November 2009 at 7.30 pm	North West Inner	Bramley Forum at The Erick Atkinson Centre, Wellington Gardens, Bramley.	Sohail Effendi West North West, Area Management 3rd Floor, Pudsey Town Robin Lane Leeds LS28 7BL Tel: (0113) 39 52833	Confirmed PRESENTATION	

			E-mail: sohail.effendi@leeds.gov.uk		
30th November 2009 at 4pm	South Outer	Outer South Area Committee meeting at Drighlington Meeting Hall	Tom O' Donovan Area Management, South Leeds City Council Dewsbury Road One Stop Centre 190 Dewsbury Road Leeds. LS11 6PF Tel: 0113 224 3040 Fax: 0113 247 6032	Confirmed PRESENTATION	
7th December 2009 at 5.30 pm	North East Outer	NE Area Committeee meeting Civic Hall	Carole Clark Area Management Officer (Outer North East) East North East Leeds Area Management Team Leeds City Council Leeds Media Centre 21 Savile Mount LEEDS LS7 3HZ Tel: (0113) 2145867 Mobile: 07891 278015 Rory Barke, East/NE Area Manager, 2145865 rory.barke@leeds.gov.uk John Woolmer, Deputy East/NE Area Manager john.woolmer@leeds.gov.uk	To be confirmed - have been asked to go to Chair's briefing on 16th oct. PRESENTATION	Clare Linley Al Sheward
7th December 2009	North East Inner	Pre-committee event for Area Committee Meeting	Sharon Hughes Area Management Officer Tel: 214 5898 Mobile: 07891 275581 Fax: 214 5870 sharon.hughes@leeds.gov.uk AMT offices, 2nd Floor, Leeds Media	Suggested having a pre-committee event Said they like to follow the same format for Outer North East, Inner North East & Inner East. So suggesting we have pre-committee event for all three.	

			Centre, 21 Savile Mount, Leeds, LS7 3HZ	NHS Leeds have already agreed to do a pre-committee event for December and Sharon is waiting to hear from them about the format this will take. She said we could have an information stand there. To get back to me. STAND	
9th December 2009 at 5pm	West Inner	Inner West Area Committee at Stanningley Rugby Club	Alison Pickering Area Management Officer Area Management, West North West Leeds City Council Tel: (0113) 3951968 Fax: (0113) 2145870 Email: alison.pickering@leeds.gov.uk	Confirmed. Sent report template & asked report be sent by first week in November. Asked who would be coming PRESENTATION	
10th December 2009, 6 - 8 pm	North East Inner	Volunteer Thank You Event for Inner NE, Leeds Civic Hall	Main contact: Kate Parry Area Assistant Kate.Parry@leeds.gov.uk Tel: 214 5871 Mob: 07545604339 Fax: 2145870 Sharon Hughes Area Management Officer Tel: 214 5898 Mobile: 07891 275581 Fax: 214 5870 sharon.hughes@leeds.gov.uk AMT offices, 2nd Floor, Leeds Media Centre, 21 Savile Mount, Leeds, LS7 3HZ	Confirmed. STAND Table and chairs provided. Can set up from 5.30 pm	Clare Linley
10th December 2009 7pm	North West Inner	NW Inner area Committee Little London Community	Chris Dickinson Area Management Officer (Inner	Confirmed	Professor D.I. Thwaites

		Centre Oatland Lanen Leeds, LS7	North West) 3rd Floor, Pudsey Town Hall Pudsey LS28 7BL Office 0113 3952835 Mobile 07891 278013 chris.dickinson@leeds.gov.uk	PRESENTATION	
	East Outer	Kippax Parish Council	Colin Child clerk.kippaxparishcouncil@btinternet.com Tel: 07775567094 0113 2876385 0113 2860033 Kippax Parish Council The Stables Rudstone Grove Sherburn in Elmet LS25 6EQ	Meet on 3rd Thursday of month - to let me know which meeting we can attend PRESENTATION	
	North West Outer	Otley Town Council	Iain Plumtree, Town Clerk , Otley Town Council, Civic Centre, Cross Green, Otley, West Yorkshire, LS21 1HD Tel: 01943 466335 Fax: 01943 468658 TownClerk@otleytowncouncil.gov.uk	Response: Wharfedale Hospital is a very sensitive subject in the Town and I am sure a public presentation and consultation meeting would attract a number of interested citizens. I think we should advertise it through the Observer and plan a separate event Cllr Jim Spencer Otley Town Council PRESENTATION	
	North West Outer	Arthington Parish Council	Jane Crowther Clerk to Arthington Parish Council Tel: 0113 284 2679 Email: arthingtonparish@tiscali.co.uk	Not enough members of public. Could attach a note to any leaflets they send out or put notices on their 3 notice boards	

LTHT FT consultation - stakeholder and public meetings / interactive workshops*

DATE	LOCATION	WORKSHOP DETAILS *
17 November	St James's University Hospital (open meeting)	Cookridge Conference Centre 7th Floor, Bexley Wing Beckett Street, Leeds, LS9 7TF
19 November	LGI (meeting for LTHT volunteers)	Kaberry lecture theatre Leeds General Infirmary
19 November	West Yorkshire Playhouse (open meeting)	Congreve Room West Yorkshire Playhouse Playhouse Square Quarry Hill Leeds, LS2 7UP
27 November	SJUH (meeting for LTHT volunteers)	Cookridge Conference Centre Bexley Wing St.James's University Hospital
20 November	Seacroft Hospital (open meeting)	Committee Room Seacroft Hospital York Road, Leeds, LS14 6UH
30 November	Leeds Metropolitan University (open meeting)	The Rose Bowl, Portland Crescent Leeds, LS1 3HB
3 December	Wharfedale Hospital, Otley (open meeting)	Education Suite Newall Carr Road, Otley, West Yorkshire, LS21 2LY
7 December	Chapel Allerton Hospital (open meeting)	Chapel Allerton Hospital Harehills Lane,

		Leeds, LS7 4SA
9 December	Leeds General Infirmary (open meeting)	Garland Gallery, Gilbert Scott Building Leeds General Infirmary Great George Street, Leeds, LS1 3EX

* A limited number of places will be available at each location. Participants are asked to book in advance if possible. Call 0113 206 6785 or e-mail public.relations@leedsth.nhs.uk

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 24 November 2009

Subject: Joint health scrutiny protocol - Yorkshire and the Humber

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 the Scrutiny Board (for agreement) with a joint health scrutiny protocol for the Yorkshire and the Humber region. This protocol will form the basis for any joint scrutiny between the constituent local authorities within the region.

2.0 Background

2.1 Previously, Leeds City Council had signed up to a West Yorkshire Joint Health Scrutiny Protocol, enabling it to undertake joint heath work with neighbouring local authorities. However, this protocol only covered the sub-region of West Yorkshire and, increasingly, issues that potentially affect the whole region have emerged.

2.2 Particularly with the advent of 'Choose and Book'[1], health services are now provided to patients living in an increasingly wider geographical area. In addition, an increase in the commissioning of 'specialised services' on a regional basis (for example, renal services) can lead to proposed service changes, potentially, affecting patients from an area that spans two or more local authorities that are not in the same sub-region.

2.3 In terms of 'specialised services', to date, there has been little scrutiny of these (often very expensive) services, however, any future work should be undertaken on a regional basis.

3.0 Joint health scrutiny protocol - Yorkshire and the Humber

[1] A national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic. Patients are able to choose the hospital or clinic at which they are treated from a selection that often includes ones that are outside their immediate locality.

3.1 To address these issues, the Regional Health Scrutiny Officers Network has drafted a protocol (presented at Appendix 1) that suggests how the local authorities in the Yorkshire and Humber region could undertake scrutiny work together.

3.2 This protocol has taken the best elements from all the sub-regional protocols previously produced and provides a framework for any number of authorities (from two upwards) to meet, investigate and make recommendations on an issue

4.0 Recommendations

4.1 Members of the Scrutiny Board (Health) are asked to consider and agree the attached protocol.

5.0 Background Documents

None

APPENDIX 1

PROTOCOL FOR THE YORKSHIRE AND THE HUMBER COUNCILS JOINT HEALTH SCRUTINY COMMITTEE

1.0 INTRODUCTION

1.1 This Protocol has been developed as a framework for carrying out scrutiny of regional and specialist health services that impact upon residents across Yorkshire and the Humber under powers for Local Authorities to scrutinise the NHS contained in the Health and Social Care Act 2001.

1.2 The Health and Social Care Act 2001 strengthens arrangements for public and patient involvement in the NHS. Sections 7 to 10 of the Act provide for local authority Overview and Scrutiny Committees to scrutinise the NHS and represent local views on the development of local health services, whilst section 242 of the National Health Service Act 2006 (formally section 11 of the Health and Social Care Act 2001), places a duty on NHS organisations to make arrangements to involve and consult patients and the public in service planning and operation, and in the development of proposals for changes. Section 242 has subsequently been amended by the Local Government and Public Involvement in Health Act 2007. NHS organisations are now required to make arrangements so that users of services are involved in the planning and development of these services.

1.3 The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 provide for local NHS bodies to consult the Overview and Scrutiny Committee where the NHS body has under consideration any proposal for a substantial development of the health service or for a substantial variation in the provision of such a service in the local authority's area.

1.4 The Directions also state that when a local NHS body consults with more than one Overview and Scrutiny Committee on any such proposal, the local authorities of those Overview and Scrutiny Committees shall appoint a Joint Overview and Scrutiny Committee for the purposes of the consultation and only that Joint Overview and Scrutiny Committee may:-

(a) Make comments on the proposal consulted on to the local NHS body;

(b) Require the local NHS body to provide information about the proposal;

(c) Require an officer of the local NHS body to attend before it to answer such questions as appear to it to be necessary for the discharge of its functions in connection with the consultation.

1.5 Notwithstanding these arrangements, individual authorities may wish to comment on proposals by NHS bodies under the broader duties imposed on NHS Bodies by Section 242 of the National Health Service Act 2006.

1.6 This protocol has been developed and agreed by all the local authorities with responsibility for health scrutiny in the Yorkshire and the Humber region (Bradford, Calderdale, Kirklees, Leeds, Wakefield, York, North Lincolnshire, Barnsley, Doncaster, Rotherham, Sheffield, East Riding, North Yorkshire, North East Lincolnshire and Hull) as a framework for carrying out joint scrutiny of health in the region in response to a statutory consultation by an NHS body.

2.0 COVERAGE

2.1 Whilst this protocol deals with arrangements within the boundary of Yorkshire and the Humber, it is recognised that there may be occasions when consultations may affect adjoining regions. Arrangements to deal with such circumstances would have to be determined and agreed separately, as and when appropriate.

3.0 PRINCIPLES FOR JOINT HEALTH SCRUTINY

3.1 The basis of joint health scrutiny will be co-operation and partnership with a mutual understanding of the following aims:

- To improve the health of local people and to tackle health inequalities
- Ensuring that people's views and wishes about health and health services are identified and integrated into plans, services and commissioning that achieve local health improvement.
- Scrutinising whether all parts of the community are able to access health services and whether the outcomes of health services are equally good for all sections of the community.

3.2 The Local Authorities and NHS bodies will be willing to share knowledge, respond to requests for information and carry out their duties in an atmosphere of courtesy and respect in accordance with their Codes of Conduct. Personal and prejudicial interest will be declared in all cases, in accordance with the Code of Conduct.

3.3 The scrutiny process will be open and transparent in accordance with the Local Government Act 1972 and the Freedom of Information Act 2000 and meetings will be held in public. Only information that is expressly defined in regulations to be confidential or exempt from publication will be considered in private.

3.4 Different approaches to scrutiny reviews may be taken in each case. The Joint Health Scrutiny Committee will seek to act as inclusively as possible and will take evidence from a wide range of opinion including patients, carers, the voluntary sector, NHS regulatory bodies and staff associations. Attempts will be made to ascertain the views of hard to reach groups, young people and the general public.

4.0 SUBSTANTIAL VARIATION AND SUBSTANTIAL DEVELOPMENT

4.1 When a NHS body is considering proposals to vary or develop health services, those authorities whose residents are affected must be given the chance to decide whether they consider the proposals to be substantial to their communities. Those that do consider the proposals to be substantial must be formally consulted and must form a Joint Health Overview and Scrutiny Committee to respond to the consultation. The decision about whether proposals are substantial (and therefore whether to participate in a Joint Health Overview and Scrutiny Committee) must be taken by the Health Overview and Scrutiny Committees within the relevant authorities.

4.2 The primary focus for identifying whether a change should be considered as substantial is the impact upon patients, carers and the public who use or have the potential to use a service. This would include:-

- ***Changes in accessibility of services:*** any proposal which involves the withdrawal or change of patient or diagnostic facilities for one or more speciality from the same location (other than to any part of same operational site).
- ***Impact of proposal on the wider community and other services:*** including economic impact, transport, regeneration (e.g. where reprovision of a hospital could involve a new road or substantial house building).
- ***Patients affected:*** changes may affect the whole population (such as changes to A&E), or a small group (patients accessing a specialised service). If changes affect a small group it may still be regarded as substantial, particularly if patients need to continue accessing that service for many years (for example renal services).
- ***Methods of service delivery:*** altering the way a service is delivered may be a substantial change, for example moving a particular service into community settings rather than being entirely hospital based.
- ***Issues likely to be considered as controversial to local people:*** (e.g. where historically services have been provided in a particular way or at a particular location.)
- ***Changes to governance:*** which affect NHS bodies' relationships with the public or local authority Overview and Scrutiny Committees (OSC's).

5.0 RESPONDING TO A STATUTORY CONSULTATION BY AN NHS BODY

5.1 Where a response to a statutory consultation is required on proposals for substantial variation or substantial development affecting two or more ocal authorities within Yorkshire and the Humber, scrutiny may be undertaken either by:-

- **Delegated Scrutiny**: The affected local authorities agree to delegate their overview and scrutiny function to a single authority which may be better placed to consider a local priority[1]; or
- **Joint Committee**: The affected local authorities establish a joint committee to determine a single response.

5.2 Accordingly, where any substantial variation or substantial development principally affects residents of a single local authority, scrutiny can be delegated to that authority. Whereas, there is a presumption of wider regional variations or developments are dealt with by a Joint Health Scrutiny Committee.

6.0 DELEGATED SCRUTINY

6.1 Regulations enable a local authority to arrange for its overview and scrutiny functions to be undertaken by a committee from another local authority. Delegation may occur where a local authority believes that another may be better placed to consider a particular local priority and, importantly, the latter agrees to exercise that function. For instance, it might be more appropriate to delegate scrutiny where an NHS body provides a service across two local authority areas but the large majority of those using or affected by the service are in one of those authority areas.

Delegated Powers

6.2 When and where such delegation takes place, the full powers of overview and scrutiny of health shall be given to the delegated committee, but only in relation to the specific delegated function (i.e. a particular inquiry or consultation).

Terms of Reference

6.3 In such circumstances and in accordance with Department of Health guidance, clear terms of reference, clarity about the scope and methods of scrutiny to be used must be determined between the affected local authorities. Formal terms of reference should be drafted and formally agreed by the respective Overview and Scrutiny Committees of the affected local authorities and subsequently shared with the relevant NHS bodies.

6.4 In the context of a proposal for a substantial development or variation to services, where the review of any consultation has been delegated, the power of referral to the Secretary of State where such a proposal is contested is also delegated. The delegating local authority is no longer able to influence the content or outcome of the review[2].

6.5 The delegated authority (the authority undertaking the consultation exercise) will be responsible for conducting scrutiny in accordance with

[1] Overview and Scrutiny of Health - Guidance. Department of Health, July 2003. P21, para 7.1
[2] Overview and Scrutiny of Health - Guidance. Department of Health, July 2003. P21, para 7.4

its own set procedures and will be expected to regularly communicate with the delegating authority(ies).

7.0 JOINT HEALTH SCRUTINY COMMITTEE

7.1 Where a wider, joint approach is required to a consultation by an NHS body, a separate Joint Health Scrutiny Committee will be established for each consultation.

Membership of a Joint Health Scrutiny Committee

7.2 Under the Local Government Act 2000 provisions, Overview and Scrutiny Committees must generally reflect the make up of full Council. Consequently, when establishing a Joint Health Scrutiny Committee, each participating local authority should ensure that those Councillors it nominates reflects its own political balance. However, the political balance requirements may be waived but only with the agreement of all the participating local authorities[3].

7.3 In accordance with the above, a Joint Committee will be composed of Councillors drawn from Yorkshire and the Humber local authorities in the following terms:-

- where 9 or more Yorkshire and the Humber local authorities participate in a Joint Health Scrutiny Committee – the Chair (or Chair's representative) of each participating authority's Overview and Scrutiny Committee responsible for health will become a member of the Joint Health Scrutiny Committee;
- where 4 to 8 local authorities participate - then each participating authority will nominate 2 Councillors; or
- where 3 or less local authorities participate - then each participating authority will nominate 4 Councillors.

7.4 Each local authority should make a decision as to whether it should seek approval from its respective full Council or Executive to delegate authority to its relevant Overview and Scrutiny Committee (responsible for health) or another appropriate body to nominate Councillors on a proportional basis to a Joint Health Scrutiny Committee.

7.5 From time to time and where appropriate, the Joint Health Scrutiny Committee may appoint non-voting co-optees for the duration of a consultation. In these circumstances, one or more co-optees could be drawn from local patient, community and voluntary sector organisations affected by substantial change or variation.

Choice of Lead Authority and Chair

7.6 Where a Joint Health Scrutiny Committee (as defined by the Health and Social Care Act 2001) is required to consider a substantial development of the health service or a substantial variation, one of the

[3] Overview and Scrutiny of Health - Guidance. Department of Health, July 2003. P22, para 8.6

affected local authorities would take the lead in terms of organising and Chairing the joint committee.

7.7 Selection of a lead authority, should where possible, be chosen by mutual agreement by the local authorities involved and take into account both capacity to service a Joint Health Scrutiny Committee and available resources. Additionally, the following criteria should guide determination of the Lead Authority:

- The local authority within whose area local communities will be most affected; or if that is evenly spread;
- The local authority within whose area the service being changed is based; or if that is evenly spread;
- The local authority within whose area the health agency leading the consultation is based.

Operating Procedures

7.8 The Joint Health Scrutiny Committee will conduct its business in accordance with the Overview and Scrutiny Committee Procedure Rules of the Lead Authority.

7.9 The Lead Authority will service and administer the scrutiny exercise and liaise with the other affected local authorities.

7.10 The Lead Authority will draw up a draft terms of reference and timetable for the scrutiny exercise, for approval by the Joint Health Scrutiny Committee at its first meeting. The Lead Authority will also have responsibility for arranging meetings, co-ordinating papers in respect of its agenda and drafting the final report.

Meetings of the Joint Health Scrutiny Committee

7.11 At the first meeting of any new inquiry, the Joint Health Scrutiny Committee will determine:

- Terms of reference of the inquiry;
- Number of sessions required;
- Timetable of meetings & venue.

Reports of the Joint Health Scrutiny Committee

7.12 At the conclusion of an Inquiry the Joint Health Scrutiny Committee shall produce a written report and recommendations which shall include:

- an explanation of the matter reviewed or scrutinised
- a summary of the evidence considered
- a list of the participants involved in the review or scrutiny; and
- any recommendations on the matter reviewed or scrutinised.

7.13 Reports shall be agreed by a majority of members of the Joint Health Scrutiny Committee.

7.14 Reports shall be sent to all relevant local authorities, to NHS Yorkshire and the Humber and the relevant health agencies, along with any other bodies determined by the Joint Health Scrutiny Committee and Lead Authority.

7.15 The Joint Health Scrutiny Committee shall request a response to its report and recommendations from the NHS body or bodies receiving the report within 28 working days.

7.16 The Joint Health Scrutiny Committee may, on receipt of the NHS body's response to its recommendations report to the Secretary of State on the grounds that it is not satisfied:

- with the content of the consultation; or
- that the proposal is in the interests of the health service in the area.

7.17 In circumstances where an NHS Body has failed to consult over substantial variation or development, or where consultation arrangements are inadequate or insufficient time provided, then the affected local authority or authorities may decide to make appropriate representations to the NHS Body concerned.

Minority reports

7.18 Where a member of a Joint Health Scrutiny Committee does not agree with the content of the Committee's report, they may produce a report setting out their findings and recommendations and such a report will form an Appendix to the Joint Health Scrutiny Committee's report.

8.0 DISCRETIONARY JOINT WORKING

8.1 Guidance issued by the Department of Health[4] states '*that the role of* (scrutiny*) committees is to take an overview of health services and planning within the locality and then to scrutinise priority areas to identify whether they meet local needs effectively.* This suggests a more proactive role for overview across Yorkshire and the Humber. It is also recognised that individual local authority scrutiny committees may wish to engage with and scrutinise regional NHS/health bodies or look at broader regional health issues.

8.2 In these circumstances, or where a health scrutiny review is initiated that affects more than one authority, then it may be appropriate and more effective for local authorities in Yorkshire and the Humber to agree on an ad-hoc basis, joint arrangements based on this protocol to undertake such work.

8.3 To enable Yorkshire and the Humber local authorities to explore potential opportunities for future joint working, all local authorities should:

[4] Overview and Scrutiny of Health - Guidance, July 2003

- share work programmes of their respective scrutiny committees (health);
- arrange for appropriate officers to meet and liaise on a regular basis; and,
- where appropriate, facilitate member level meetings across Yorkshire and the Humber.

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 24 November 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 for consideration, amendment and/or agreement.

3.0 Work programme (2009/10)

3.1 At the previous meeting (20 October 2009), the Board was presented with a comprehensive update on a number of matters, including:

- Scrutiny Inquiry: The role of the Council and its partners in promoting good public health
- Provision of renal services at Leeds General Infirmary (LGI)
- Provision of dermatology services at Ward 43 (Leeds General Infirmary (LGI))
- Use of 0844 Numbers at GP Surgeries
- Health Proposals Working Group
- Openness in the NHS
- Children's cardiac and neurosurgery services – national reviews

3.2 A revised outline work programme is presented at Appendix 1 for consideration.

3.3 For information, the minutes from the Executive Board meetings held on 14 October and 4 November 2009 are attached at Appendix 2. The Scrutiny Board is asked to consider these minutes within the context of making any adjustments to its work programme.

3.4 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. As such, the Scrutiny Board is asked to consider the attached outline work programme for the remainder of the year and agree / amend as appropriate.

4.0 Recommendations

4.1 Members are asked to consider the outline work programme attached at Appendix 1 and agree / amend as appropriate.

5.0 Background Documents

- Scrutiny Board (Health) – Updated Work programme (20 October 2009)

APPENDIX 1

Scrutiny Board (Health)
Work Programme 2009/10

Item	Description	Notes	Type of item
Meeting date – 24 November 2009			
Provision of Renal Dialysis at Leeds General Infirmary	To consider LTHT's response to the additional questions posed by the Scrutiny Board regarding the provision of renal dialysis services across the City and specifically the previously proposed unit at Leeds General Infirmary. The Board will also consider the draft Renal Strategy for Yorkshire and The Humber (2009 – 2014).	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)	RP

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

APPENDIX 1

Scrutiny Board (Health)
Work Programme 2009/10

Item	Description	Notes	Type of item
		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. 6 November 2009 – response from LTHT received.	
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. 29 October 2009 – further letter issued seeking same information. 13 November 2009 – formal response from LTHT	RP
Leeds Teaching Hospital NHS Trust – foundation trust consultation	To consider LTHT's foundation trust consultation document and details of the planned engagement and consultation.		B

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

APPENDIX 1

Scrutiny Board (Health)
Work Programme 2009/10

Item	Description	Notes	Type of item
Meeting date – 15 December 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.	Rescheduled from 24 November 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 1

Scrutiny Board (Health)
Work Programme 2009/10

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 1

Scrutiny Board (Health)
Work Programme 2009/10

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 1

Scrutiny Board (Health)
Work Programme 2009/10

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 1

Scrutiny Board (Health)
Work Programme 2009/10

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

Scrutiny Board (Health)
Work Programme 2008/09

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

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

Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Health Scrutiny – Department of Health Guidance	To receive and consider revised guidance associated with health scrutiny and any implications for local practice.	Guidance was due to be published in November 2009. Indications are that this is likely to be delayed. No firm publication dates are yet available.
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

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EXECUTIVE BOARD

WEDNESDAY, 14TH OCTOBER, 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

88 Exclusion of the Public

RESOLVED – That the public be excluded from the meeting during consideration of the following parts of the agenda designated as exemption the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the public were present there would be disclosure to them of exempt information so designated as follows:-

(a) Appendix 4 to the report referred to in minute 94 under the terms of Access to Information Procedure Rule 10.4(3) and on the grounds that it is considered that it is not in the public interest to disclose this information at this point in time as it could undermine the method of disposal, should that come about, and affect the integrity of disposing of the property/site. Also it is considered that that the release of such information would or would be likely to prejudice the Council's commercial interests in relation to this or other similar transactions in that prospective purchasers of this or other similar properties would have information about the nature and level of consideration which may prove acceptable to the Council. It is considered that whilst there may be a public interest in disclosure, much of this information will be publicly available from the Land Registry following completion of any transaction and consequently the public interest in maintaining the exemption outweighs the public interest in disclosing this information at this point in time.

(b) Appendix 1 to the report referred to in minute 106 under the terms of Access to Information Procedure Rule 10.4(3) and on the grounds that the public interest in maintaining the exemption outweighs the public interest in disclosure in that the appendix, and the Outline Business Case, include commercial information where publication could be prejudicial to the Council's interests.

(c) The appendix to the report referred to in minute 99 under the terms of Access to Information Procedure Rule 10.4(3) and on the grounds that the public interest in disclosing the alternative funding strategy outlined in the appendix could be prejudicial to the Council's ability to finalise the

funding plans for the scheme and would therefore outweigh the public interest in disclosure of the information.

89 Late Item

A late item on the subject of Yorkshire Forward funding for the Leeds Arena had been admitted to the agenda as a late item as a result of emerging information which required that the Board consider possible alternative funding arrangements in relation to the Arena development. If these matters were not considered at this meeting delays in the programme already commenced could result which would be detrimental to the scheme.

90 Declaration of Interests

Councillor A Carter declared a personal interest in the item relating to the New Generation Transport Scheme (minute 101) as a member of the Regional Transport Panel.

Councillor Wakefield declared a personal interest in the items relating to Special Educational Needs (minute 95), The National Challenge and structural change to secondary provision (minute 96) and the September 2009 school admissions round (minute 105) as a school and Leeds College governor (Councillor Wakefield declared an interest in the same terms during the discussion under minute 93).

91 Minutes

RESOLVED –

(a)That the minutes of the meetings held on 26th August and 17th September 2009 be approved.

(b) That in receiving the minutes the Board noted that the four members referred to in the minute of 17th September had met on 1st October and received a paper on matters which had been agreed within the terms indicated by the Board and that consequently those members had authorised officers to proceed to conclude the transaction.

(c) That it be also noted that the Chair had agreed that a verbal update be received in the private part of the meeting with regard to the matters referred to in (b) above. Such verbal report to be exempt in the terms previously agreed for this matter and the imminence of the conclusion of the transaction being the reason for admission of the item.

NEIGHBOURHOODS AND HOUSING

92 Reform of Council Housing Finance - Leeds City Council's response to the CLG consultation paper

The Director of Environment and Neighbourhoods submitted a report on the Council's response to the Department for Communities and Local Government's consultation paper.

RESOLVED - That proposed response to the Governments consultation paper "Reform of council housing finance" be approved in accordance with the submitted report.

93 Bangladeshi Community Centre: Community Asset Transfer

The Director of Environment and Neighbourhoods submitted a report on the outcome of discussions which had taken place with the Bangladeshi Management Committee over a number of months in relation to the possible transfer to the Committee of the Bangladeshi Community Centre on a 50 year Full Repair and Insurance lease at less than best consideration.

RESOLVED –

(a) That approval be given to the principle of a fifty year lease for the Bangladeshi Community Centre at peppercorn rent to the Bangladeshi Management Committee to operate the premises as community facility for the benefit of the local residents.

(b) That the Director of City Development be authorised to approve the detailed terms and conditions of the lease.

(During the discussion of this item Councillor Wakefield declared a personal interest as a school and Leeds College governor).

DEVELOPMENT AND REGENERATION

94 The Former Royal Park Primary School

The Director of City Development submitted a report on the current position with regard to the former Royal Park Primary School and on the preferred options for the future.

The report identified the following six possible options:

i Traditional marketing of the refurbishment opportunity
ii Convert to Council use
iii Deal exclusively with one interested party or invite best and final offers
iv Community Asset Transfer
v Disposal by way of auction
vi Immediate demolition of the main school buildings and the retention of the site until such time as the property market improves

Following consideration of Appendix 4 to the report designated as exempt under Access to Information Procedure Rule 10.4(3) which was considered in private at the conclusion to the meeting it was

RESOLVED –

(a) That the withdrawal of the preferred developer be noted.

(b) That the decision made at the meeting held on 22nd August 2007 be rescinded.

(c) That this Board declines the Royal Park Community Consortium's request that no action be taken for a period of six months to allow the consortium time to develop funding applications which might, subsequently, lead to the lease or transfer of the ownership of the property.

(d) That this Board notes the negotiations that have taken place with the two organisations seeking to acquire the property, at market value, and refurbish it for subsequent use, instructs that the Director of City Development invites unconditional best and final financial offers from these two organisations in accordance with the terms of the report including business plans illustrating the ability of the bidder to guarantee the long term sustainability of the building, the latter representing 30% of the marks in any assessment, notwithstanding the outcome of any assessment, the bidders be advised that the Council will be under no obligation to accept either of the offers and that the purchaser must demonstrate the financial capacity not only for the purchase but also to address the very substantial cost of the refurbishment that would be required.

(e) That the decision at (d) above shall not preclude the consideration of a bid from another party submitted in the same terms as those detailed above.

CHILDREN'S SERVICES

95 The Development of Specialist Provision and Support for Special Educational Needs in Learning Environments - A Discussion Document

The Chief Executive of Education Leeds submitted a report providing an overview of the recent activity undertaken as part of the Leeds Inclusive Learning Strategy and introducing a new discussion document and accompanying appendices aimed at progressing the strategy.

RESOLVED –

(a) That current and ongoing discussions with partners, stakeholders and parent/carers during the Autumn Term 2009 on the discussion document be noted and approved.

(b) That the developmental priorities and emerging Action Plan for 2009/10 be noted.

96 The National Challenge and Structural Change to Secondary Provision in Leeds

Further to minute 217 of the meeting held on 4th March 2009 the Chief Executive of Education Leeds submitted a report presenting options and recommendations for delivering the next phase in structuring secondary provision in Leeds, and in particular, the response to the Government's National Challenge initiative.

Members also had before them a letter from the NUT, NASUWT and ATL trade unions regarding the same matter

RESOLVED – That the proposals detailed in section 5.2 of the submitted report be adopted.

(Under the provisions of Council Procedure Rule 16.5 Councillor Wakefield required it to be recorded that he voted against this item).

CENTRAL AND CORPORATE

97 Joint Service Centres - Formal Approval to the Next Stages of the Joint Service Centre Project, Capital and Revenue Budget Implications

The Deputy Chief Executive submitted a report providing an update on progress and providing budget implications associated with the delivery of the Chapeltown and Harehills Joint Service Centres.

RESOLVED –

(a) That the successful financial close on 12th June 2009, which was within the maximum affordability deficit of £396,000 approved at Executive Board of 4th March 2009, be noted.

(b) That the final affordability position at financial close, as set out in Table A of the report be approved.

(c) That the £600,000 capital receipt, received from LIFT Co (Community Ventures Leeds Ltd) for the sale of the two Joint Service Centre sites at Chapeltown and Harehills, be formally ring fenced to the JSC project and used for Stamp Duty Land Tax, temporary library bus and other ICT costs, as set out in Table B of the report.

(d) That the revenue expenditure for the provision of ICT and furniture and fittings to the new Joint Service Centres, as set out in Table B of the report be approved.

98 2010: A Year of Volunteering

The Assistant Chief Executive (Planning, Policy and Improvement) submitted a report on the background to the '2010: A Year of Volunteering' initiative in Leeds and outlining progress in relation to developing a programme of activities and arrangements in this respect.

RESOLVED –
(a) That the proposal to make 2010 Leeds Year of Volunteering be endorsed.

(b) That additional activities and events that will contribute to making the year a success for the city be sponsored and endorsed.

DEVELOPMENT AND REGENERATION

99 Leeds Arena - Yorkshire Forward Funding

The Director of City Development submitted a report on the potential outcome that the Government would not agree to authorise the Yorkshire Forward funding, in whole or in part, for the above scheme and on an alternative strategy to secure progress of the scheme in the event of that outcome.

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

RESOLVED –

(a) That the alternative funding strategy as outlined in the exempt appendix to the report be approved in order to ensure that the Leeds Arena scheme can progress as planned, should the government not agree to the release of the whole of the £18,000,000 Yorkshire Forward funding which had been proposed.

(b) That a Design and Cost Report for the scheme be brought back to this Board upon completion of RIBA Stage D design by the Council's design team in order that the design and cost freeze for the project can be agreed.

100 Leeds Core Cycle Network Project

The Director of City Development submitted a report providing an overview of proposals being developed to implement a strategic approach to the longer term development of cycle facilities and routes within Leeds.

RESOLVED –

(a) That the design and implementation of the proposed Leeds Core Cycle Network Project be approved, subject to financial approvals and regulation.

(b) That authority be given to incur £1,311,500 works and £135,500 supervision fees and monitoring, for the following routes that form part of the proposed Core Cycle Network Project, to be funded from the Integrated Transport Scheme 99609 within the approved Capital Programme:

(i) Route 16 Wyke Beck Way (Roundhay Park to Easterly Rd section)
(ii) Route 5 Cookridge - City Centre
(iii) Route 3 Middleton – City Centre
(iv) Route 15 Alwoodley – City Centre.

101 Submission of the Major Scheme Business Case (MSBC) for the New Generation Transport Scheme

The Director of City Development submitted a report outlining the progress made to date on the development of the New Generation Transport (NGT) proposals and detailing the key information for inclusion within the project's Major Scheme Business Case (MSBC) proposed for submission to the Department of Transport in the latter half of October 2009.

RESOLVED –
(a) That a Major Business Scheme Case for NGT be submitted in October 2009, based on the scheme options as set out in Section 2.4 of the submitted report.

(b) That the proposed approach for delivering the 10% local contribution to the scheme as set out in Section 3.4.4 of the report be approved.

(c) That the City Council share of the 'Additional Risk Layer' of the project be underwritten as set out in Section 3.4.6 of the report.

CHILDREN'S SERVICES

102 Playbuilder Initiative Update

The Director of Children's Services submitted a report on the proposed locations of the six remaining playbuilder sites as recommended by the Strategic Play Partnership and on proposals to progress to development of those six sites.

RESOLVED –
(a)That the proposed six sites as recommended by the Strategic Play Partnership be approved.

(b) That scheme expenditure for Cross Flatts, Seacroft Gardens, Horsforth HIPPO and Naburn Close Park be authorised.

(c) That authority be given to proceed with Tinshill Garth and Butcher Hill subject to agreement on long term maintenance and inspection being secured.

103 Proposal for Statutory Expansion of Primary Provision for September 2010

The Chief Executive of Education Leeds submitted a report on the proposed statutory consultation process for the expansion of primary provision.

RESOLVED –
(a) That statutory formal consultation be undertaken on the prescribed alterations to permanently expand the primary schools identified in paragraph 3.3 of the submitted report.

(b) That formal consultation be undertaken on a proposal at New Bewerley Primary School, in addition to the proposed expansion within (a) above, to add community specialist provision for up to 14 pupils with complex medical, physical needs.

(c) That a report detailing the outcome of these consultations be brought back to this Board in Spring 2010.

(d) That it be noted that proposals for further primary school expansion from 2011 onwards are being developed and will be the subject of further reports to this Board.

(Under the provisions of Council Procedure Rule 16.5 Councillor Wakefield required it to be recorded that he abstained from voting on this matter).

104 Proposal for Expansion of Primary Provision in the Richmond Hill Area

The Chief Executive of Education Leeds submitted a report on proposals to undertake consultation with respect to permanently expanding Richmond Hill Primary School by one form of entry from September 2012.

RESOLVED -

(a) That formal consultation be undertaken on the proposal to permanently expand Richmond Hill Primary School by one form of entry to three forms of entry with effect from September 2012.

(b) That a report detailing the outcome of these consultations be brought back to this Board in Spring 2010.

105 Report on the September 2009 Admission Round for Community and Controlled Schools

The Chief Executive of Education Leeds submitted a report providing a range of statistical information on the 2009 admission round for community and controlled schools.

RESOLVED – That the report and the statistical information therein be noted.

(Under the provisions of Council Procedure Rule 16.5, Councillor Wakefield required it to be recorded that he abstained from voting on this matter).

ADULT HEALTH AND SOCIAL CARE

106 Holt Park Wellbeing Centre - Outline Business Case and Affordability Position

The Director of Adult Social Services and the Director of City Development submitted a joint report on the proposed submission of the Outline Business Case for the Holt Park Wellbeing Centre to the Department of Health for approval.

Following consideration of Appendix 1 to the report designated as exempt under Access to Information Procedure Rule 10.4(3) which was considered in private at the conclusion of the meeting it was

RESOLVED –

(a) That the report be noted and approval given for the submission of the Outline Business Case for the Holt Park Wellbeing Centre project to the Department of Health.

(b) That approval be given to the affordability implications over the life of the proposed PFI contract for the Centre, summarised in table 1 of the exempt appendix to the report, and that officers be authorised to issue the Council's affordability thresholds relating to the PFI project to the LEP and to Environments for Learning.

(c) That the governance of the Centre be under the Education PFI Project Board in accordance with paragraph 8.7 of the report.

(d) That the decision of the Director of City Development to approve the delivery of the project through the LEP, as described in paragraph 8.2 of the report, be noted and supported.

(e) That the Project Initiation Document for this project be noted

DEVELOPMENT AND REGENERATION

107 Leeds United Thorp Arch Academy

Further to minute 87 of the meeting held on 17th September 2009 the Board received a verbal update on progress of the above transaction in private at the conclusion of the meeting and

RESOLVED - That the Chair, the Executive Member (Development and Regeneration), and the Leaders of the Labour and Morley Borough Independent groups be briefed on 15th October 2009 as to the position prior to the conclusion of the transaction on the same day.

DATE OF PUBLICATION: 16th October 2009
LAST DATE FOR CALL IN: 23rd October 2009

(Scrutiny Support will notify Directors of any items called in by 12:00 noon on 26th October 2009)

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EXECUTIVE BOARD

WEDNESDAY, 4TH NOVEMBER, 2009

PRESENT: Councillor R Brett in the Chair

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

Councillor R Lewis - Non-Voting Advisory Member

108 Minutes

RESOLVED – That the minutes of the meeting held on 14th October 2009 be approved.

ADULT HEALTH AND SOCIAL CARE

109 Deputation to Council - The 'Time to Change' City Wide Steering Group Seeking Leeds City Council Support for the Events Planned to be held in Leeds as part of the National 'Time to Change' Campaign

The Director of Adult Social Services submitted a report in response to the deputation to Council from the 'Time to Change' City-Wide Steering Group on 16th September 2009.

RESOLVED –

a) That the Council's support for the Deputation be confirmed, and that the work of Time to Change be endorsed by promoting the campaign to a wide audience across the City.

b) That it be noted that the Council will carry promotional materials in One Stop Centres, Libraries etc and place links to the Time to Change campaign on the LCC website and intranet.

c) That the Board notes the Council's approach in tackling these issues, as described in paragraph 3.1.2 of the report, and agrees that the Council can lead by example in line with its Disability Employment Strategy, by ensuring that good practice is followed in supporting employees with mental health problems.

110 Deputation to Council - The Access Committee for Leeds regarding Planned Day Centre Closures

The Director of Adult Social Services submitted a report in response to the deputation to Council from the Access Committee for Leeds on 16th September 2009.

RESOLVED - That the response to the deputation be noted and considered in conjunction with the accompanying report from Day Centres to Day Services: Response to the Consultation on Day Services as referred to in minute 111 below.

111 From Day Centres to Day Services - Response to the Consultation on Day Services

Further to minute 43 of the meeting held on 22nd July 2009 The Director of Adult Social Services submitted a report summarising the consultation process undertaken with respect to the future role and purpose of the Council's day centres for older people, and detailing the recommendations for the development of day services for older people, following consideration of the responses received.

RESOLVED -

a) That the outcome of the consultation and comments received be noted.

b) That the revised proposals outlined at paragraphs 5.4 to 5.8 of the report be approved

c) That the implementation plan outlined in paragraph 6 be endorsed.

d) That active consideration be given to the future use of the buildings with a particular review of locally based services in the Holbeck area.

e) That further work to publicise and promote the implementation of self directed support and personal budgets be championed through the scrutiny review of Personalisation.

f) That supply and demand of day care services be kept under close review with further reports as required.

(Under the provisions of Council Procedure Rule 16.5 Councillor Wakefield required it to be recorded that he abstained from voting on this matter)

CENTRAL AND CORPORATE

112 Financial Health Monitoring 2009/10 - Half Year Report

The Director of Resources submitted a report on the financial health of the authority after six months of the financial year in respect of the revenue budget and the housing revenue account.

RESOLVED –

a) That the projected financial position of the authority after six months of the financial year be note and that directorates be requested to continue to develop and implement action plans.

b) That Council be recommended to approve a virement in the sum of £1,000,500 from debt charge savings to fund the early leavers initiative.

(Under the provisions of Council Procedure Rule 16.5 Councillor Wakefield required it to be recorded that he abstained from voting on this matter).

113 Capital Programme Update 2009-2013

The Director of Resources submitted a report providing financial details of the 2009/10 month 6 Capital Programme position and proposing a small number of scheme specific approvals which had arisen since the 2008/09 – 2012/13 Capital Programme was approved in February 2009.

RESOLVED –

a) That the latest position on the general fund and Housing Revenue Account capital programmes be noted together with the fact that further work will take place with East North East Homes to clarify funding responsibilities.

b) That it be noted that the general fund capital programme now takes account of £1,000,000 of additional highways maintenance costs and £1,600,000 of Building Schools for the Future development costs in 2009/10.

c) That approval be given to the release of £844,000 from the Strategic Development Fund already earmarked for New Generation Transport to meet the Council's share of development costs in 2009/10.

d) That approval be given to the transfer of £50,000 from the capital contingency scheme to meet the development costs on the Accelerated Development Zones pilot scheme.

e) That the earmarking of the Wortley High School capital receipt to the Building Schools for the Future programme be approved.

f) That the injection of additional spend of £600,000 on the City Varieties Music Hall be approved.

(Under the provisions of Council Procedure Rule 16.5 Councillor Wakefield required it to be recorded that he abstained from voting on this matter).

114 Treasury Management Strategy Update 2009/10

The Director of Resources submitted a report providing a review and update on the Treasury Management Strategy for 2009/10.

RESOLVED - That the update on Treasury Management borrowing and investment strategy for 2009/10 be noted.

115 Gambling Act 2005 Statement of Licensing Policy

The Assistant Chief Executive (Corporate Governance) submitted a report providing an update on the review and public consultation of the Gambling Act 2005 Statement of Licensing Policy, and presenting the revised document for the purposes of the Board's recommendation to full Council.

The Assistant Chief Executive (Corporate Governance) reported the outcome of discussions at the meeting of the Scrutiny Board (Central and Corporate) on 2nd November 2009.

RESOLVED –

a) That having considered the responses to the consultation carried out, including the comments of Scrutiny Board given verbally at this meeting and the Final Consultation Report at Appendix 2, this Board endorses the proposed responses to the consultation exercise and recommends to full Council that these be approved as the Council's response to matters raised in consultation.

b) That the revised draft Statement of Gambling Policy as set out at Appendix 1 to the report be noted and that full Council be recommended to approve this as the final Policy under the Gambling Act 2005.

116 Council Business Plan 2008-11: Mid-Term Review and Refresh

The Assistant Chief Executive (Planning, Policy and Improvement) submitted a report outlining a number of proposed amendments to the Council Business Plan 2008-2011.

RESOLVED –

a) That the proposed changes to the Council Business Plan 2008-11 be approved.

b) That Council be recommended to approve these amendments at their meeting on 18th November 2009.

c) That the Chief Executive be authorised to review and update any performance targets for the final year of the plan.

ENVIRONMENTAL SERVICES

117 Revised Environment Policy

The Director of City Development submitted a report presenting for adoption the revised Environment Policy, clarifying the rationale behind the Policy and identifying the core elements and the links to the Leeds Strategic Plan, Eco Management and Audit Scheme (EMAS) and other requirements.

RESOLVED – That the revised Environment Policy at Appendix 1 to the report, which will be signed by the Joint Leaders of the Council and the Chief Executive, be approved for adoption.

DEVELOPMENT AND REGENERATION

118 Remediation of Gardens in the Meanwood Area - Contaminated Land Inspection Strategy

The Director of City Development submitted a report on a proposed scheme of remediation works to 41 properties in the Meanwood area to remove contaminated soil from all garden areas, to a minimum depth of 0.6m, and replacement with clean soil; the scheme to be funded by grant from the Department for the Environment, Food and Rural Affairs.

RESOLVED –

a) That approval be given to a fully funded injection of £1,375,503 into the 2009/12 Capital Programme from DEFRA government grant.

b) That approval be given to the incurring of expenditure of £1,375,503 on the construction works relating to the scheme.

NEIGHBOURHOODS AND HOUSING

119 New Social Housing in EASEL

The Director of Environment and Neighbourhoods submitted a report providing details of a new funding opportunity which would enable two of the EASEL phase 1 sites to be brought forward for the provision of new social housing.

RESOLVED –

a) That the construction of a 63 unit scheme within the EASEL area be authorised and that responsibility for the appropriate negotiations within

the funding approved in this decision be delegated to the Directors of Environment and Neighbourhoods, City Development and Assistant Chief Executive (Corporate Governance).

b) That approval be given to an injection into the capital programme of £7,089,000 and that expenditure in the same sum be authorised for the building of 63 new social houses which will be funded from £3,509,000 of Homes and Communities Agency grant and £3,580,000 prudential borrowing funded from the Housing Revenue Account.

CHILDREN'S SERVICES

120 Proposal for Expansion of Primary Provision in the Gildersome Area

The Chief Executive of Education Leeds submitted a report on a proposed consultation exercise with respect to permanently expanding Gildersome Primary School by one form of entry with effect from 2011, as part of the remodelling work planned through the Primary Capital Programme.

In presenting the report the Executive Member (Learning) corrected a reference to a recommendation of the report as contained in the Executive Summary by deletion of the reference to 2012 and its replacement with 2011.

RESOLVED –

a) That formal consultation be undertaken on the proposal to permanently expand Gildersome Primary School by one form of entry to two forms of entry with effect from September 2011.

b) That a report on the outcome of the consultation be brought back to the Board in Spring 2010.

121 Design and Cost Report - Boston Spa Children's Centre

The Acting Chief Officer of Early Years and Integrated Youth Support Service Leeds submitted a report outlining proposals with respect to the development of Boston Spa Children's Centre.

RESOLVED – That approval be given to the transfer of £468,900 from the Phase 3 Children's Centre Parent (capital scheme 14778) and £100,000 from the GSSG Extended Services Parent 2008-2010 (capital scheme 14777), £100,000 from GSSG Quality and Access funding, £60,000 Section 106 monies, £105,000 Area Management funding, £20,000 of Youth Capital funding and that authority be given to incur expenditure on construction £668,300, equipment £30,000, and fees £155,600.

122 Multi-function centre: Co-Location Capital Grant

(a) Design and Cost Report: 'Wyke Beck Community Centre' Co-Location Capital Grant 2009/10 – 2010/11

The Director of Children's Services submitted a report on the proposed injection of the £3,335,000 Co-Location Capital Grant funding into the Council's capital programme and seeking authority to spend the capital monies on the 'Wyke Beck Community Centre' scheme.

RESOLVED – That the injection of capital expenditure in the sum of £3,335,000 into the capital programme be approved and that authority be given to spend in the same amount as set out in section 3 of the report.

(b) Lease of Land Adjoining the David Young Academy

The Director of Children's Services submitted a report on a request received from the David Young Community Academy for a lease of land associated with the Co-location scheme referred to in (b) above.

RESOLVED – That the request from the David Young Community Academy to lease the additional land on the terms outlined in the report be agreed and progressed.

DATE OF PUBLICATION: 6th November 2009
LAST DATE FOR CALL IN: 13th November 2009

(Scrutiny Support will notify Directors of any items called in by 12:00 noon on 16th November 2009)

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