Leeds CITY COUNCIL

Originator: Ruth Mason
Tel: 206 4053

Report of the Making Leeds Better Programme

North East (Outer) Area Committee

Date: 11th December 2006

Subject: Making Leeds Better Progress Report

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

Council Function	x	Delegated Executive Function available for Call In	☐	Delegated Executive Function not available for Call In Details set out in the report	☐

Executive Summary

Making Leeds Better is the strategic programme for improving health and social care services in the city. The aim for the programme is:

"To improve the health and wellbeing of the people who use health and social services in Leeds by providing them with speedy access to high quality care and treatment that is response to their needs and provided in the best possible settings".

Recommendations:

1. Area Committee members are requested to note progress on Making Leeds Better

2. Area Committee members are asked to note the resolution of the NHS Boards on September 19th 2006

3. Area Committee members are asked to raise any questions, concerns or ideas that can be fed into the plans for Making Leeds Better

1. The Making Leeds Better Vision

1.1 Making Leeds Better is the city wide strategy for improvements and new services in health and social care. At the heart of this strategy is a vision for change which will bring benefits for patients, service users, carers and their families from Leeds and across the region.

The Making Leeds Better Vision

Our vision is for a future where people who need health and social care get the best possible care and treatment in modern facilities closer to their own homes.

Care and treatment that until now have only been available in hospitals will be provided by doctors, nurses and other health and social care staff working in the community.

Staff will be able to take advantage of the latest development in medical science and technology, and in clinical practice – free from the limitations of old buildings and outdated ways of doing things.

When people do need hospital care they will get it in modern facilities truly fit for the 21st century.

1.2 The Making Leeds Better vision is being achieved through a programme of work across a range of project areas. The programme has made significant progress. The purpose of this paper is to update members on that progress, and to ask members to note the joint resolution of the NHS Boards agreed on September 19th 2006.

1.3 A detailed working paper for each project is available on the Making Leeds Better website at www.makingleedsbetter.org.uk

2. Better care for children and adults

2.1 Making Leeds Better is about creating opportunities to look after people better and improve their health outcomes. By ensuring more effective use of resources across the city and reducing the inefficiencies inherent in delivering complex and specialist care from two hospital sites, Making Leeds Better will provide the platform for more investment both in primary and community services so that people can receive care more locally and in a new Children's & Maternity Hospital.

2.2 Our ambition for community-based care has been driven by a focus on care pathway development. This ensures that patients and clinicians benefit from a more systematic approach to providing care, which support safe, high quality and equitable care and treatment.

2.3 There has been detailed consideration of over 90 condition specific care pathways, through the significant involvement of clinicians, patient representatives and their carers, and other health and social care professionals.

2.4 We expect the result of the community developments to reduce emergency admissions to hospital by around 6,400 (about 8%) a year. In addition, around 115,000 outpatient visits (about 15%) and 55,000 diagnostic appointments (about

25%) that currently take place in hospital would be provided in community healthcare facilities by 2012.

3. Modelling capacity

3.1 A significant amount of work has been undertaken to model and plan the capacity required to deliver new models of patient care, in the long term. These models have factored in population change, the impact of new services such as intermediate care, the impact of patient choice, and a wider range of services that GP's will be able to offer in the future.

3.2 For community and social care services the modelling has concentrated on only the service changes identified, including the impact of the care pathways, movement of paediatric medical outpatients into community settings, and movement of some adult outpatients and radiology into community settings.

3.3 Capacity for hospital services has been modelled for a specified number of areas: inpatient and day case beds; operating theatres; outpatient clinics; the emergency department; and radiology. Areas of specific potential improvement have been identified. These include: the pooling of hospital beds, theatres and clinics to promote more flexible use of capacity; removing pre-operative stay so that patients come into hospital on the day of surgery; increasing the rates of day case surgery across all adult surgical specialties; reducing length of stay in line with best practice recommended by the new care pathways; assuming patients are discharged when they are fit rather than when it is convenient for staff; changing the new versus follow up outpatient appointment ratios for all consultants to the upper quartile performance in each specialty.

4. Developing the workforce

4.1 There are currently over 30,000 staff employed delivering health and social care services in Leeds – approximately 1 in 10 of the working population. The three largest MLB partner organisations – Leeds Teaching Hospitals Trust (LTHT), Leeds PCTs and Leeds Social Services – employ the majority of these staff, but Making Leeds Better will also impact, in differing degrees, on staff employed by primary care contractors (GPs, Dentists, Optometrists, Pharmacists), on those employed by Leeds Mental Health Services NHS Trust, and on staff employed in nursing and residential homes, in the voluntary sector, and on carers.

4.2 To deliver the investment in community services proposed by Making Leeds Better, it is expected that the numbers of community-based clinical staff will increase by around 35%. This takes account of additional staff needed to deliver the new care pathways and provide 'generic' services (such as intermediate care and rapid response) that support the Making Leeds Better aim of caring for people close to or in their own homes; projected staffing levels have also been increased to the national average, to counter the historic under investment in community services in Leeds. The increased numbers in community staff would not apply equally across all staff grades: the expectation is to see staff in specialist grades supported by more staff in 'lower' grades with NVQ type qualifications.

4.3 For LTHT, it is expected that staffing numbers will change to reflect the increased investment in community-based services and the centralisation of hospital services on the St James's site. Although there will be fewer hospital beds needed in future as more patients are cared for in community settings, the level of need of patients cared for in hospital will be proportionately greater. Overall, it is predicted that, by caring for more patients in community settings and delivering hospital services more efficiently on a main hospital site at St James's, fewer staff would be needed in the hospital sector.

4.4 It is expected that most of the new community workforce will be created by training and developing staff currently employed in the Leeds health and social care economy. Some of the new skills required will be relatively straightforward, for instance requiring the provision of specific training in a technique or procedure; others will require more substantial action. Training programmes may be required to enable staff to adopt entirely new roles – for instance, Midwifery Support Workers may be recruited from the existing workforce, but will need an extensive training programme to develop them. Some staff will need to relocate, such as where services currently being provided in hospital settings move fully to community based facilities. Given that the changes proposed by MLB are to take place over a period up to 2012, it is expected that any workforce reductions to be managed through natural turnover or deployment of staff.

5. Children's and Maternity hospital

5.1 Detailed modelling work on the bed, theatre and outpatient clinic capacity needed in LTHT has been carried out. Beds have been grouped into pools of similar specialties for bed management purposes, allowing more flexible use and further reducing the overall number. The modelling has assumed that most hospital outpatient activity, therapy support and diagnostics will take place away from the proposed single acute site at St James's. The configuration of clinical specialties by site has then been reviewed to identify which clinically appropriate estate option gives the best opportunity for an affordable solution from a workforce and estates perspective. At this stage, a variant on the original Strategic Outline Case (SOC) proposal best meets these criteria because it maximises the use of existing buildings, provides the minimum new build requirement and maximises potential savings by reducing workforce costs (by reducing on call, rotas and duplication of services).

5.2 The SOC variant option proposes a single acute site at St James's, with new build for children's & maternity, cardiac & neurological services, and A&E. The Jubilee Wing at LGI, part of the Seacroft site and Wharfedale Hospital would continue to be used. However, compared with the original SOC option, it is proposed to provide more hospital services from St James's and the Jubilee Wing, with orthopaedic services transferring from Chapel Allerton to the Jubilee Wing, and most of Seacroft and Chapel Allerton being available for community-based facilities.

6. Cost and affordability

6.1 The MLB affordability modelling assumes that PCT growth is fully committed in future years and that any developments in primary, community and social care services will need to be funded by resource transfer from hospital care or from internally generated efficiencies. The modelling indicates that £37m could be transferred from acute care to community health and social care services. More work is required to model the impact for community based services however initial work indicates that the programme is broadly affordable.

6.2 The approach to costing community services has been to work up the additional cost of delivering community services in the future, taking into account the proposed shifts in services from LTHT and care pathways. Affordability is then determined by comparing PCT resources available through disinvestments in LTHT services.

6.3 Based on the expectation that LTHT's income will reduce by £37m (at 2006/07 levels) as a result of activity being shifted to community-based settings, efficiency savings in community provider services of around £5 million are needed between 2006/07 and 2012/13 for the MLB proposals to be affordable. This represents a 3.3% cost reduction from the future estimated community services cost of £152 million. This level of saving should be achievable over the medium term, and actions are already being taken to begin an external review of community provider services, which should generate efficiency savings through a range of productivity measures.

7 Engaging stakeholders

7.1 To facilitate engagement, MLB stakeholders have been organised into four stakeholder groups. These groups are shown in the table below, along with an explanation about how MLB has engaged with them.

Group	Consists of	Engaged through
Public & Patients	▪ Patients. ▪ General public. ▪ Voluntary, community and faith sector organisations. ▪ 10 identified communities of interest; women; children; older people; carers; black & minority ethnic communities; people with disabilities; users of mental health services; lesbian, gay, bisexual, transgendered people; gypsies and travellers; homeless people ▪ The media.	▪ Involvement of specific patient groups and members of relevant Expert Patient Programmes in development of care pathways. ▪ Events and activities targeted at other patients, service users and voluntary sector organisations. ▪ Work via lead organisations to reach and involve the communities of interest. ▪ Communications strategy, including a media campaign and use of the Making Leeds Better website to reach and involve members of the general public.
Staff, including Clinicians	▪ Staff, including clinicians, of the seven Leeds health trusts. ▪ Local Authority social care staff. ▪ General Practitioners (GPs). ▪ Other independent contractors: pharmacists, optometrists, dentists. ▪ Relevant academic staff of the two Leeds universities.	▪ Involvement in driving development and implementation of care pathways. ▪ Clinical Leadership & Engagement Group for Clinical Champions ▪ Staff newsletters. ▪ Open meetings, roadshows and events. ▪ Health Impact Assessments.

Group	Consists of	Engaged through
Democratic	▪ Health & Adult Social Care Overview & Scrutiny Committee (OSC). ▪ Leeds City Council (LCC) leadership. ▪ Leeds City Councillors (through Area Committees). ▪ Members of Parliament (MPs). ▪ Members of Leeds Initiative Executive Boards. ▪ District Partnerships. ▪ Community Forums.	▪ Visits, presentations and progress reports to meetings of the Area Committees, Leeds Initiative Boards, District Partnerships etc. ▪ Personal briefings to MPs and LCC leadership. ▪ Formal scrutiny by Health & Adult Social Care OSC. ▪ Involvement of West Yorkshire Scrutiny Chairs in scrutiny process.
Outside Leeds	▪ Cardiac Services Network, Cancer Services Network & Specialist Obstetrics and Paediatric Services. ▪ West Yorkshire PCT Chairs, Chief Executives Forum & Commissioning Group. ▪ PCTs in North East Yorkshire & Northern Lincolnshire that border Leeds metropolitan district. ▪ Members of Parliament for constituencies that border Leeds.	▪ Regular presentations and progress reports to meetings of key groups such as West Yorkshire PCT Chairs. ▪ Briefing for West Yorkshire Chief Executives on the emerging Strategic Services Plan for Leeds. ▪ Involvement of West Yorkshire Scrutiny Chairs in scrutiny process.

7.2 As the MLB proposals clearly involve a substantial variation and development of health services in Leeds, local NHS organisations have a statutory duty to consult patients and the public on its proposals. The MLB approach is to develop options for change with people and not for them, starting from the patient experience and working with staff to develop new ways of working. In taking a whole system view the contribution of all health and social care providers has been explored, and providers are working together to build a sustainable solution for the whole community. It is this solution that will be the subject of public consultation in 2007.

8 NHS Board resolution

8.1 On Tuesday 19 September 2006 all seven statutory NHS Boards in Leeds reviewed the progress and outputs to date of Making Leeds Better in a "Board of Boards" meeting. The Boards met in the same location to discuss a single agenda item.

8.2 The meeting began with presentations to all Board members in plenary. These briefly outlined the PCT commissioning and Local Authority strategic context, and then described in some detail the work undertaken to demonstrate that the Making Leeds Better proposals for the development of community based services and the building of a new Children's and Maternity Hospital are broadly affordable.

8.3 Following the presentation in plenary, each statutory Board met separately in public and passed a series of resolutions in respect of the Programme's work. The seven NHS Boards agreed the following joint statement at the conclusion of the meeting:

"Members of the seven NHS Boards in Leeds have resolved that the vision set out in Making Leeds Better concurs with and builds upon the Government's new direction for the health and social care system, and that the delivery of that vision will offer significant additional benefits to patients, service users and local communities. The Boards are committed to achieving that vision.

The Boards are assured of the scope, quality and outputs of the work undertaken to date and agreed it as a robust base from which to develop more detailed service proposals for public consultation and an outline business case for capital development."

9 Recommendations

- Members are asked to note the progress on Making Leeds Better
- Members are asked to note the resolution of the NHS Boards on September 19th 2006-11-10
- Members are asked to raise any questions, concerns or ideas that can be fed into plans for Making Leeds Better.