Public Document Pack

Supplementary information for Scrutiny Board Health and Wellbeing and Adult Social Care meeting – 25th January 2012:

Draft Leeds Tobacco Action Plan – (agenda item 7)

Major Trauma in Yorkshire – additional information (agenda item 9)

Review of Children's Neurological Services – additional information (agenda item 10)

This page is intentionally left blank

Draft Leeds Tobacco Action Plan

Version: 17th January 2012 (Version 5 (4))

Strategic Priority 1	H&W Board Sponsor – Ian Cameron
Help protect people from the harmful effects of tobacco.	**Delivery Lead: Brenda Fullard**

Performance Indicator

Reduce the prevalence of the adults over 18 who smoke from 23% to 21% by 2015

Priority Actions

Priority Action 1 – Establish an infrastructure to achieve comprehensive tobacco control

Action	Targeting	Action Owner	Contributing Officers	Milestone or Target
Establish a tobacco control management group to address tobacco control through strategic multi-agency partnership working, senior level accountability and a dedicated resource	Tobacco plan action owners	Brenda Fullard: NHS	Heather Thomson: NHS Elizabeth Bailey: LCC	Developed, implemented, monitored and performance managed Leeds tobacco action plan in place

DRAFT

Draft Leeds Tobacco Action Plan

Version: 17th January 2012 (Version 5 (4))

Maximise influence on national, tobacco industry and local policy by building a tobacco control alliance that involves both the public and organisations	Council officers; local businesses; schools and colleges; children and youth groups; local councillors/MPs; NHS providers including coronary care, maternity respiratory and mental health services; Trading Standards officers; Environmental Health officers; HM Revenue & Customs; police; fire and rescue services; civil society groups	Brenda Fullard: NHS	Heather Thomson: NHS Elizabeth Bailey: LCC	Tobacco control alliance advocacy, engagement and communication plan in place
Measure return on investment of tobacco control actions		Specialist Public Health Registrar (TBC)	Heather Thomson: NHS Brenda Fullard NHS Elizabeth Bailey: LCC	Report completed by July 2012

DRAFT

Draft Leeds Tobacco Action Plan

Version: 17th January 2012 (Version 5 (4))

DRAFT

Develop and implement communications and advocacy programme that cuts across all priority actions in the tobacco action plan		Paul Lambert	Tobacco control management group, tobacco alliance	Stakeholder mapping and management exercise completed Annual programme agreed and aligned with national tobacco campaigns
Establish a central point / team for data collection and information to support tobacco control work		Nichola Stephens	Frank Wood James Womack Adam Taylor Heather Thomson All action owners	Established systems for collection of data to evidence progress against target and completion of report cards
Ensure comprehensive collection of information and data on smoking status of patients attending GP practices	GP practices	Nichola Stephens	James Womack Heather Thomson	Timely data collected on a quarterly basis
Priority Action 2- Preventing the uptake of smoking				
This priority action will incorporate the following strands of the national tobacco action plan: • Stopping the promotion of tobacco • Making tobacco less affordable • Effective regulation of tobacco products • Effective communications for tobacco control				
Action	**Targeting**	**Action Owner**	**Contributing Officers**	**Milestone or Target**

Draft Leeds Tobacco Action Plan

Version: 17th January 2012 (Version 5 (4))

Support retailers to implement the legislation on removal of tobacco product displays	Retailers citywide	Trading standards - officer to be confirmed (TBC)	TBC	All large retailers no longer displaying tobacco products by April 2012 All smaller retailers no longer displaying tobacco products by xxxx 2015
Scrutinise arrangements for public events to identify and address covert tobacco industry promotions.	TBC	Trading standards - officer TBC	TBC	TBC
Raise awareness of magistrates of the social, health and economic impact of sales to under 18s to encourage maximum penalties.	Magistrates	Trading Standards- officer to be confirmed (TBC)	TBC	TBC
Introduce programmes to tackle retailers selling tobacco to under 18s	Retailers within specific areas of high smoking prevalence Retailers who are situated with walking distances of high schools	Trading Standards- officer to be confirmed (TBC)	TBC	Reduce the percentage of retailers who when tested sell tobacco to under 18s

DRAFT

Draft Leeds Tobacco Action Plan

Version: 17th January 2012 (Version 5 (4))

Roll out a schools based social norms programme to prevent the uptake of smoking among young people subject to evaluation of pilot due June 2012.	Children in school year 8 within specific areas of high smoking prevalence	NHS ABL: Gemma Mann	University of Leeds NHS ABL Education Leeds Space 2	TBC
Engage young people in advocacy on health and environmental impacts of tobacco, linking with the Child Friendly City strategy	Children and young people	Child Friendly City: Officer TBC	Paul Lambert: NHS Gemma Mann NHS Youth Agency	Increase in the number of local children's voices on tobacco
Work with regional network of Directors of Public health to increase levels of activity on counterfeit and smuggled tobacco		Ian Cameron: NHS	Regional DPHs, HMRC, police, trading standards	TBC

DRAFT

Draft Leeds Tobacco Action Plan

Version: 17th January 2012 (Version 5 (4))

Action	Targeting	Action Owner	Contributing Officers	Milestone or Target
Create better links between regulatory partners so that inspectors "eyes and ears" can be used to enhance referrals of illicit tobacco found in premises		Graham Wilson: LCC Environmental Health/ Trading standards officer (TBC)		Evidence of environmental health linked to trading standards more effectively
Priority Action 3– Helping tobacco users to quit				
This priority action will incorporate the following strands of the national tobacco action plan: • Helping tobacco users to quit • Effective communications for tobacco control				
Action	**Targeting**	**Action Owner**	**Contributing Officers**	**Milestone or Target**
Commission cost effective stop smoking services for Leeds in line with evidence and best practice	Communities with high prevalence of smoking, pregnant women, smokers with long term mental/ physical health and wellbeing conditions	Heather Thomson: NHS	Brenda Fullard: NHS Karen Haw : LCHC	Standards commissioned services assure consistent quality across Leeds
To raise the standards of commissioned services to assure consistent quality across Leeds	All service providers	Heather Thomson NHS	Paul Lambert Leeds NHS Stop Smoking Service	All service providers will have achieved NHS Centre for Smoking Cessation and Training certification by March 2013

DRAFT

Draft Leeds Tobacco Action Plan

Version: 17th January 2012 (Version 5 (4))

Work with health and social care providers to establish systems to support the delivery of stop smoking interventions in a range of settings	Adult smokers, specifically those form routine and manual groups, and vulnerable groups. Referrers to smoking cessation services, particularly those working in health and social care	Heather Thomson NHS	Leeds Let's Change project team: Leeds NHS Stop Smoking Service	Increase the number of interventions delivered and referrals to stop smoking services
Deliver training to increase the number and confidence of frontline staff to be able to identify smokers who may wish to quit and provide advice and signposting to services	Adult smokers, specifically those form routine and manual groups, and vulnerable groups. Referrers to smoking cessation services, particularly those working in health and social care	Heather Thomson NHS	Leeds Let's Change project team: Leeds NHS Stop Smoking Service	Increase the number of frontline staff who are confident to deliver brief interventions for smoking cessation
Ensure referral to for smoking cessation support is integrated into long term condition care pathways	Adult smokers on LTC registers	Heather Thomson NHS	Lucy Jackson(TBC)	Increase in the number of patients on LTC registers accessing smoking cessation support

DRAFT

Draft Leeds Tobacco Action Plan

Version: 17th January 2012 (Version 5 (4))

Ensure midwives receive training and development to identify pregnant women who smoke and deliver effective interventions.	Pregnant smokers	Sharon Yellin: Public Health, NHS	Karen Haw: Leeds: NHS Stop Smoking Service LCH, Heather Thomson: NHS Head of Midwifery: LTHT Jane Mischenko: NHS Commissioning	Increase the number of pregnant women accessing smoking services Full implementation of NICE Guidance for smoking in pregnancy
Increase priority access to stop smoking services within Leeds Early Start Service	Babies born to families living in deprived areas of Leeds and families with complex needs e.g. substance misuse, mental health, offenders, teenage parents/carers	Andrea Richardson: LCC	Jane Mischenko: NHS Commissioning, Sam Prince: LCHT Sal Tariq: LCC Sue May: LCC Heather Thomson: NHS	Clear service entitlement across health, early education and family support for families at risk
Develop a workplace programme to reduce the number of employees who smoke	GPCCs, LCC, LTHT, LPFT, LCHC, alliance partners who are employers and commercial sector	Dawn Bailey : NHS	Leeds NHS Stop Smoking Service Lorraine Shuker: NHS Chris Ingham: LCC Lisa Mallinson: LCC Jane Hopkins: LCC LTHT LPFT LCHC GPs	Increase in the number of Boards of local organisations signing up to prioritise tobacco policies and support staff to stop smoking

Draft Leeds Tobacco Action Plan

Version: 17th January 2012 (Version 5 (4))

Support smokers who wish to quit smoking without using services	Adult smokers in neighbourhoods with high smoking prevalence	Heather Thomson: NHS	Third Sector, Pharmacists,	More clinically effective and value for money options available and promoted to increase quitting without services
To develop a community social norms programme to promote smoke free as the norm	Adult smokers in neighbourhoods with high smoking prevalence	Paul Lambert NHS	Heather Thomson Space 2	Pilot currently being delivered in Seacroft, evaluation due June 2012. Develop roll out plan if effective
Increase the number of people who are aware of stop smoking services through the Multi-agency Referral Scheme (MARS)	Localities with higher levels of infant mortality, integrated health and ASC projects, people receiving home insulation visits	Bash Uppal: LCC	Brenda Fullard: NHS, Karen Haw: LCHC, Elizabeth Bailey: LCC, Public Health Neighbourhoods team: NHS	Increase in the number of people who attend stop smoking services as a result of MARs
Implement a communications plan on risks of tobacco use and how to quit	Adult smokers in neighbourhoods with high smoking prevalence	Heather Thomson NHS	Leeds Let's Change project team: Leeds NHS Stop Smoking Service	Increase in the numbers of people accessing Stop Smoking Services
Priority Action 4 – Protecting the population from the environmental impacts of tobacco				
This priority action will incorporate the following strands of the national tobacco action plan: • Reducing exposure to second-hand smoke • Effective communications for tobacco control				
Action	**Targeting**	**Action Owner**	**Contributing Officers**	**Milestone or Target**

DRAFT

Draft Leeds Tobacco Action Plan

Version: 17th January 2012 (Version 5 (4))

Respond to complaints about premises which are not smoke free	Citywide workplaces and hospitality establishments	Graham Wilson: LCC Environmental Health		
Lobby government to change and make the smoke free legislation enforceable	National policy makers	Graham Wilson: LCC Environmental Health	Leeds Tobacco Alliance	
Annual reminder letter on the smoke-free legislation requirements	All premises which are believed to encourage smoking on site.	Graham Wilson: LCC Environmental Health		
Develop a community social norms programme to promote smoke free as the norm	Middle Super Output Areas (MSOAs) with the highest prevalence of smoking	Paul Lambert NHS	Heather Thomson Locality Health Improvement Managers: LCC (TBC)	
Integrate smoke free homes programme into wider community initiatives e.g. home fire checks and family and children's programmes	Families living in areas of high smoking prevalence	Gemma Mann: NHS	West Yorkshire Fire ad Rescue Service Early years Children's Centres ALMOs	Increase in the numbers of homes that pledge to be smoke free

DRAFT

Draft Leeds Tobacco Action Plan

Version: 17th January 2012 (Version 5 (4))

Investigate the use of a voluntary compliance approach to reduce smoking in outdoor family areas	LCC children's play areas, school grounds, areas around schools	Environmental Health - officer to be confirmed (TBC)	Paul Lambert NHS	Increase in the number of enforced designated smoke-free outdoor areas
Include actions on tobacco control within the delivery of West Yorkshire Fire and rescue fire prevention and protection programme (TBC)		Sarah Laidlow-Moore: West Yorkshire Fire and Rescue Service (TBC)		Reduce the incidence of smoking related fires

DRAFT

This page is intentionally left blank

MAJOR TRAUMA IN YORKSHIRE AND THE HUMBER: ADDITIONAL INFORMATION FROM LEEDS TEACHING HOSPITALS NHS TRUST

Leeds Teaching Hospitals Trust

Y&H Major Trauma Network information requested by Leeds Health Scrutiny Board 25th January 2012

Overview

- Establishing a major trauma network is mandated by the NHS Operating Framework 2010-11 and the NHS has therefore been committed to change by the Secretary of State for Health and Parliament.

- **Leeds Teaching Hospitals Trust (LTHT) board are committed in principle to supporting this designation** as it will clearly benefit critically ill patients to be treated at LGI, but the board has a duty to ensure that other services and patients are not adversely affected if we are chosen to host the Major Trauma Centre.

- We are still in negotiation about how the NHS can best mitigate the impact of this change. It will require us to find extra capacity at an already busy City centre hospital and extra money to cope with that changing demand. We are hopeful of reaching agreement soon.

Background

The major trauma programme was established in 2009 and has involved all NHS organisations in the region, coordinated by NHS Yorkshire and the Humber. Patients, charities and stakeholders are engaged in the process. The proposals have evolved and they continue to change as issues are addressed in detail and we move, in West Yorkshire, towards opening the network in April (phase 1).

Major trauma data is incomplete and therefore providing definitive major trauma patient numbers is difficult. We have undertaken *activity & financial modelling* work based on the best data available to provide a sensible best estimate. The Regional NHS approach is designed is phases so that changes to patient flows are in (as much as possible) aligned with the available capacity within major trauma centres and do not compromise local trauma services.

LTHT have discussed with the Strategic Health Authority the level of public engagement required which has, to date been co-ordinated at this level by Strategic Commissioning Group (SCG) of Primary Care Trusts. For the West Yorkshire network the main patient movement will be from the surrounding Trauma Units to Leeds General Infirmary.

LTHT is trying to manage this change be ensuring that this increase in complex workload is matched by sufficient capacity to cope so we avoid any impact on Leeds's own trauma patients. To mitigate any risks from activity change a network will actively coordinate existing services with a Trauma Co-ordination team repatriating patients back to local trauma units (based in the District General Hospital's of the Region) as soon as their initial treatment has been completed –

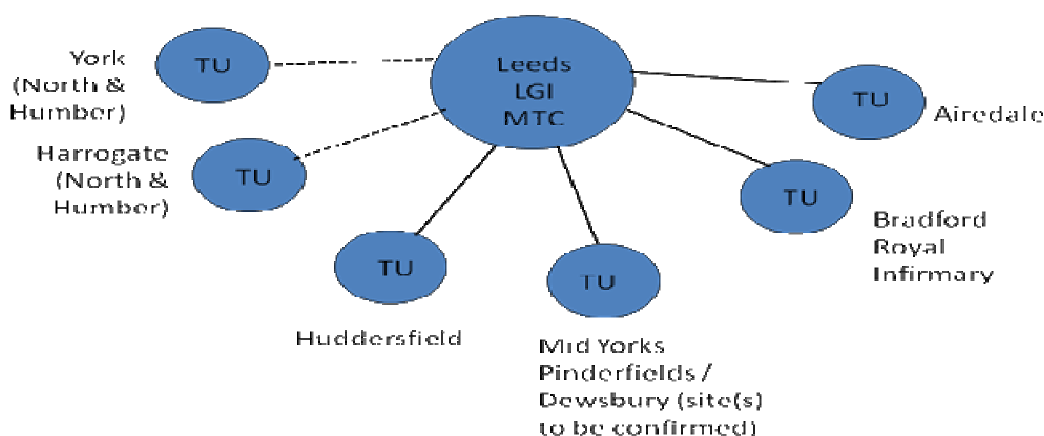
our working assumption is that patients will probably spend the first seven days of their treatment in LGI - though this will depend on the severity of their injury.

This development for West Yorkshire does not see services decommissioned. And, whilst the change to outcomes for an individual patient could be dramatic (return to fully able life rather than life changing disability), the NHS across England does not view this as “significant change” to service.

Specific information requested by Leeds OSC

Details of the proposed networks / patient flows - including projected patient numbers

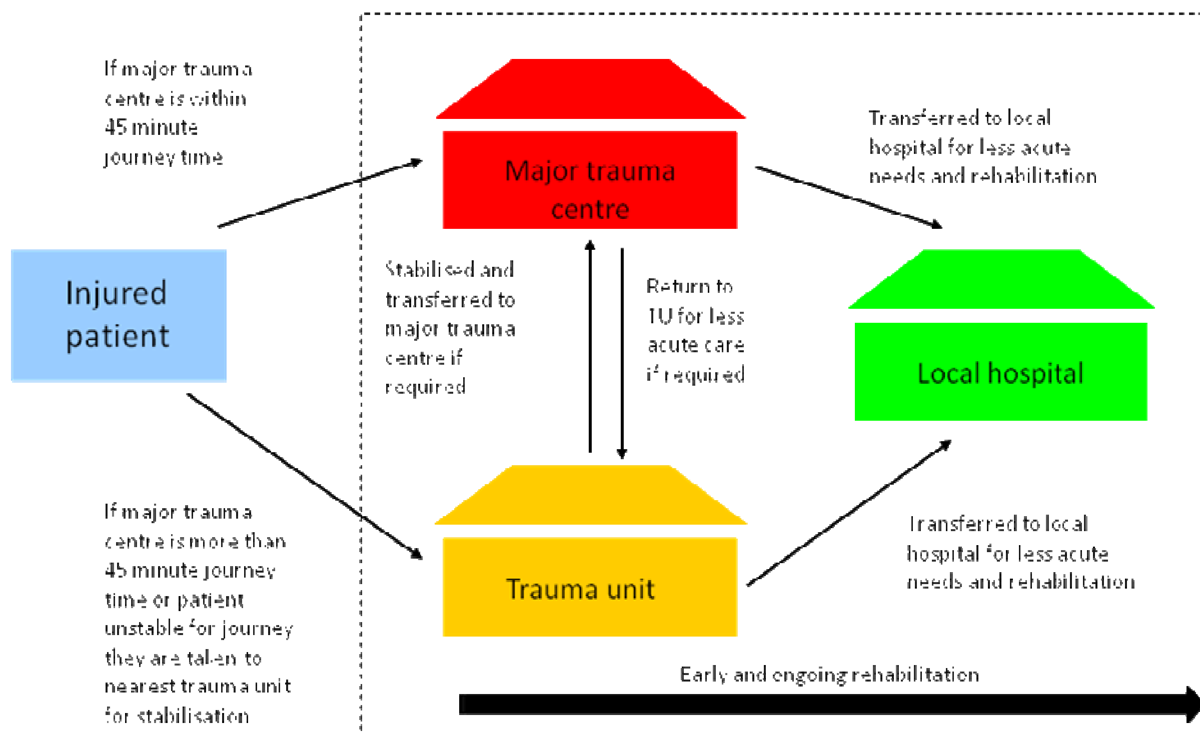
The West Yorkshire network has LGI as the Major Trauma Centre (MTC) with a number of Trauma Units (TUs) in the district general hospitals surrounding the city.



Details on the implications / benefits for patients

What will the network mean for patients who sustain major trauma?

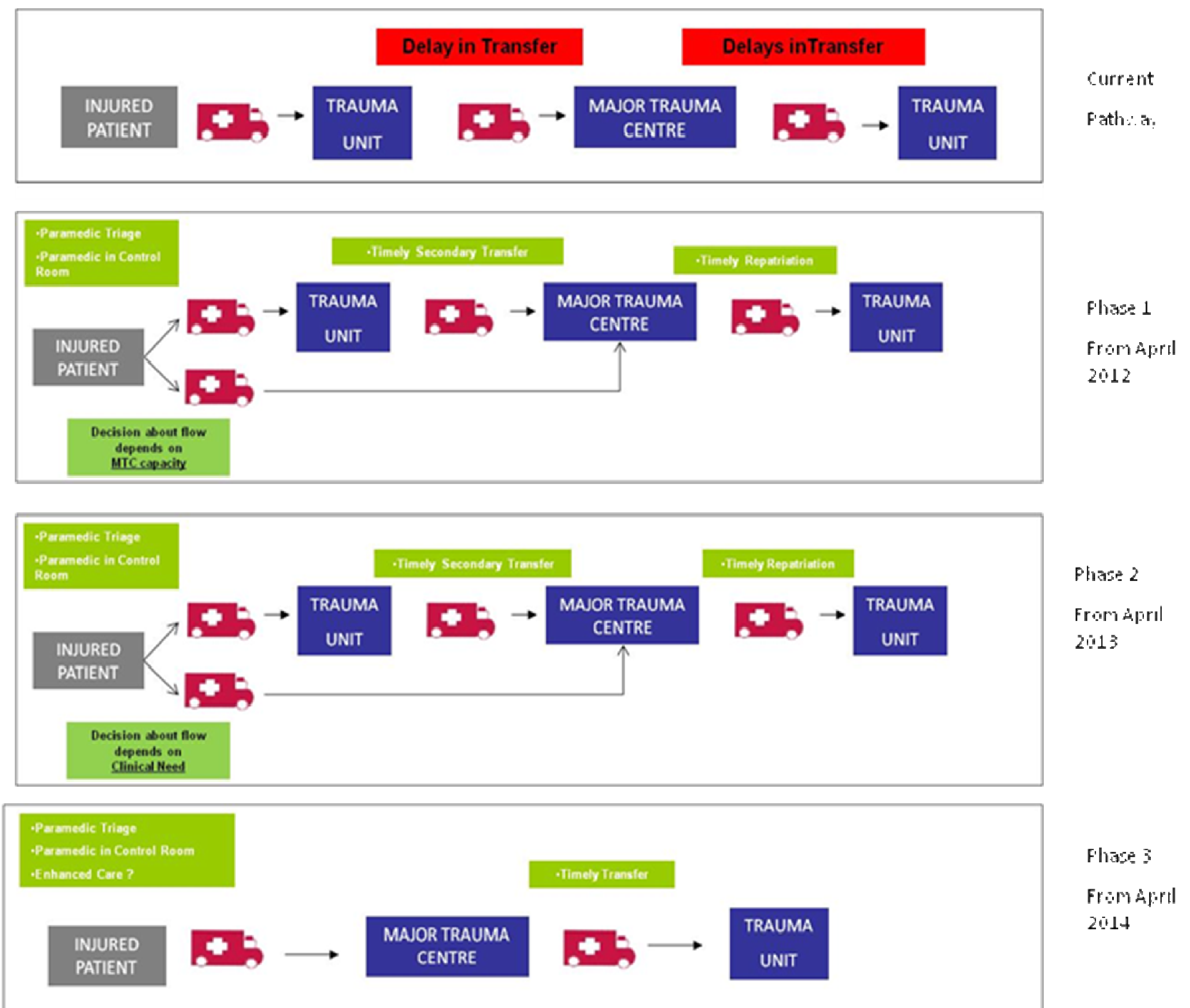
- Major trauma patients will be assessed immediately and taken directly to the Major Trauma Centre. If they arrive first at a Trauma Unit (TU) there will be no delay in transferring them to receive the specialist care they require. Many of these patients will currently be taken to a major trauma centre, but only after having initially being taken to their local hospital and then potentially delayed waiting for tests and a transfer for the more specialist care they urgently require
- As soon as it is clinically appropriate to do so patients will be transferred back to their local hospital for follow up care and to begin their rehabilitation. Our working assumption on this is up to seven days at LGI.
- The impact of this improved coordination will mean quicker diagnosis and specialist treatment for patients resulting in a better change of avoiding death or long-term disability and access to highest grade of treatment available in the Region’s Teaching Hospital.



A phased approach will be taken to implementation to help ensure that demand meets capacity within the system.

The phasing described in the diagram below will run from 1 April 2012 to 2014. It is proposed that phase 1 commences in April 2012 with the implementation of a senior paramedic in the ambulance control room who will liaise directly with the paramedic on scene and the Major Trauma Centre to determine the clinical needs of the patient and the most suitable destination based on an assessment of clinical condition and Centre capacity.

As a result of these changes small numbers of extra patients are expected in the first phase. The main impact of this phase is to bring patients who already access the facilities of Leeds earlier in their pathway and repatriate them to local hospitals in a timely manner. Funding does remain an issue which needs agreement, however, we remain committed in principle to supporting the move to centralisation is this is at all possible and believe that an equitable solution can be found before we move to full implementation.



By introducing a major trauma network we will:

- **Significantly improve the numbers of major trauma patients making a recovery to a "non-dependent" life.** Currently 75% are left with a significant long-term disability.
- **Save lives** (an estimated 15% reduction in lives lost), in Yorkshire and the Humber we estimate that we can save an additional 30 lives a year (Source: Cost Effectiveness of Regional Networks for Major Trauma in England 2011)
- **Improve access to specialist services regardless of where in the region** they are injured – reducing variations in treatment and outcomes
- **Reduce Length of Stay** (LOS) by an estimated 4 days due to earlier transfers, more rapid and definitive care and fewer complications (Source: NCEPOD Regional trauma system guidance for commissioners 2009)
- **Improve access to rehabilitation services for all**

Details on the likely impact on other LTHT hospital based services

Modelling from the Yorkshire & Humber Observatory (YHO) indicates an annual shift of 521 major trauma patients from the TUs to LGI, an increase of 68%, taking the total number of major trauma patients treated in Leeds from 758 to 1279 a year.

The 758 patients LGI currently treats in a year include patients that are currently received as secondary transfers from other trusts within the sub-region. It is likely that a proportion of the additional 521 patients would also have been received by LTHT as secondary transfers from other trusts.

However, there are concerns over the accuracy of the modelling and the impact of over-triage (patients diverted to the MTC from scene of incident when their injuries do not require this level of intervention) has yet to be fully understood. Experience from London suggests for every major trauma patient, two more suspected MT patients arrive in the Emergency Department who thankfully do not require MT specialist care. The unanticipated impact of these patients could have a significant impact on the Emergency Department, plus have a knock-on effect on other services as these patients are treated before being sent to their local Trauma Unit. The sub-region will therefore work very closely with Yorkshire Ambulance Service (YAS) during phase 1 to understand and mitigate the impact.

LTHT are establishing the Clinical Governance / Quality Improvement programme for the sub-region, with the first meeting scheduled for January 2012. During this phase, preparatory work will be undertaken to ensure the network is ready for direct transfer of patients and also improve the current provision of major trauma care for patients that are already transferred between trusts as secondary transfers.

Monthly meetings for clinicians and managers will focus on:

- Development of cross organisational patient pathways that ensure timely and efficient secondary transfer and repatriation
- Development of protocols that ensure consistent clinical management and improved patient experience
- Development of Key Performance Indicators
- Cross organisations clinical governance meetings, analysis of morbidity and mortality, outcome data
- Establish data capture to inform Activity and Finance monitoring
- Establish sub regional infrastructure to support the management of the Major Trauma Network.

It is proposed that from April 2012 we will receive direct transfers to Leeds General Infirmary (LGI) based on clinical need. We have a way to go to reach agreement about this with our commissioner. There is still a disagreement about the number of patients we can realistically treat. The level of clinical need is yet to be determined and until this is, there is a risk to this phase.

We believe that in the first phase this will be a small number of patients with severe major trauma, such as head injuries, who would probably already be transferred to LGI as secondary transfers under the current model.

From April 2012 LTHT will also accept secondary transfers from Trauma Units (TUs) within 2 days of initial request. As stated previously, LTHT already receive a number of major trauma patients from local TUs as secondary transfers. The requirement to receive them in a timely manner will make having robust repatriation and discharge protocols in place critical to avoid having a negative impact on LTHT's ability to manage existing activity; this work will be developed through the Clinical Governance / Quality Improvement Forum.

Early calculations about what it will cost to implement the phase 2 suggest that LTHT could need to find up to £5.3 million above the tariff being currently offered for this service. Phase 3 extends this to the provision of comprehensive long-term rehabilitation which, so far, has not been accounted for in any of the financial modelling.

There will also be financial pressures felt by Trauma Units (based in the district general hospitals in the rest of West Yorkshire) if they lose activity but are unable to remove any of their fixed costs there will be financial consequences.

LTHT and the rest of the Western sub-region network have therefore only agreed to progress to phase 2 once the financial issues are resolved. Moving into this phase will require agreement by all Trust Boards within the sub-region.

LTHT board are committed in principle to supporting this designation as it is the best thing to do for critically ill patients, but we also must ensure that our other services and patients are not adversely affected.

Impact on other related services and/or organisations (e.g. YAS, Embrace)

- We have been informed that an analysis of the ambulance service business case for implementing the major trauma network has been undertaken and a "confirm and challenge" process, led by senior managers and clinicians has tested the plans.
- YAS do want consistency in approach across their operating region - we support this call.
- The Network structures are being designed to ensure a whole system view is taken into account allowing any cross boarder issues to be identified and addressed early than at present.

Leeds Teaching Hospitals Trust

January 2012

CHILDREN'S NEUROLOGICAL SERVICES: ADDITIONAL INFORMATION FROM LEEDS TEACHING HOSPITALS NHS TRUST

Leeds Teaching Hospitals

Children's Neurosurgery Review

Information provided for the Leeds HOSC re the above as at 16th January 2012.

Service Profile - The service based at the Leed's Children's Hospital, LTHT delivers care to approx 2,500 children per annum.
This service provides 500 day case and inpatient operations/procedures and supports 2,000 outpatients per year.

1) Timetable

The timetable for the review is currently unclear and has not been made generally available. The most recent Newsletter stated Spring 2012 for the start of implementation.

1.1) History to date:

Over the course of the review there are three distinct work streams that have evolved. The first is the proposal to establish Children's Neurosurgical Networks, the second is the need to provide additional complex epilepsy surgical treatments supported by strong multi-disciplinary team assessments, and the third is establishing a national/regional multi-disciplinary team review to agree the clinical plan for rare and complex Brain Tumours which would support treatments provided in centres across the country. Detail of these work streams is provided within this briefing.

Safe and Sustainable first published draft standards in November 2009. Yorkshire and Humber OSC were invited (and attended) an engagement event on 30 November 2009. OSC's were asked to provide comments on the draft standards.

2010 - The Model of Care Group was established to develop exemplar pathways and standards for brain tumour, brain trauma, hydrocephalus, spinal dysraphism and epilepsy

2010 - Steers and Stower undertook a fact finding visit of the current children's neurosurgical centres and published a report.

November 2010 - Parents interviews and workshops were held around the country and report published with key findings.

November 2010 - A clinical workshop was held to agree the model of care and pathways held in November

June 2011 - The Steering Group agreed the circulation of two documents for comments from Professional organisations

- Children's Neurosurgical Services in England: A Framework for the Future
- Children's Neurosurgery - draft service specification standards May 2011

These documents have been amended and are due for wider circulation and comment in January 2012 - these have not been received as yet.

1.2) Epilepsy Procurement

The Advisory Group for National Specialised Services (AGNSS) has agreed the case made for commissioning additional complex epilepsy surgical treatments supported by strong multidisciplinary assessment teams. The process for procuring these services is currently underway with recommendations for national designation being made to AGNSS in February 2012.

Leeds submitted a joint consortia bid with Sheffield and Newcastle against the Epilepsy procurement - this was successful at Stage 1 but unfortunately did not progress beyond Stage 2. The parties in the consortia withdraw the bid as we could not agree on all aspects of the bid.

This does mean that pending the recommendations from AGNSS in February that children and families from Leeds and West Yorkshire may have to travel outside of the Yorkshire and Humber region to access complex Epilepsy surgery.

2) Profile of service users

The Children's Neurosurgical review encompasses children from 0-18 years, (up to the 19th birthday). Some aspects of the review do include antenatal diagnosis. The review focuses on 4 main patient pathways;

- Hydrocephalus
- Brain Tumours
- Epilepsy
- Brain Trauma

The average length of for a patient undergoing care for a Neurosurgical condition is 3.4 days. However much of the child's care is undertaken by the Paediatric Neurologists and the extended multidisciplinary team, whereby there are much longer pathways involved for children and their families. The inpatient aspect of care can for example many months in the case of children undergoing rehabilitation following brain trauma.

3) Access to services

Currently there are services based in;

- Leeds Teaching Hospitals NHS Trust on the Leeds General Infirmary site
- Sheffield Children's Hospital NHS Foundation Trust and Sheffield Teaching Hospitals NHS Foundation Trust Royal Hallamshire Hospital site.
- Hull and East Yorkshire NHS Trust Hull Royal Infirmary site. The numbers of Paediatric Neurosurgical operations undertaken in Hull are very small and SCG have advised that the service in Hull should not be viewed as a stand alone service. The Hull service is strategically aligned to the Leeds service.

4) Numbers and patient flows

The Paediatric Neurosurgical review has concluded that the evolution via a managed network approach consisting of all current children's neurosurgical centres working to agreed standards of care is the best way forward.

1. All the different hospitals and trusts contributing to the child's care will have formal agreement to work together with an identifiable leadership team.

2. They have a shared approach to collecting information, measuring quality and improvement in care.

3. They share policies, clinical guidelines and protocols for care.

4. They share common aspects of training and development.

5. There is a regular shared assessment and review against standards.

6. There is common record keeping.

7. They can share and transfer images and scans between the different hospitals so that the right expert can see and advise about care and treatment. They must have an education and training plan for different staff groups within the centre and across the network.

8. They can develop co-ordinated approaches to audit, and research.

What this actually means in terms of patient flows is unclear since it is envisaged that all the current centres will remain.

5) Facilities

The service based on the Leeds General Infirmary site benefits from vertical integration with all of the Children's services on one site, and horizontal integration with the adult neurosurgical service. This ensures that children with these life long conditions can be transitioned to care as an Adult in an optimum service model. The Leeds service provides services across the full range of conditions included in the scope of the review.

6) Impact on related services

It is not feasible to assess at this stage of the review, it will depend upon the outcome of the networks and the procurement of the highly specialist clinical services highlighted in this paper.

It is of some concern to Leeds Teaching Hospitals that when you consider not only this review, but other similar reviews e.g. the Congenital Cardiac Review/s for children and Adults there could be a significant knock impact to a range of other services provided from the Leed's Children's Hospital.
Losing specialist services does have wider impacts on critical care, other medical and surgical specialities. This is something that needs to be kept under review as the detail of the specific service reviews and their implementation emerges.

Stacey Hunter
Divisional General Manager
Leeds Teaching Hospitals
January 2012

This page is intentionally left blank