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Leeds CITY COUNCIL

SCRUTINY BOARD (HEALTH)

Meeting to be held in on
Tuesday, 16th September, 2008 at 10.00 am

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

MEMBERSHIP

Councillors

D Atkinson	-	Bramley and Stanningley
A Blackburn	-	Farnley and Wortley
J Chapman	-	Weetwood
P Grahame (Chair)	-	Cross Gates and Whinmoor
J Illingworth	-	Kirkstall
M Iqbal	-	City and Hunslet
G Kirkland	-	Otley and Yeadon
A Lamb	-	Wetherby
J Langdale	-	Temple Newsam
A McKenna	-	Garforth and Swillington
J Monaghan	-	Headingley
L Rhodes-Clayton	-	Hyde Park and Woodhouse

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A G E N D A

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

Item No	Ward/Equal Opportunities	Item Not Open		Page No
3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATIONS OF INTEREST** To declare any personal / prejudicial interests for the purpose of Section 81 (3) of the Local Government Act 2000 and paragraphs 8 to 12 of the Members Code of Conduct.	
5			**APOLOGIES FOR ABSENCE** To receive any apologies for absence.	
6			**MINUTES OF THE PREVIOUS MEETING** To receive and approve the minutes of the previous meeting held on 22 July 2008	1 - 8
7			**RENAL SERVICES** To receive and consider the attached report of the Head of Scrutiny and Member Development.	9 - 16
8			**PERIPHERAL HOSPITALS** To receive and consider the attached report of the Head of Scrutiny and Member Development	17 - 22
9			**NEONATAL SERVICES** To receive and consider the attached report of the Head of Scrutiny and Member Development	23 - 38
10			**LOCAL INVOLVEMENT NETWORK** To receive and consider the attached report of the Head of Scrutiny and Member Development	39 - 66

Item No	Ward/Equal Opportunities	Item Not Open		Page No
11			**LOCALISATION OF HEALTH AND SOCIAL CARE SERVICES - RESPONSE TO THE SCRUTINY INQUIRY REPORT** To receive and consider the attached report of the Head of Scrutiny and Member Development	67 - 82
12			**WORK PROGRAMME** To receive and consider the attached report of the Head of Scrutiny and Member Development	83 - 122
13			**DATE AND TIME OF NEXT MEETING** Tuesday, 21 October 2008 (Pre-meeting for all Members at 09.30 a.m.)	

SCRUTINY BOARD (HEALTH)

TUESDAY, 22ND JULY, 2008

PRESENT: Councillor P Grahame in the Chair

Councillors A Blackburn, J Chapman, J Illingworth, A Lamb, J Langdale and J Monaghan

7 Declarations of Interest

Councillor Langdale declared a personal interest in Agenda Items 11, Clinical Services Reconfiguration and 12, PCT Performance Report due to her employment with Leeds Primary Care Trust. (Minute Nos. 11 and 12 refer).

8 Apologies for Absence

Apologies for absence were submitted on behalf of Councillors Atkinson, Iqbal, Kirkland, McKenna and Rhodes-Clayton.

9 Minutes of the Previous Meeting

RESOLVED – That the minutes of the meeting held on 17 June 2008, be confirmed as a correct record subject to the inclusion of Councillor Iqbal under Members present.

10 Review of the National Blood Strategy

The Head of Scrutiny and Member Development submitted a report which provide Members with a range of information in relation to the proposed changes to the National Blood Service (NBS) and the implications for Leeds City Council. Appended to the report were submissions from NHS Blood and Transplant (NHSBT), Unite and Leeds Primary Care Trust.

Further to the publication of the agenda, a further submission from Leeds Teaching Hospitals NHS Trust had been received, and was distributed at the meeting.

The Chair welcomed the following to the meeting:

- Clive Ronaldson, Director of Patient Services, NHSBT
- Dr Sheila Maclennan, Clinical Director – Products, NHSBT
- Michelle Ashford, Head of Strategy – Processing and Testing – NHSBT
- James Buckley, Head of Strategic Communications, NHSBT

Clive Ronaldson gave a brief presentation on proposed changes at a national level and made specific reference to the Leeds Blood Centre. Main issues highlighted included the following:

- Changes to be made at the Leeds Blood Centre
  - Blood testing to be moved by the end of 2009/10
  - Blood processing to be moved by the middle of 2010/11
  - After 2010, roughly 50 % of processing and testing to be done at Sheffield, the remainder at Manchester and Newcastle.

- Facilities to remain in Leeds
  - Blood Issue Department – to supply local hospitals with blood including the provision of special and short shelf life products
  - The Red Cell Immunohaematology Services
  - Stem cell processing and storage

Members expressed various concerns over the proposals, including the following:

- That scientific and medical knowledge base and experience was being lost from Leeds and this would have an economic impact on the City.
- That this review had been a matter of concern since July 2007 and was only just being formally presented to the Board.
- That the hospitals in Leeds are a significant customer requiring high volumes of blood and blood related products. As such, in line with the proposed changes there would be a significant environmental impact arising from transporting blood to Leeds from Sheffield, Manchester or Newcastle.

In response to concerns, NHSBT made the following points:

- NHSBT was required to provide a cost effective service nationally
- Currently there was too much excess capacity (nationally) in some of the services provided
- Maintaining all the current sites in terms of capital expenditure was high. These costs were then passed to hospitals in the price of products.
- The proposed changes were presented in the context of falling demand for blood products.
- Other costs had also risen due to a fall in donations and rising treatment costs.
- There was a need to align NHSBTs operations with its Estates Strategy.
- Senior management at NHSBT understood this was a painful process for a number of staff and it was reported that a redeployment programme had commenced and everything possible would be done to avoid compulsory redundancies.
- Transport costs would remain approximately the same under the new proposals.

- It was recognised that there had been some past communication issues. NHSBT were continuing to try hard to address these issues.

The Chair introduced Dr Ian Cameron, Director Public Health and Dr Fiona Day, Specialist Registrar in Public Health to the meeting.

Dr Cameron made the following points:

Consultation

- Expressed concern regarding the consultation process and stated that the initial consultation on a revised strategy and communication of the review outcomes had been unsatisfactory.
- Reported that Leeds PCT had initially been informed of the review by Leeds City Council in July 2007 (after the publication of initial proposals).
- While Leeds PCT had had some involvement since July 2007, the process had been difficult and there were a number of lessons to be learned.

Proposals (patient impact)

- In considering the proposals, it was reported that the patients of Leeds were the first priority.
- There had been concern about the initial proposals to close the Leeds Blood Centre as a whole (i.e. including the distribution element).
- It was recognised that the initial proposals had been amended, and the current plan included retaining Leeds as a Blood bank and distribution centre.
- There was confidence that the revised proposals would not have a significant impact on health care provision – with patients not feeling or seeing any difference.

Proposals (wider implications)

- There was concern on some of the wider implications of the proposals,
- The loss of skills, knowledge and expertise associated with the provision of blood testing and processing services, was likely to have a negative economic impact on Leeds.
- It was restated that the patients of Leeds were the first priority.

Other issues

- There was a need for partners to work together in order to maintain a focus on and drive-up blood donation.

The concerns expressed by Dr Cameron were echoed by a number of Members from the Board.

The Chair introduced representatives from the trade-union, Unite to the meeting. These were Rob Wilson, Leeds Processing Team Manager and Dr Anatole Lubenko, Head of Stem Cell.

Rob Wilson addressed the meeting and reported that Leeds was one of the top performing blood centres nationally and the best centre in the North of England. Examples of areas where Leeds excelled were given, alongside details of the potential difficulties should these services be located elsewhere. The following issues were also highlighted:

- Flooding issues associated with the Blood Centre in Sheffield.
- Transport issues associated with the new proposals – including multiple journey issues.
- In noting the NHSBT comments regarding capacity, it was reported that quality and patient care had not formed part of the evaluation criteria.
- The loss of local knowledge rgarding named patients and specialist products.
- Queries regarding the long-term sustainability of the proposals.

In addressing the meeting, Dr Lubenko raised the following points:

- Leeds Teaching Hospital Trust was one of the biggest providers of Health Care in the north and biggest users of blood products.
- The negative impact of the proposals on emergency calls for cross-matching blood products
- Costs of transport figures – it was felt that these would be affected by significant rises in fuel costs, which had not been taken into account.
- Environmental charges that would be levied on NHS Bodies would be picked up by service users.
- The site at Sheffield had physical constraints for expansion.

Mr Wilson and Dr Lubenko also reported on difficulties that had been received in accessing information and requests under the Freedom of Information Act had been made.

RESOLVED – That further information be requested on the Review of the National Blood Strategy and be presented to the Board at a future meeting.

11 Clinical Services Reconfiguration

The report of the Head of Scrutiny and Member Development referred to the Health Proposals Working Group of the Scrutiny Board (Health and Adult Care) which had considered the impact of the centralisation of children's in-patient services at Leeds General Infirmary (LGI). The report sought to update the Board on the engagement and involvement process to date.

The Chair welcomed the following to the meeting:

- Jill Copeland – Executive Director of Strategic Development, Leeds PCT
- Sylvia Craven – Director Planning, Leeds Teaching Hospital Trust.

Jill Copeland and Sylvia Craven gave the Board an overview of the reconfiguration of Clinical Services. In brief summary, the following issues were highlighted:

- There was a proposed £25 million investment to bring Children's Services to one site and this had received strong support from the PCT, Clinicians and parents.
- Current facilities were not child friendly and improvements needed to be made for parents whose children were hospitalised.
- Proposals would see children's services located at LGI and some adults and elderly medicine transfer to St James' Hospital.
- Pathways to children's services would remain the same and hospital bed places for children would also remain approximately the same.
- An assessment unit would be created at LGI and complex out-patient cases would also be dealt with there. Less complex out-patient cases could be dealt with at other hospitals including St James' and Seacroft.
- Adult, acute and elderly out-patient services would remain the same though there would be some changes to address dignity and safety issues.
- Consultation groups and staff planning groups involved to ensure right service models are developed.
- Links with Education and Social Services – ensure schooling and social work is maintained.
- It was hoped to achieve reconfiguration outcomes between 2009 and February 2010. Approval was awaited from the PCT and Strategic Health Authority and work was hoped to commence in December 2008/January 2009.

In response to these representations and Members questions, the following issues were discussed.

- Benefits of having all services for children on one site,
- Provision of services and associated support for children's care at home
- Funding for the proposals – it was reported that a business case was to be presented to the Strategic Health Authority and an application would then be submitted to the Department for Health. Support had been expressed by the Minister for Health. Contingency plans had been prepared should borrowing requirements not be met.
- Older people's out-patient services would still be available at LGI.

RESOLVED –

(i) That the report and information presented be noted.
(ii) That a further report detailing the Business Case for the Clinical Services Reconfiguration be brought to the Board's meeting in November 2008.

12 PCT Performance Report

The Head of Scrutiny and Member Development submitted a report which asked the Board to consider the Performance Report of the Leeds PCT. Appended to the report was detailed performance information from the PCT including a full list of their 2008/09 indicators.

The Chair welcomed Beverley Bryant, Director of Performance, Leeds PCT to the meeting. She informed the Board of priority areas to improve performance and where joint delivery of services was carried out. Reference was also made to other areas of performance monitoring and targets as found in the Annual Health Check and Local Area Agreements.

Specific issues discussed related to:

- Timescales around cancer diagnosis, referrals and subsequent treatment.
- Yorkshire Ambulance Service response times.
- Teenage pregnancy rates.

RESOLVED –

(1) That the report be noted.
(2) That the Board continues to receive bi-monthly performance reports.

13 Scrutiny Inquiry: GP led Health Centres (Polyclinics) – draft terms of reference

Further to the Board's agreement to undertake an inquiry to consider the proposals for and implications of developing GP led Health Centres (polyclinics) in Leeds, the Head of Scrutiny and Member Development submitted terms of reference for the inquiry. Initial thoughts of the Director of Adult Social Services and the PCT had been sought and had been reflected in the terms of reference.

RESOLVED – That the terms of reference for this inquiry be agreed.

14 Scrutiny Inquiry: Teenage Pregnancy – draft terms of reference

The report of the Head of Scrutiny and Member Development outlined proposed terms of reference for the scrutiny inquiry into teenage pregnancy. Attached to the report was a copy of a statement produced by the Scrutiny Board (Health and Adult Social Care).

Members discussed the proposed terms of reference and it was suggested that the inquiry be expanded to take account of sexual health issues for young people. It was also suggested that young people from the Youth Sexual Healthy Advisory Group (Y-SHAG) be involved in the inquiry.

RESOLVED – That the terms of reference be agreed and amended to take account of discussion at the meeting.

15 Work Programme

The Head of Scrutiny and Member Development submitted a report which detailed the Board's Work programme. Also included in the report was the report of the Scrutiny Board (Health and Adult Social Care) following the inquiry into the Localisation of Health and Social Care Services and draft terms of reference for the Health Proposals Working Group.

Further issues suggested for the Work Programme included preventative medicine, obesity, exercise and cardio vascular health.

RESOLVED –

(1) That the Work Programme be noted and agreed.
(2) That the Localisation of Health and Social Care Services scrutiny inquiry be noted.
(3) That Councillor Lamb replace Councillor Chapman on the Health Proposals Working Group and the draft terms of reference for the group be agreed.

16 Date and time of next meeting

Tuesday, 16 September 2008 at 10.00 a.m. (Pre-meeting at 09.30 a.m.).

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Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 16 September 2008

Subject: 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 Introduction

1.1 As part of the initial discussions regarding the work programme, the Scrutiny Board (Health) was advised that Renal Services, particularly in relation to the transport of kidney patients, had remained an area of concern for some time.

1.2 At its meeting in June 2008, the Scrutiny Board (Health) agreed to revisit this service area and consider the current level of provision and any issues highlighted.

2.0 Report Issues

2.1 As such, a number of organisations have been contacted and asked to provide information for the Board to consider. The information appended to this report includes:

- A briefing paper from Leeds Teaching Hospitals NHS Trust on the provision of renal services in general and the renal patient transport service (Appendix 1).
- A submission from the National Kidney Federation (Appendix 2).
- A submission from the Yorkshire Ambulance Service (YAS) (Appendix 3) – to follow.

2.2 Representatives from Leeds PCT and the two local kidney patients association have also been invited to attend the meeting to help inform the Board's discussion and consideration of the issues raised.

3.0 Recommendations

3.1 The Board is requested to consider the information provided in the attached papers, identify any areas where further information is required and determine what, if any, further action is required.

4.0 Background Papers

Scrutiny Board (Health) – 17 June 2008: Item 6 – Work Programming (Appendix 11: Outstanding/ potential items)
Scrutiny Board (Health) – 17 June 2008: Minutes of meeting
Scrutiny Board (Health) – 22 July 2008: Item 12 – Work Programme (Appendix 1: Draft work programme)

APPENDIX 1

REPORT TO THE LEEDS SCRUTINY BOARD - 16 SEPTEMBER 2008

LTHT RENAL SERVICE - CHANGES, DEVELOPMENTS AND THE RENAL PATIENT TRANSPORT SERVICE

1. Background to Renal Care in Leeds

There are a number of treatments for end stage renal failure, all of which are provided by the Leeds renal service:

- haemodialysis in main renal units at SJUH (Ward 55) and Seacroft (Parsons Unit)
- haemodialysis in satellite renal units (six in total) across West Yorkshire - five in NHS hospitals and one in a GP surgery. Two of these are in Leeds, at Seacroft (B Ward) and Beeston
- home haemodialysis - patients self care at home and can dialyse up to six times per week
- peritoneal dialysis (PD) - patients self care at home. There are three modalities: continuous ambulatory peritoneal dialysis (CAPD); automated PD (APD) and, recently, Assisted APD (AAPD) - where the patient is provided with help in the home to start or sustain APD.
- transplantation - by far the most clinically effective, cost efficient and quality of life enhancing treatment.

In addition, approximately 300 patients a year are treated for acute renal failure. This is kidney failure, which almost always recovers but these patients are seriously unwell and need intensive inpatient care.

Finally, outpatient review occurs for approximately 5,000 individuals with much less severe kidney disease. A proportion of these patients, however, do have kidney failure which is steadily progressing and these would be considered a “pre-dialysis/low clearance” cohort.

2. Service Changes

Following the closure of Wellcome Wing, the inpatient ward at the Leeds Infirmary (formerly Ward 32) moved to ward 62 in Lincoln Wing at St James’s in February 2008.

Work started in May on the 24-station unit on R&S wards at Seacroft Hospital, which is expected to complete in January 2009.

Work is due to start shortly on ward 46 at the LGI, to create a 10-station chronic unit, with 2 acute beds, completing in Spring 2009.

Discussion will start shortly with the patients at the Parsons’ Unit at Seacroft to identify those who will transfer to the LGI. When the 2 new dialysis units are operational, the temporary unit on T&U wards at Seacroft will close.

3. Service Developments

2.1 Live Donor Renal Transplantation.

The Specialist Commissioning Group approved, from 2008/09, an increase in live donor transplantation activity in Leeds from 40 to 70 per year. The increase will be phased over the next three years.
This is a highly significant investment which, over time, will make a real difference to the number of patients who receive a transplant.

3.2 Pre-Dialysis/Low Clearance Care.

Primary care refers patients for the management of anaemia, which involves injections of iron and a hormone. We are in discussion with PCT colleagues about the level of demand for this service and the optimal means and location for treating patients with anaemia.

4. Renal Patient Transport Service

In April 2007, YAS was awarded the contract to convey renal haemodialysis patients to the 8 dialysis units managed by the LTHT Renal service. There is another, separate contract between LTHT and YAS for the provision of a patient transport service to all other clinical service areas across LTHT.

This report to the Health Scrutiny Board is concerned with the contract to convey renal haemodialysis patients. There are 2 main dialysis units - one at St James's University Hospital and the other at Seacroft Hospital (Parsons' Unit). There are 6 satellite units located in Seacroft, Beeston, Wakefield, Huddersfield, Dewsbury and Halifax.

Since March 2008, by far the greatest amount of difficulty has been experienced by the patients attending the Parsons' Unit at Seacroft Hospital. There has been close dialogue between LTHT Renal Service and YAS. YAS acknowledged that there were problems and, in July, communicated by letter with all their drivers on the following issues: -

- YAS staff entering clinical areas checking to see if patients were ready, interrupting treatment and causing patients to cut short their treatment in order not to miss their transport home.
- Drivers arriving too early for patients appointments (up to one hour before) even though they were planned to arrive within half an hour - the quality standard time for appointment.
- Patients left unaccompanied outside units when drivers arrive before units have opened.
- Patients being dropped off at different addresses rather than the address on the drivers' log sheets

An audit will be conducted in late September to assess the change in practice since the letter was issued.

For its part, the Leeds Renal Service, from 16 June, instituted staggered patient appointment times at Parsons' unit, ie each patient has an appointed time at which they should start their dialysis.

In April 2008, YAS identified the renal service as a pilot site for its new online booking system. Work has progressed, jointly, to the point where the system went 'live' at Parsons' Unit in mid August. It is too early to comment on its efficacy or the pace at which it will be rolled out to the remaining 7 renal units.

By 1 September 2008, all YAS vehicles will be equipped with Personal Digital Assistant technology (PDAs). LTHT Renal Service is optimistic about this new technology.

On 8 August, Counsellor Andrew Carter, at the request of the LGI KPA, met patients at the Parsons Unit, primarily to talk about their transport.

5. National Kidney Care Audit

The Department of Health has recently announced a 3-year National Kidney Care Audit, covering the 2 key areas of patient transport services for haemodialysis patients and vascular access services. An early piece of work, in October 2008, is a national survey of patient transport.

Renal Services : A Patients' Perspective.

Introduction.
I am grateful to the Scrutiny Board for being given this opportunity to make representations on behalf of renal patients in Leeds.

I shall begin by providing some background information, go on to examine, in broad terms, some of the main issues of importance to such patients, and finish by addressing the specific issue of transport provision for patients undergoing haemodialysis treatment in hospital.

Patient Priorities.
As is the case with many patients with long term, chronic conditions, renal patients tend to be extremely knowledgeable about their own disease, the range of possible treatments, national standards, and how services are delivered in other parts of the country.

Not unreasonably, they expect to receive equity of access to high quality services regardless of where they live or are treated.

Furthermore, they require a holistic approach to their condition, given that it affects not only their physical well being, but also impacts on other aspects of their lives, (e.g., employment, financial circumstances, etc), and the lives of those closest to them.

There are a number of issues about which all renal patients are concerned, and which can, broadly speaking, be categorised under the following headings. Some examples are given in each category, but do not comprise an exhaustive list.

Choice – Clinical considerations as to the appropriateness of treatments for individual patients must be paramount. Once that is determined, the venue and timing of treatment, (i.e. hospital or home based in the case of haemodialysis, and at a time that fits in with other commitments, e.g., employment), should be the choice of the patient, but that is not always possible, owing to capacity, staffing, and other issues.

Consistency – Avoidance of the so called 'postcode lottery' whereby patients with the same need are treated differently according to their place of residence is particularly important for this group of patients, most of whom are well aware of minimum standards, such as those laid down in the national service framework for renal services, (renal NSF).

Communication – All patients are meant to have an individual care plan, (standard 1 of the renal NSF). These should be monitored on a regular basis, and patients should play an active role in them. Such written plans help to avoid confusion as to what was agreed between the doctor and patient at a clinic appointment, and give patients a share in the responsibility for their own well being. In many cases, such plans do not exist.

Continuity of Care – As patients progress through the 5 stages of chronic kidney disease, (CKD), it is important that appropriate and timely measures and protocols are in place to ensure they are referred from primary to secondary care, (and that other agencies are involved also, where required, e.g., social services). Given the long term nature and complexity of their condition and treatment, wherever it is practicable patients should have access to the same staff within the multi disciplinary team who are conversant with their medical history and individual social and other circumstances.

Service Development and Monitoring – The forum in which this takes place is the North, East, West Yorkshire & North Lincolnshire renal strategy group, (NEWNYL RSG). Membership of the RSG includes clinical and managerial representation from Leeds Teaching Hospitals Trust, the 3 other main renal centres in the region, (Bradford, Hull and York), a local GP, PCT commissioners, and patient representation through the author of this report. Arrangements for meetings lie with Leeds PCT.

It is a matter of great concern that this group has only met once in 2008, and that, by the time of its next meeting on 26 September, virtually 8 months will have elapsed since it last met.

Transport Provision for Hospital Based Haemodialysis Patients.

I must begin this section of my report by apologising for my non-attendance at the Scrutiny Committee meeting as, ironically, I have to be at a renal transport meeting in the North West of England at the same time.

I shall leave it to others who will be present at the meeting to deal with specific local issues, as they are much more knowledgeable about, and directly affected by, the current concerns.

Transport is an essential part of a hospital based haemodialysis patient's care; without access to the treatment, they will die.

The renal patient population is composed increasingly of more elderly and frail individuals, many of whom have co-morbid conditions. Those factors, together with the distance many patients have to travel to receive their treatment, even in an urban conurbation such as Leeds, make the provision of an effective and efficient transport system vital.
Failure so to do not only affects patients in terms of increased stress, long delays, and, on occasions, reduced treatment hours, but also creates difficulties for the staff in units when the late arrival of patients can cause a 'knock on' effect for other patients later in the day, and extend staff working hours.

It can lead to vulnerable patients returning home late at night, having spent up to 10 hours away from home for a 4 hour treatment session.

There are occasions also when patients have to be kept in hospital overnight as no transport is available, or it is too late for them to return home safely, and this is not a cost effective use of scarce hospital in-patient beds.

Other problems include staff time being wasted in ringing transport providers to ascertain why patients have not arrived on time for their treatment; transport providers making aborted journeys because they have not been informed patients have been admitted to hospital or are on holiday, and generally increased and unnecessary levels of stress caused to patients.

This is a national problem; not one only for patients treated at the various units in the Leeds area. As a result, the Department of Health set up 2 action learning sets to make recommendations as to how the service might be improved.

The author of this report was a member of the Cheshire & Merseyside action learning set, which reported with a list of recommendations for improvement early in 2007.

At the present time, a pilot scheme to implement the recommendations is in place, and the findings from that pilot will be shared widely within the renal community when it finishes in May 2009, and have been evaluated externally.
I should like to end this report by using an analogy which, I hope, encapsulates the points I have made above, and makes them meaningful to individual members of the Scrutiny Committee.

Imagine you have booked a taxi to take you to the airport at the start of your annual, and much looked forward to, Summer holiday.

5 minutes before the time the taxi is due to arrive, you start looking for it approaching. It fails to appear on time, and, despite the fact you have allowed plenty of time for a late arrival, you start to feel concerned.

After another 5 minutes with no vehicle in sight, you phone the company concerned, only to be told, ‘it’s on the way’. Eventually, some 10 minutes later it turns up. By then your relaxed mood at the prospect of a well earned break has disappeared.

Now, imagine that situation being replicated 3 times a week, week in, week out, over a long period of time, and where your end destination is not a warm and welcoming holiday resort but an aggressive, invasive and tiring form of hospital treatment.

Wouldn’t you feel aggrieved and expect something better?

Conclusion.
This report is presented for the information of the Scrutiny Board.

Dennis Crane, North Region Advocacy Officer National Kidney Federation.

Author's Note.

Dennis Crane has been an identified renal patient for more than 40 years.

He has first hand experience of all forms of renal replacement therapy; home and hospital based haemodialysis, peritoneal dialysis, and failed and successful transplantation.

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

He was awarded the MBE for his services to people with renal disease in 2002, and was appointed to his present part time salaried post in April 2004.

Prior to that, he worked for almost 36 years in the Education Department of Manchester City Council, retiring from his post as Head of School Governor Support and Training in September 2002.

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 16 September 2008

Subject: Leeds Teaching Hospitals NHS Trust – Peripheral Hospitals

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

1.0 Introduction

1.1 As part of the initial discussions regarding the work programme, the Scrutiny Board (Health) was advised that Wharfedale Hospital and the services delivered from that site, had remained issues of some concern for the former Scrutiny Board (Health and Adult Social Care). This was reflected in one of the recommendations of the scrutiny inquiry report which examined the localisation of health and social care services, which requested a report setting out the long-term strategy for Wharfedale Hospital be presented to the Board. At its meeting on 17 June 2008, the Board requested a briefing on the service area, including any relevant performance data, in order to determine whether to proceed

1.2 At its meeting on 17 June 2008, the Board received an outline of the key priorities and targets for the Primary Care Trust (PCT), Leeds Teaching Hospitals NHS Trust (LTHT) and the Leeds Partnership Foundation Trust (LPFT). As part of the discussion with LTHT, reference was made to the role of a number of peripheral hospital sites across Leeds. Following this discussion, it was agreed to expand the scope of the report to the Board to cover the overall strategy for peripheral hospitals.

1.3 The report from Leeds Teaching Hospitals NHS Trust is attached at Appendix 1 for consideration.

2.0 Recommendations

2.1 The Board is requested to consider the information provided in the attached report, identify any areas where further information is required and determine whether there are any specific matters that require more detailed scrutiny.

3.0 Background Papers

Scrutiny Board (Health and Adult Social Care) – May 2008: Inquiry Report – The Localisation of Health and Social Care Services
Scrutiny Board (Health) – 17 June 2008: Item 6 – Work Programming (Appendix 11: Outstanding/ potential items)
Scrutiny Board (Health) – 17 June 2008: Minutes of meeting
Scrutiny Board (Health) – 22 July 2008: Item 12 – Work Programme (Appendix 1: Draft work programme)

THE LEEDS TEACHING HOSPITALS NHS TRUST

WHARFEDALE, SEACROFT AND CHAPEL ALLERTON HOSPITALS BRIEFING UPDATE SEPTEMBER 2008

1. PURPOSE OF THE PAPER

The purpose of this paper is to:

- demonstrate how these three important locality hospitals are used, providing high quality care to patients and good, safe working environments for staff in the context of their developing identities, the national Darzi agenda and the requirements of the organization to make most effective use of existing resources in estate, clinical and human resources terms

2. BACKGROUND

2.1 Seacroft hospital

Clinical governance issues and the way older peoples services in particular have developed over the recent past has led to a change in the nature of the hospital which now contains no LTHT inpatient beds.

Accommodation ranges from the good to the very poor. The site is sprawling although the good accommodation is close together. This accommodation is being used to maximum effect whilst the poor accommodation is deteriorating.

The site contains a large amount of 'leftover' accommodation from when the hospital site had inpatient wards on it, for example mortuary, education centre, crèche, social work area. A number of blocks house administrative staff or are used for storage: they are all in poor condition. There are now a number of empty blocks on the site and vandalism is starting to become a problem.

The Receipt and Distribution Unit was built about 5 years ago on a 10 year lease in the middle of the site. The site also houses the Newsome Centre (Mental Health Trust PFI), the National Blood service and the Health Protection Agency to which LTHT provides some estate services.

The site now contains the following clinical services which will remain:

- Radiology with plain film, fluoroscopy and ultrasound with a mobile MRI and PET scanner as well as breast screening.
- Large numbers of outpatients including orthodontics, pain, general medicine, elderly medicine, dermatology, cardiology, gastroenterology, urology, retinal screening, clinical genetics, cystic fibrosis, ID, neurology, anti coagulation and breast screening.
- There is a large renal dialysis department, as well as a satellite dialysis unit and the prosthetics, orthotics and wheelchair centre.

- Urology day cases not requiring general anaesthetic are also based at the site.
- The Trust reproductive medicine service will be on this site.
- PCT Community Dentistry is currently on the site and this is likely to continue on an outpatient basis.
- Supported by a dining room and coffee lounge

2.2 Chapel Allerton hospital

Following significant investment, in 2005, additional theatres were created and wards and departments developed and CHOC opened along with virtually all Rheumatology including the important academic department, to deliver a major Musculoskeletal Centre. At the same time, as care of older people developed, the older peoples inpatient wards which had been on the site moved into more acute settings at both LGI and SJUH leaving 2 empty wards with a further 2 wards becoming vacant by September 2008

The Trust Board has recently agreed that one of these vacant wards will be used to house the musculoskeletal biomedical research unit having a research MRI, one ward will be developed to house the clinical genetics department and one will be converted to provide additional outpatient capacity away from the two acute sites. The remaining ward is currently being used for medical education teaching and examinations.

The accommodation on the site ranges from the very good to the acceptable, the electrical infrastructure has recently been reinforced, the site is compact but parking can expand into an adjacent area.

The hospital contains the following:

- Elective orthopaedics: 4 theatres, 1 inpatient ward (36 beds) 1 post operative unit (16 beds) outpatients and offices/admin support
- Rheumatology: 1 inpatient ward (22 beds) 1 day case ward (16 beds) dedicated outpatients offices/admin support
- University Rheumatology Research department
- Neuro rehabilitation: 1 inpatient ward (19 beds)
- Radiology: MRI, digital plain film X-ray, fluoroscan and ultrasound
- General outpatients including elderly medicine
- Physiotherapy
- Supported by medical records, a small post graduate centre, a shop, coffee area and a dining room

2.3 Wharfedale Hospital

Wharfedale Hospital (WH) was opened in October 2004. It is a high quality facility that was designed to provide a range of healthcare services to the population of in and around Otley that are safe and appropriate to their needs.

In the three and a half years since it opened, the Trust and its partners in the health economy have struggled to utilise the facilities at WH efficiently and effectively.

In April 2007, the LTHT Board approved a Framework for the development of WH, which had been jointly developed by the Trust and the PCT. This framework clarified the vision and strategic direction for WH

3. PROPOSALS

3.1 Seacroft hospital

The Trust has been developing the ambulatory nature of the Seacroft site for some time and has been investing in the infrastructure in the good quality accommodation in order to support this. The majority of the clinical work delivered from the site is in one part of the site - identified as area 3 on the attached plan. The remainder of the site contains mainly non clinical accommodation, much of it empty or part empty and the site is becoming subject to vandalism in areas 1 and 2. Leeds PCT has stated that it does not wish to have any of its services on the site, apart from the single older people's non acute ward, which is in area 3.

The proposal for Seacroft hospital therefore is:

i. To continue to locate as much ambulatory care as possible into area 3.

ii. To move the clinical services remaining in areas 1 and 2 into area 3 or into other more appropriate areas of the Trust so that areas 1 and 2 are vacated. This would include relocating genetics staff to CAH, moving the paediatric outpatient clinic currently in a half empty building, into W ward, moving physiotherapy into the 8 ward block and relocating the breast screening service into area 3.

iii. To move the remaining non clinical services into more appropriate accommodation off the site.

iv. To then dispose of areas 1 and 2.

3.2 Chapel Allerton hospital

The hospital is a vibrant place providing both inpatient and ambulatory care.

The Board has recently agreed:

i. To use ward 6 to house the Musculoskeletal Biomedical Research Unit (timescale Helen's e-mail)
ii. To use wards 10 and 11 to house both the Clinical Genetics department, which from a clinical viewpoint is purely an outpatient based service, and to house a generic outpatient department. The work is well underway (timescale - see Helen's e-mail)
iii. There is just on vacant ward and it is propose to reserve ward 7 for potential further elective orthopaedic development should the Trust wish to do so. There could also be day case expansion into the adjacent external courtyard. In the meantime, the area is being used, very successfully, for medical student examinations.

3.3 Wharfedale hospital

Since the agreement of the strategy, the Trust and PCT have been working to deliver a better utilised hospital within the agreed parameters.

The review of the 2007/8 business plans resulted in the Lymphodema Service being relocated to WH.

During April 2008, all Directorate Managers and Clinical Directors within the Trust were asked to consider the following questions in relation to Wharfedale:

- How might they better utilise/expand the volume of any existing services?
- Are there any new services, either for the local population or the whole city that could be relocated to Wharfedale?

This exercise generated a longlist of projects. Some of these are still in the process of being assessed, however, a number of developments are planned for 2008/9:

- Improved utilisation of the 2 theatres. A plan to improve utilisation will be implemented from October with the objective of achieving an average 90% utilisation across all lists (average in 2007/8 was 66%).

- Establishment of a 4 chair low risk chemo facility for the local population

- Full utilisation of the endoscopy facilities (part of the Endoscopy Services Business Case currently being implemented and numbers already rising)

- Improved utilisation of the outpatient capacity via the roll out of direct booking and the continued efforts of directorates to allocate trust booked patients to WH

- Improved utilisation of the radiology facilities and possibly creation of a permanent breast screening facility.

Work has been undertaken in the PCT to identify potential service moves and development opportunities. A key area of work is to investigate the need, desirability and potential for some local primary care and community based services to be relocated to accommodation at Wharfedale. This might include, for example, GP and GPSI led services and community services such as podiatry, substance use services, falls clinics and audiology. The potential for some community intermediate care beds for older people to be based at Wharfedale is also being explored.

The PCT is working to develop community based services for people with long term conditions(COPD, chronic vascular disease etc) so that, for those people whose care can be provided appropriately outside an acute hospital setting, services are available in the local community. We are looking at the demand for and opportunities for such services to be provided at Wharfedale.

Both the PCT and LTHT acknowledge that finding a mix of services that can utilise the WH facility effectivey has been and remains challenging. We are jointly aiming to develop a plan for the next 5 years by the end of 2008/9.

Leeds CITY COUNCIL

Originator: Steven Courtney

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Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 16 September 2008

Subject: Leeds Teaching Hospitals NHS Trust – Neonatal Services

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

1.0 Introduction

1.1 As part of the initial discussions regarding the work programme, the Scrutiny Board (Health) was advised that a former co-opted member of the former Board had raised maternity services / neonatal transfers as a potential area for scrutiny. At its meeting on 17 June 2008, the Board requested a briefing on the service area, including any relevant performance data, in order to determine whether to proceed with an inquiry.

1.2 A briefing paper from Leeds Teaching Hospitals NHS Trust is attached to this report for consideration.

2.0 Recommendations

2.1 The Board is requested to consider the information provided in the attached report, identify any areas where further information is required and determine whether any specific matters require more detailed scrutiny.

3.0 Background Papers

Scrutiny Board (Health) – 17 June 2008: Item 6 – Work Programming (Appendix 11: Outstanding/ potential items)
Scrutiny Board (Health) – 17 June 2008: Minutes of meeting
Scrutiny Board (Health) – 22 July 2008: Item 12 – Work Programme (Appendix 1: Draft work programme)

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Neonatal Services

Scrutiny Board Briefing Paper

August 28th 2008

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The Leeds Neonatal Service

The Leeds Neonatal Service provides Specialist care to newborn infants from Leeds and the Yorkshire Network and is delivered on two sites within the Trust, Leeds General Infirmary and St James's University Hospital.

It is one of the largest neonatal services within the UK providing support to two very large Obstetric Units within Leeds with over 9000 deliveries per annum as well as tertiary services to several Trusts as part of the Yorkshire Neonatal Network.

Approximately 10% of all newly born infants will be admitted to the neonatal service, generally due to being born prematurely or because they have congenital anomalies or perinatal infection. In addition to the two delivery suites in Leeds the service supports the care of newborn infants on maternity wards and provides outreach services to mother and babies across the Leeds Health Community

Neonatal Networks

The Department of Health published the Expert Working Group report on Neonatal Intensive Care Services, April 2003. The Report suggests a more structured, collaborative approach to caring for newborn babies. It proposed that hospitals worked closely together in formal, managed networks, to provide the safest and most effective service for mothers and babies. This would include the designation of some hospitals that were specially equipped to care for the sickest and smallest babies, with other hospitals providing high dependency care and shorter periods of intensive care as close to home as possible. The numbers of hospitals in each network would be for local decision but must reflect local need and geography.

The Yorkshire Neonatal Network was established in 2002 with the purpose of delivering

- Appropriate care for mothers and babies as close to home as possible i.e. within their own network with an end to inappropriate or long distance transfers.
- Ensure equity of access to high quality services.
- Allow collaboration on workforce planning, education, training and clinical governance.
- The concentration of skills and expertise.
- Achieving consistency of care across the Network.
- Structured transport arrangements.
- Agreed categories of care and designation of units.

- Ensure that babies with complex needs or requiring long periods of respiratory support have their initial care in an intensive care Unit (designated level 3).

Unit Designation

Neonatal care is highly specialised and therefore different hospitals within the Yorkshire neonatal network (YNN) have been designated to provide different levels of care:

- **Level 1** Units provide special care but do not aim to provide any continuing high dependency or intensive care. The network has 2 such units (Scarborough and Harrogate)

- **Level 2** Units provide High dependency care and some short term Intensive care as agreed within the Network. There are currently 5 such units in the network (York, Dewsbury, Pontefract, Calderdale and Airedale)

- **Level 3** Units provide the whole range of neonatal care - special care, high dependency and intensive care. There are 3 such units in the network (Leeds, Hull and Bradford). Hull and Leeds provide newborn surgical intensive care. Leeds provides newborn cardiology intensive care in conjunction with the cardiology service[1].

Both Leeds units are designated at Level 3 with Specialist Neonatal Surgery, Cardiology and Neuroscience on the Leeds General infirmary site and Specialist Hepatology and Renal medicine on the St James site. These specialist services cannot be delivered elsewhere within the network.

Also provided by the Leeds Neonatal Service

- Transitional Care
- Neonatal Network Transport Service
- Cot Bureau.
- Neonatal Outreach
- Surgical Neonatal Outreach

Neonatal care levels

Somewhat confusingly, levels of care within neonatal units are described as level 1, 2 or 3. The highest level of intensive care (level 1) tends to take place in level 3 neonatal units.

- Level 1 (intensive care)

- Level 2 (high dependency)

[1] Specialist services defined as those newborn infants who have complex medical needs such as advanced ventilation and nitric oxide and/or need access to specialist surgical, cardiac and neuroscience services

- Level 3 (special care)

- Transitional Care - is a ward that allows the Mother and baby to stay together when the baby requires Level 3 care. The transitional care has both Midwives and Neonatal Nurse providing holistic care to both the mother and baby.

Cot Capacity

Hosp Site	Unit Designation	Level 1	Level 2	Level 3	Total NNU	Transitional Care (Level 3)
LGI	Level 3	9	14	12	35	9
SJUH	Level 3	6	6	8	20	10

The cots are used flexibly across all the levels of care. Neonatal Units are unique as they deliver all levels of care within the confines of one ward. A baby will switch levels of care throughout their admission while remaining on the unit. Using the cots flexibly allows the service to respond to the demand for all levels of care.

Admissions to neonatal units

There are in excess of 9000 deliveries within the Leeds Teaching Hospitals Trust per year and approximately 10% of all newborn babies require admission[2] to the neonatal units. In addition, as a tertiary centre, the unit receives babies delivered in DGHs who require this enhanced level of intervention/support accounting for the higher than 10% ratio of admissions to deliveries within the Trust.

The table below describes the trends in admissions since 1998.

	SJUH		LGI		SERVICE	
year	Total patients	Total admissions	Total patients	Total admissions	Total patients	Total admissions
1998	469	471	753	834	1222	1305
1999	414	419	694	764	1108	1183
2000	468	476	672	740	1140	1216
2001	386	402	668	737	1054	1139
2002	433	455	730	805	1163	1260
2003	437	500	700	778	1137	1278
2004	470	488	737	821	1207	1309
2005	415	431	711	793	1126	1224
2006	433	449	890	951	1323	1400
2007	406	418	773	823	1179	1241

[2] some babies are admitted more than once (especially surgical referrals) and so the admission rate (admissions) is greater than the admission rate (patients).

The advances in complex Neonatal surgery and medicine have seen an increase in the survival of babies who would have previously succumbed. The number of admission per year will vary dependant on the complexity of the interventions required and gestation, as this will determined the length of stay and the availability of cots for admission within the unit. This explains variation in admission rates over the last 10 years.

LTHT is a tertiary centre for many Paediatric specialties requiring a greater link between Paediatrics and Neonatal services within the Trust. The type of support required covers many subspecialties but is specifically evidenced at the LGI site in Paediatric General Surgery and Cardiac surgery where clinical and technological advances are particularly prevalent improving survival rates but requiring an enhanced level of neonatal nursing and medical support.

Occupancy Rates

The Leeds Neonatal Service runs at a total occupancy level in excess of this 70% at all times with an average occupancy over the last 8 years of 90% which is higher than many comparable units. All levels of care can, at times, exceed 100% occupancy due to the flexible use of cots within the service. If we are delivering greater than 100% occupancy at any level of care there will be a subsequent decrease in the occupancy in of the other levels of care. This allows the nurse to patient ratio to be consistent and appropriate without compromising quality of care.

Length of stay

Length of stay is determined by the gestation of the baby and the complexity of care required which may included surgery i.e. the earlier the baby is born and dependant on the surgery required at any gestation the longer they will remain within the service. Most babies are discharged on or around their original expected delivery date.

The recommendations within the Yorkshire Neonatal Network plan are likely to increase the volume of premature babies transferred into Leeds and the impact of this is currently being identified

Leeds babies, within the Leeds units have an apparent longer length of stay as they spend their entire admission within one of the Leeds units whilst non Leeds babies will be repatriated to their local DGH for ongoing care once their level of care becomes aligned with that unit's designation. Leeds Service did at times encounter difficulties in repatriate babies to their local hospitals. These issues are being resolved by the change in the way the Transport team now works within the Yorkshire Network

Reasons for refusals:

<u>Post delivery</u>

We do all we can to fulfil our specialist service to the network and our tertiary service to Leeds residents but on rare occasions we may need to transfer a patient out of Leeds after birth. This occurs approximately 12 times per year.

[2007 data: 15 babies transferred out after birth, 10 to other units in YNN, 5 to units out of region, of which 2 needed specialist services] This is usually due to the units in Leeds being at or over capacity and the babies are repatriated to Leeds at the earliest opportunity.

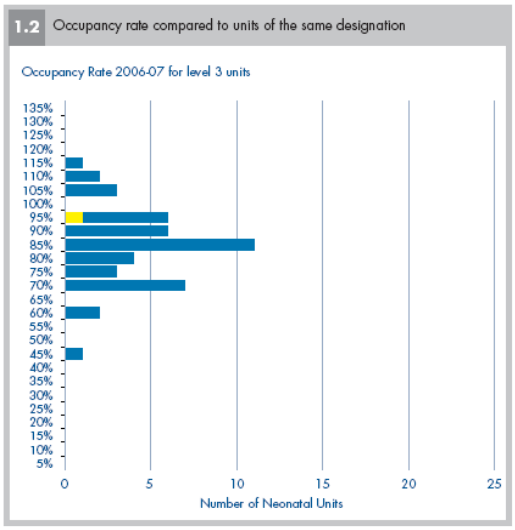
In Utero

Refusals of in-utero transfers for specialist care can happen for 2 reasons- either lack of capacity on the NICU or lack of capacity on delivery suite.
Wherever possible the cot bureau will try to locate an NICU bed for these transfers within one of the other YNN neonatal units. This equates to approximately 3 per month these may be either requested transfers into LTHT or unfortunately involve the transfer of a mother from LHTH to another unit that is able to offer the appropriate level of care for the baby. Although this is not the ideal for the mother involved it does ensure the delivery takes place in a safe environment for both mother and baby.

Investment into Maternity & neonatal nurse staffing from LTHTs 2008/9 business planning is specifically aimed at reducing refusals and effectiveness is monitored monthly through the performance review process

Comparison with national picture

The National Audit Office audited neonatal care provision in the UK in 2007. The following graphs outline how the Leeds service compares with similar units nationally. The Leeds data are outlined in yellow.



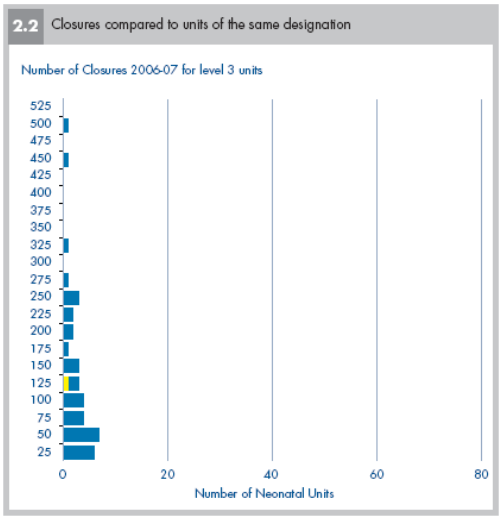


Figure 1.2 shows Leeds has a relatively high occupancy rate compared with other level 3 (tertiary) units. The recommended rate is 70%. Despite this our closure rate compares favourably to equivalent units (Fig 2.2)

Transitional Care

Transitional Care provides care to mothers and vulnerable babies together on the ward. Those babies that require special care Level 3, for example the preterm infant of 33 week gestation who is otherwise well but needs to be fed

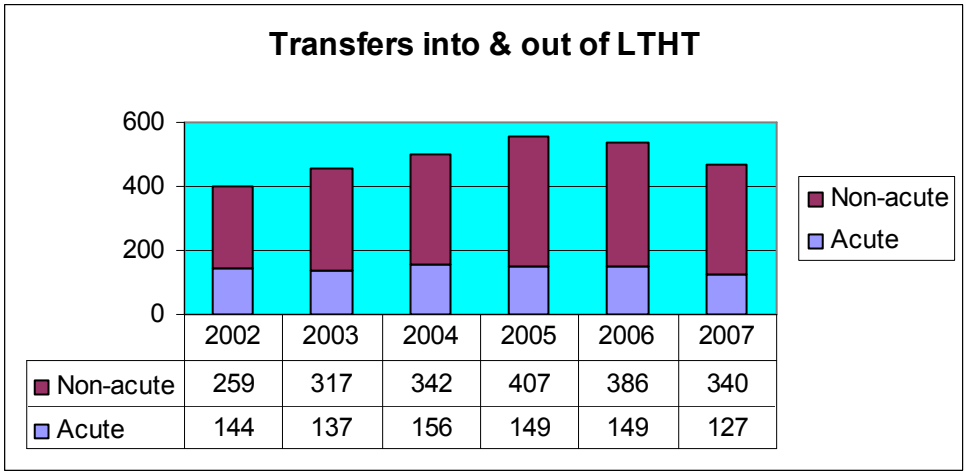
through a nasogastric tube until they are able to feed by breast or bottle. Babies whose mothers have taken substance such as drugs or alcohol during pregnancy will be admitted to Transitional care so that the baby can be closely monitored and treated alongside their mother. Babies over 33 week's gestation who may require a course of antibiotics due to infection are managed here. Transitional Care also allows the service to re admit mothers to establish breast feeding the preterm infant prior to discharge home from the Neonatal Intensive care unit.

Neonatal Transport

The Network Transport team is comprised of 9 WTE (whole time equivalents) nurses who are hosted by Leeds Teaching Hospitals but Network funded and supernumerary. The service was originally limited to acute transfers into the Leeds units for specialist care from the Network (although sometimes could be beyond these boundaries), and repatriation of these babies when the level of care they required could be delivered at their local hospital.

No funding was allocated for medical staff to support transport. If a doctor is required to accompany the baby this doctor is provided from the LTHT staffing establishment i.e. the team of doctors working on NICU. If the team of doctors are busy this can lead to an inability to retrieve babies from within the network which is estimated to be about 14 times over the last 2 years although exact numbers are not available.

The table below gives numbers of transfers undertaken both into and out of LTH over the last six years.



	2002	2003	2004	2005	2006	2007
Non-acute	259	317	342	407	386	340
Acute	144	137	156	149	149	127

In January 2008 the service provision from LTHT to the Network was increased within existing Trust resources to support the transfer of non acute patients (not ventilated) between *any* of the hospitals within the Yorkshire neonatal Network (YNN) and between YNN and hospitals and those outside the Network. This was done to maximise the efficiency of the cots within the Network and allow for earlier repatriation of all babies within the Network. This was achieved by providing core transport time between the hours of 8am and 10pm daily. An acute emergency transport services can be provided out of

hours if required. This change in service has resulted in a 36% increase in activity from January to July 2008.

Cot Bureau

The Yorkshire neonatal Cot Bureau was set up in 2002 to assist all hospitals in the YNN to locate cots with the appropriate level of care for babies. The Cot Bureau also assists the Obstetric services to locate the hospitals with the appropriate level of Neonatal Care for mothers that require transfer before giving birth.
The Cot Bureau is manned daily from 8am – 10pm. All request for cots in the Network come through the Cot bureau allowing an overview of the capacity within Yorkshire. This service also assists the Transport team with up to date information of where babies are located that may need to be transferred back to their referring unit.

Provision of Community Outreach

Neonatal Outreach

A team of five experienced neonatal nurses based cross city at both Neonatal Unit sites provide on-going support to babies and their families who require specialist nursing care when they are discharged home from hospital. Each member of the team is responsible for the management of a defined caseload and carries responsibility for the assessment of care needs, and the development, implementation and evaluation of individual programmes of care. This level of support to parents and carers allows vulnerable babies with complex needs to be discharged home safely; it reduces the length of hospital stay, and by identifying potential problems early, prevents unnecessary readmission.

The team take the lead when planning any complex discharges, i.e. babies who require home oxygen therapy, or long term nasogastric tube feeding etc. The team have also recently started to offer all parents the opportunity to learn how to safely feed their babies via a nasogastric tube, utilising this skill reduces hospital admission time, re-uniting babies with their families as soon as possible at home. In a six month trial period, on one site only, short term tube feeding at home led to a saving of 224 in-patient days.

Neonatal Outreach also run a nurse led clinic providing Palivizumab therapy to babies who are at exceptional risk from Respiratory Syncitial Virus (RSV). The success of the clinic during the last RSV season ensured that none of the high risk group of babies was readmitted into hospital with RSV [Expected admission rate 10-15% in this population]. The team also identified potential cost savings of approx £15,000 with vial sharing and this is currently being explored with the pharmacy team.

Neonatal Outreach also offer support and act as a resource for midwives and health visitors working in the community.

By offering a seven day service, covering all of Leeds, the work of the team has improved the care offered to vulnerable babies and families it has also resulted in improving the capacity of the Neonatal Units.

Surgical Outreach

The appointment of the Network Consultant Nurse supported by a Surgical Outreach service has seen a significant decrease in the length of stay of those babies receiving Neonatal Surgery in Leeds. The Team provides on going support to infants, children and their families who require surgical intervention. The team is instrumental in facilitating early discharge to home or local hospital and also educates staff in order to ensure safe continuation of care. Many of the infants we manage require complex packages of care ie; tracheostomy, stomas and specialist feeding tubes.

Establishment & budget

2005/06	2006/07	2007/2008	2008/2009
£9,071,215	£9,414,361	£9,890.877	£10,588,870

Funded Nursing Establishment Neonatal Units, Transport Team and Transitional Care

ROLE	**WTE**
Band 8A ANNP	2
Band 7 Senior Sister	25.97
Band 6 Junior Sister	36.72
Band 5 Staff Nurse	97.66
Band 4 Nursery Nurse	7.97
TOTAL	170.32

The service has undertaken a skill mix reviews to ensure resources are used to the maximum benefit of babies and their families; this has included the creation of Advanced Neonatal Practitioner Roles (ANNPs). These are two of our most highly experienced senior sisters who have undertaken further training and education and now actively function on the medical rotas. The ANNPs work alongside the medical teams supporting junior doctors and nurses in education and training while delivering advanced clinical skills.

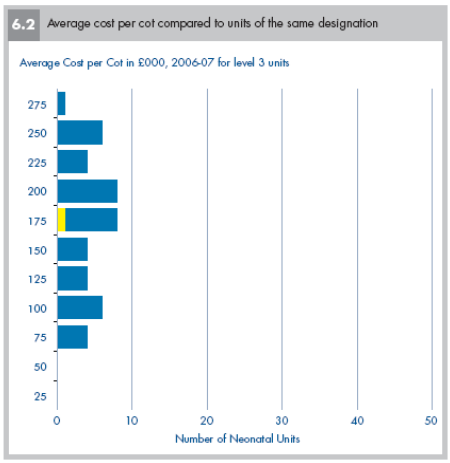
Medical Rotas:

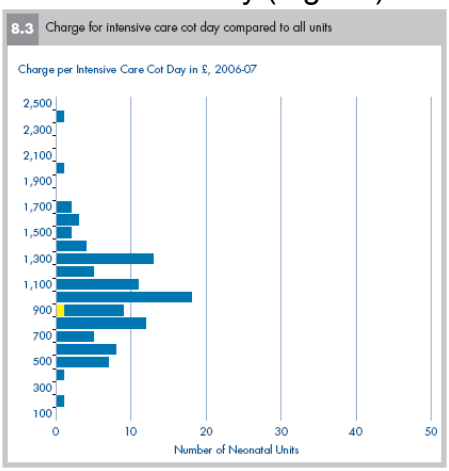
The two neonatal units within the service each have a separate medical rota of consultants and junior doctors comprising of 4 WTE consultants, 4 WTE neonatal registrars and 7-8 Senior House Officers on each unit. The Registrar rota is supported by doctors from other daytime paediatric specialties giving a total of 8 on each rota.

There is an increasing trend towards consultant delivered care as junior doctor training has reduced the experience of the resident doctors as seen by

the rota changes required to ensure Junior doctor rotas are European working time directive 2009 compliant (maximum 48 hours per week)[3]. This requires the Trust to look again at how the service is delivered and work is ongoing to define the service strategy.

Efficiency/cost
Costs per cot are similar to equivalent units nationally, though some other trusts' costs are considerably higher: (National audit office data 2007) Fig 6.2. Leeds service highlighted. The calculated charge to commissioners per intensive care day is lower in Leeds than nationally (Fig 8.3).





Role of the Leeds Service within the Network

The Leeds neonatal service operates within the framework of the Yorkshire Neonatal Network business plan, which was agreed with the trust in 2006. There are 42,000 births within the YNN region per year.

- Of the 9 NHS Trusts (12 units) with neonatal services, assuming reconfiguration of paediatric and maternity services in the future the neonatal network will consist of units based on nationally recognised classifications[i]
- 3 units classified as Level 3 Units
    - 4 units classified as Level 2 Units
    - 4 units classified as Level 1 Units

The Leeds Neonatal Service is designated as one of the three Level 3 Units with the Yorkshire Network.

The Yorkshire Neonatal Network Plan (2006)

- The national policy on the strategy for neonatal intensive care (www.dh.gov.uk) forms the framework for this plan

- Initially for all babies **under** 26 weeks gestation and those needing

[3] Training reviews (RCPCH) for the Leeds units have been very positive about the training provided to junior doctors

specialist services to receive their intensive care in one of the three level 3 neonatal services in the Network. Consideration will extend to consider whether this limit be revised over the course of the plan.

- All infants requiring neonatal care do so as close to their family home as is appropriate for their needs.

- The quality of care afforded to all patients and families within the YNN is to the highest standards of neonatal care

- Networks will not be able, nor will it always be appropriate, to deliver 100% of all NIC within its boundaries. This plan aims for at least 95% of IC for network residents will be delivered by the network.

Source: Yorkshire Neonatal Network Business Plan 2006

Changes in care pathways resulting from the YNN plan will have an effect on the capacity on the neonatal service within Leeds as some of the babies now cared for within local hospitals will be required to be transferred to the Leeds Neonatal service for initial care .The Trust are currently scoping the potential impact of this and will be working with the YNN to ensure appropriate capacity is in place and that the Leeds population are not adversely effected by these proposed changes.

Summary

- The Leeds neonatal service continues to offer an excellent specialist service to the most premature and ill newborn babies within the Yorkshire Network.
- The Leeds neonatal service runs with a high occupancy rate but uses cots flexibly to ensure it is responsive to need and has mechanisms in place to ensure any risks are appropriately managed
- On occasions tertiary referrals cannot be accepted or Leeds patients have to be transferred to another neonatal service but these are kept to a minimum and recent investment is intended to reduce this further.
- When a patient is transferred, this is almost always to another hospital within the Yorkshire network, but on a very few occasions it is to a hospital outside our network. This must be reduced and we continue to work with the YNN to minimise these occasions.
- We continue to review our service in response to local and national drivers. Service strategies are being developed with clinicians at the heart of these discussions to ensure safe and appropriate clinical models are in place.
- The service is currently working with Obstetric colleagues looking at the changes planned with the centralisation of Inpatient Children's services to ensure that a safe and responsive Neonatal service is in place as reconfiguration commences
- The YNN transport team (hosted in Leeds) provides an excellent service transferring an increasing number of babies around the region.

However this service has never been fully funded to include junior doctor cover. A joint PICU-NICU supernumerary transport team has been approved for 2009/10 by the SHA.

- The National Neonatal Task force (2008) has been jointly set up by the DH and the NHS to support Trusts in identifying and delivering real improvements to neonatal Services and will report in due course.

Circulation: Leeds Scrutiny Committee

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 16 September 2008

Subject: Performance Report

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

1.0 Introduction

1.1 At its meeting on 17 June 2008, the Board was advised that the process for appointing an organisation to host Leeds' Local Involvement Network (LINk) was well advanced and that an update would be provided in due course. As such, the report from the Director of Adult Social Services is attached.

1.2 The Board was also advised that as the LINk develops, consideration should be given to the developing relationship between the host organisation and the Scrutiny Board. To assist the Scrutiny Board (Health) to give some initial consideration to this, Tim Gilling from the Centre of Public Scrutiny (CfPS) has been invited to discuss such issues, within the context of national developments and examples of emerging good practice.

2.0 Recommendations

2.1 The Board is requested to consider:

2.1.1 The information provided in the attached report from the Director of Adult Social Services, identify any areas where further information is required and determine whether there are any specific matters that require more detailed scrutiny.

2.1.2 Any specific issues associated with the Boards future relationship with the appointed host organisation.

3.0 Background Papers

Item 6: Work Programming (Appendix 11: Outstanding/ potential items) – Scrutiny Board (Health) – 17 June 2008
Minutes of meeting: Scrutiny Board (Health) – 17 June 2008

Leeds CITY COUNCIL

Originator: Mike Simpkin

Tel: 24 74306

Report of the Director of Adult Social Services

Health Scrutiny Board

Date: 16th September 2008

Subject: The Leeds Local Involvement Network (LINk) – Update

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

Executive Summary

1. Following passage of the Local Government and Public Involvement in Health Act on 30th October 2007, the Department of Health funded local authorities to procure an independent organisation to act as Host for the future LINk in their area.

2. Scrutiny has a role in overseeing the Host procurement process. The Health and Adult Social Care Board received a first briefing on developments in Leeds to establish a Local Involvement Network (LINk) for health and social care at its October 2007 meeting.

3. This was followed by a further update in January 2008 and verbal reports have been given subsequently. This report outlines the process which the Council established in order to secure best value and looks forward to what can be expected of Host and LINk with particular reference to the relationship with the scrutiny function.

4. The procurement process has recently concluded with award of a three year contract to the Shaw Trust who will be represented at the meeting.

5. In the meantime, as required by legislation, the City Council enabled an independent LINk Preparatory Group to undertake transitional functions and prepare for the LINk proper.

6. LINk involvement will cover both health and social care and will therefore have implications for both the Scrutiny Boards covering these areas as part of the LINk's role is to promote and support public and patient involvement in the commissioning, provision and scrutiny of local care services. Protocols for relationship between the LINk and the Council's scrutiny function will need to be agreed.

1.0 Purpose Of This Report

1.1 This report is to report the award of the Host contract and to enable the Board to consider matters relating to the development of the LINk and future relationships with LINk and the Host Organisation.

2.0 Background Information

2.1 The background to LINks was contained in a report to the October meeting of the Board. The latest Department of Health leaflet explaining LINks to the public is attached as Appendix.3

2.2 The Local Government and Public Involvement in Health Act in on 30th October 2007 provided for the winding up of the Commission for Patient and Public Involvement on 31st March 2008, signifying the end of Patient and Public Involvement Forums. Local Authorities with Social Services responsibilities are required to commission an organisation to act as Host for the Local Involvement Network (LINk) in their area. The LINk replaces local Forums and also extends to social care. Brief details of the Act are contained in Appendix 1 and Appendix 2 has website references for further information.

2.3 The Department of Health provided all relevant local authorities with £10,000 to meet consultation and procurement costs and announced the individual allocations for local LINks in December 2007. Leeds is to receive slightly over £300,000 per annum for the next three years. However these allocations are not ring fenced and form part of the Area Based Grant which Local Authorities are entitled to spend as they wish in pursuit of their statutory and agreed objectives. The Council's policy on the Area Based Grant has been to make allocations for Year 1 according to expectation but to seek opportunities in Years 2 and 3 to review allocations for duplication and more effective spend. However the Council has also recognised that a number of 3 year contracts have to be made using the ABG.

2.4 The Department of Health also initially insisted that the exercise should be led independently of Social Services, but later came to the view that this was not practicable since many authorities had no other source of expertise in this field.

3.0 Procurement Process for the Leeds LINk

3.1 An Advisory Group was set up in June 2007 with representatives from the Council, local NHS involvement leads, the Patient and Public Involvement Forum, the Service Users and Carers Alliance and the VCF sector. As the procurement process began, potential VCF bidders withdrew and the Advisory Group became a Project Team. It was agreed to follow the restricted procedure (two stage process) according to EU regulations. The tender inviting Expressions of Interest was advertised in the Official Journal of the EU, in the local press, through the Voluntary Action Leeds newsletter, and on the Council's contracts website. By the closing date of 31st December, 8 expressions of interest had been received including three local organisations.

3.2 A city-wide event for patient, service user and carer groups was hosted in the Civic Hall on 4th December to publicise the new LINk arrangement and gain views on its development in Leeds. The event was well attended by local organisations and individuals, including elected Members and the then Chair of the Scrutiny Board.

3.3 On a more technical level there were separate discussions around contractual issues including the possible application of TUPE. On this matter, following legal advice circulated from the Department of Health in December 2007 and after consultation with the Council's Legal Services, the conclusion from the Council's point of view was that TUPE did not apply.

3.4 Also in December a LINk Reference Group was established for Patient and Public Involvement members and representatives of Service Users and Carers.

3.5 An Evaluation Team was selected including one PPI member and one representative of social care service users. Using a consensus method and working on previously agreed scoring criteria the Evaluation Team, supported by the Corporate Procurement Unit, recommended a short list of five organisations, two of which were from Leeds. However one shortlisted national organisation then sent notice of withdrawal from all its local LINk bids.

3.6 The Project Team prepared a service specification which was commented on and agreed by the Project Team and Reference Group. The specification also went through an equality assessment. The specification included a timetable of milestones to enable the establishment of the LINk by September 2008.

3.7 A Project Board was convened, chaired by the Head of Corporate Procurement and including the Deputy Director of Social Services, a PCT Executive Director, the Council's Equality Strategy Manager and two representatives of patients and service users (not those on the Evaluation Team). The Board approved the specification and shortlist.

3.8 Four shortlisted organisations, two from Leeds and two external, were invited to prepare tenders with a closing date of April 9th. One local organisation was granted permission to withdraw from the process because of capacity.

3.9 Three tenders were received and evaluated against the agreed criteria. The LINk is a new concept whose essence will be as much in the development as the specification. Both tendering and evaluation were complex matters. Following the initial evaluation the Project Board decided that the two leading tenders required further clarification. The subsequent interviewing process meant that the evaluation took longer than expected and the final recommendation could not be included in the Council's revised Forward Plan until the beginning of August at which point it was agreed that the contract for Hosting the new Local Involvement Network should be awarded to the Shaw Trust. Further details about commencement of the contract and initial arrangements will be given at the Board meeting.

4.0 Shaw Trust

4.1 The Shaw Trust is a national charity with 25 years experience of supporting people with disabilities and people with a disadvantage especially into employment. There is already a branch of this service in Leeds. In recent years the Trust has become increasingly active in representation and advocacy and from 2003 was a major contractor to the Commission for Patient and Public Involvement for the support of over 40 PPI Forums, the predecessors of the LINks. The Trust therefore brings considerable experience to the task while recognising that LINks will be completely different. Indeed the Trust was itself involved in working with the Department of Health in recommending changes to the Forum system and has been successful in winning a number of other Host contracts, including Wakefield.

5.0 Consultation and Engagement

5.1 The Project Team sought to distribute information about the LINk widely within Leeds and to make information available on the internet from different local websites. Information has been made available on audio tape and Braille where requested. This work was supported by the NHS Trusts in Leeds which have simultaneously been developing their own involvement networks.

5.2 The Service User, Carer and Patient Reference Group met for the first time on 19th December and continued to meet until the March, providing advice and contributing to work such as the equality impact assessment. The group provided nominees for the Project Team and Procurement Board, to be drawn equally from NHS patient representatives and users of Social Care services. The group also looked to the future and agreed the direction and scope of transitional arrangements.

6.0 Transitional Arrangements

6.1 The Act instructs Local Authorities to make transitional arrangements where there will not be a Host or LINk operative by the time the current PPI Forums are wound up at the end of March. This transitional period expires on 30th September.

6.2 Leeds was fortunate in having an active and involved section of the community supported by local organisations, the NHS and former PPI Forum members to assist with this task. The LINk Reference Group agreed to become an independent LINk Preparatory Group and elected a Chair from the Service User and Carer Alliance, supported by a former PPI Forum Member. The City Council, anticipating guidance which subsequently appeared from the Department of Health, sought and secured an independent VCF organisation not connected with the bidding to support the Preparatory Group and an agreement was made with Leeds Older People's Forum. This is funded out of the Department of Health LINk allocation and is now expected to last until mid September.

6.3 The Preparatory Group has met approximately on a monthly basis, has created subgroups and pursued a number of issues. However these have been limited because of the transitional nature of the group. The Group has discussed future governance possibilities but has also recognised that it will not necessarily become the Steering Group of the new LINk because governance arrangements and scope of the LINk will be for the Host organisation to develop along with old and new LINk members as it moves towards a firm and agreed structure.

7.0 Regulations for the LINk

7.1 Regulations relating to the LINk were issued in March/April 2008. These included the necessity for providers of health and social care (other than the care of children looked after by the local authority) to allow visiting by LINk representatives within stated parameters and on an agreed basis. There is a requirement that local authority and NHS contracts with independent providers include this facility.

7.2 A formal Code of Conduct for LINk visitors was issued in July 2008. The Code explains the legal responsibilities and duties; sets out good practice in terms of preparing for a visit; provides advice for authorised representatives at the time of their visit (including conduct); and covers what LINks should consider once a visit has finished (including how to share information).

8.0 Regional and National Support

8.1 During the procurement process the Project Team has kept in touch with developments in the region and elsewhere. The Care Services Improvement Partnership (CSIP) set up a regional network for local authorities during the procurement process and has now transferred this support to Host organisations. The Department of Health has itself been keen to offer support and there are a number of national websites with information, guidance documents and the opportunity to share and comment on issues. The Shaw Trust will join the Leeds LINk to the Community Voices Network.

8.2 There has been considerable discussion about the desirability of national branding for Local Involvement Networks. There seems to be most consensus about having some core statements and products which prevent LINks having to reinvent statements of purpose, vision or values. The Department of Health is also keen to ensure that these statements are communicated effectively. It is therefore developing a visual identity that LINks can tailor, as it will be used by more than one area, but which will also maintain a level of consistency in order to build public recognition and trust. There will also be a communications toolkit that will provide LINks with tools they can use to engage their communities.

9.0 Implications for Council Policy And Governance

9.1 The Local Authority will have responsibility for assigning the contract for the Host and performance managing it over its three year period. Although the Host will eventually be primarily accountable to the LINk itself, a mechanism will be needed for formally reporting on contract performance mainly around technical issues and probity issues. However there could also be a troubleshooting role and it may also be that an offer of support and liaison from the statutory agencies would be welcomed by the LINk and the Host.

9.2 However the independence of the LINk is protected in the legislation. The local authority is not permitted to influence the LINk through management of the contract.

9.3 Implementation of the Council's Duty of Involvement will need to take account of the LINk and offer it support and information, particularly in relation to social care and the proposed Equality Assembly. The specification for the Host encourages it to support the LINK in looking at broader health as well as at service issues.

9.4 Section 226 of the Local Government and Public Involvement in Health Act empowers the LINk to refer social care matters to the relevant Local Authority Scrutiny Committee. The referral must be acknowledged (within 20 working days) and the referrer kept informed of any action but the scrutiny committee is not obliged to take up issues referred to it by the LINk. Under Section 227 the LINk is also required to send its Annual Report to the Local Authority Scrutiny system.

10.0 Legal And Resource Implications

10.1 The City Council is required by law to commission a Host for the LINk. The Host is accountable to the local authority in terms of performance to contract but its major accountability is to the LINk which is itself broadly accountable to the Secretary of State for Health.

10.2 The LINK is funded by the Department of Health through the Area Based Grant and the financial allocation for the LINk is detailed in Paragraph 2.3.

11.0 Comments

11.1 The LINk process has been complex and occasionally fraught. It is clear that in order to win support for the LINk concept, the Department of Health loaded it with expectations which caused considerable anxiety both for local authorities and for local communities. In particular many PPI Forum members remained unconvinced that the LINk would provide any better a model than the one which they were developing. The concept remained contested until the legislation was almost complete and provision for transitional arrangements was included only at the last moment. However once the legislation was passed, the Department has tended to hold off and enable local arrangements to develop; this made the process easier for everyone. However if the Department had recognised a little earlier that the scheme required a longer implementation timetable than they had originally anticipated, local processes could probably have been developed more smoothly.

11.2 It is hoped that by the time of this meeting the work of all concerned in the Host procurement process will be beginning to show fruit. As stated in a previous report, this work could not have been successfully carried out without the active support of partners from the NHS, the VCF sector, and from patient, service user and carer groups and particular tribute must be paid to the latter, who put aside their dissatisfaction about the past (in the case of PPI Forum Members) and their anxieties about the future of involvement n order to play a constructive role in the preparation. This is especially true of those who have given their time and commitment to being members of the procurement exercise and to participating in the LINk Preparatory Group.

12.0 Conclusions

12.1 Despite some unforeseeable delays, the Council has been able to complete a satisfactory procurement process within the required timescale. The appointment of the Shaw Trust can be expected to add a fresh dimension to existing involvement structures in Leeds which will offer broader connections with other areas and some economies of scale. At the same the local Host will have a full commitment to the local LINk.

13.0 Recommendations

13.1 The Board is requested to note the information in this report and to make such comment as it deems appropriate.

13.2 The Board is also requested to ask officers to consult with the LINk Host in order to formulate suitable proposals for the connection between the Scrutiny function and the LINk.

Background Documents

Listed at Appendix 2.

APPENDIX 1 LOCAL GOVERNMENT AND PUBLIC INVOLVEMENT IN HEALTH ACT Part 14: Patient and Public Involvement in Health and Social Care

Procurement of "hosts" - Section 221 requires each social services authority to procure an organisation or "host" to establish and support a Local Involvement Network (LINks) in each local authority area. The "host" will support LINks to:

- promote and support the involvement of people in commissioning, provision and scrutiny of local care services ("care services" refers to both health and social care)
- enable local people to monitor and review the standard of local care services and report on how they could be improved
- obtain the views of local people about their experience of local care services and their care needs.

The responsibilities of LINks can be amended by regulation by the Secretary of State but that they can only be added to not taken away, as was possible in the original Bill. The Act outlines the bodies that are not permitted to provide such support or become a LINk: they are local authorities; NHS trusts; NHS foundation trusts; primary care trusts or strategic health authorities.

Local Involvement Networks (LINks) – LINks will be required to have a clear governance structure including: the process for decision-making; how LINks members are authorised to act on behalf of the LINks; financial arrangements; and how breaches of authority are dealt with.

Health and social care providers will be required to: respond to LINks requests for information; consider and respond to reports and recommendations made by LINks; allow authorised representatives of LINks to enter and view premises on which care is delivered (but representatives will not be permitted to enter and view private rooms of individuals).

LINks must produce an annual report giving details of their activities, their membership and their financial arrangements.

Relationship between LINks and overview and scrutiny committees – LINks are able to refer "social care matters" to the appropriate overview. There is no obligation for the committee to act on every referral but they must acknowledge the receipt of the referral and "keep the referrer informed of the committee's actions in relation to the matter".

Transitional arrangements – Local authorities will be expected to procure host arrangements by 31 March 2008 but in those areas where this has not been possible, local authorities will be subject to "temporary duty" lasting until 31 September 2008 to ensure that there are means to support LINks activities. Temporary arrangements could include the local authority providing support to LINks or agreeing an interim contract with another organisation to provide support to LINks. The Act does not specify the consequences for local authorities if they have not procured host support by 31 September 2007.

Abolition of the Commission for Patient and Public Involvement in Health and Patients' Forums – The Act abolishes the CPPIH and all Patients' Forums with effect from 1 April 2008. All property, rights and liabilities of Patients' Forum will transfer to the Secretary of State for Health. Furthermore, any legal proceedings may be continued by the Secretary of State. Before they are abolished, they will be required to prepare a report of "anything being done by the Patients' Forum".

Duty to involve service users (Section 233) – All NHS bodies, including strategic health authorities, must make arrangements to involve service users and/or their representatives in the planning, delivery, development and decision-making in relation to health services. Furthermore, all health bodies must publish a report (believed to be annual although this is not specified in the Act) giving details of the consultation it has carried out or proposes to carry out before making commissioning decisions. It must also report on "the influence the results of any relevant consultation had had on such matters".

APPENDIX 2

Website links

A Stronger Local Voice July 2006 – the original consultation document setting out intentions.
http://www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=GET_FILE&dID=20130&Rendition=Web

Government Response to comments on A Stronger Local Voice December 2006
http://www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=SS_GET_PAGE&siteId=en&ssTargetNodeId=566&ssDocName=DH_062839

House of Commons Select Committee on Health report and the government response can be downloaded via:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075501

Getting Ready for Links Guidance Documents **August 2007**

Planning your Local Involvement Network

Contracting a Host for your Local Involvement Network

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_077266

The **NHS national centre for involvement** has a section on LINks and Department of Health **LINks bulletins** so far can be downloaded from
http://www.nhscentreforinvolvement.nhs.uk/index.cfm?Content=142

LINks exchange

A network for sharing best practice and supporting and developing those implementing Local Involvement Networks (LINks). Access is currently by accepted registration only.

http://www.lx.nhs.uk/

APPENDIX 3

Stronger Voice Better Care
The LINk Explained

.pdf document attached.

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Department of Health

Stronger voice, better care

Local Involvement Networks (LINks) explained

A Local Involvement Network (LINk) has been set up in every area of England to help people influence or change the way their local NHS and social care services are delivered.

This document explains more about LINks and how you can make your voice heard by getting involved.

What is a LINk?

A LINk is made up of individuals and community groups who work together to improve local health and social care services.

The job of a LINk is to find out what people like and dislike about local services, and to work with the people who plan and run them to help make them better.

This may involve talking directly to health and social care professionals about a service that is not being offered, or suggesting ways that an existing service could be made better.

LINks also have powers to help them do their job and to make sure that changes happen.

What does it do?

A LINk can:

- ask local people what they think of local health and social care
- give people a chance to suggest ideas to care professionals that may help improve services
- look into specific issues of concern to the community (like a dirty hospital), make recommendations to the people who plan and run services, and expect a response
- ask for information about services and get answers within a specified amount of time
- carry out spot checks, when necessary, to see if services are working well (checks are carried out under safeguards)
- refer issues to the local council Overview and Scrutiny Committee if it seems that action is not being taken

LINks at work: an example

A number of people raise the issue of GP opening hours with a LINk. GPs at the local surgery say they want to open during the evening and at weekends but they have limited resources.

The LINk offers to help the surgery staff find out the hours that will best suit local people by asking the community for their views. It also asks LINks in other areas how they have dealt with the same issue.

The LINk's research finds that people who work would prefer more early morning appointments, so they can see a GP but not be late for work.

As a result, the GPs decide that the surgery will close one afternoon a week so that they can open for more early morning appointments. They also start a call-back service, so people can have quick telephone consultations.

Who can join?

Anyone – carers, service users, community leaders, patient representatives … everyone's views matter.

Groups can also join – charities, faith groups, residents' associations, youth councils, black and minority ethnic organisations, business federations … anyone who wants to make sure that the needs of their community are listened to.

Why get involved?

There are a number of benefits to becoming involved in a LINk. These include:

- getting attention for neglected issues or ideas
- influencing those who make decisions about new or existing health and care services
- helping the community speak with a stronger local voice
- helping services provide better care

How much time will it take?

It's up to you how and when you get involved. Your LINk should provide different ways for you to make your views count.

You can just comment on issues when contacted by your LINk, or you can get more involved – by raising awareness of an issue or by helping to find solutions (for example, by meeting providers or being part of a working group).

It's up to you how and when

- Take a few minutes to answer a survey
- Attend an occasional meeting on an issue that interests you
- Get involved in an online group looking at a specific issue
- Become an 'authorised representative' who goes to services to see how they are run

How a LINk is run

There is no set structure for a LINk, and it is unlikely that any two LINks will be run in the same way. A LINk will only work if it is owned by, and involves, the whole community.

Local councils have been given money to fund LINks, but each LINk will decide how best to operate and what priorities to concentrate on.

Every local council has employed an independent organisation to set up, advise and support the LINk for its area.

Most LINks should be up and running by September 2008.

Support for LINks

The role of organisations employed to support LINks can include:

- telling the community about a LINk and encouraging people to get involved
- advising the LINk
- providing office support and helping the LINk to develop clear systems
- managing the LINk's budget and recording its activities
- letting the community know about what the LINk is doing and asking for their views
- reporting the LINk's progress to Government

Getting started

To find out what is happening in your area, contact your local borough or county council.

LINks and the law

LINks can:

- ask health and social care commissioners for information about their services and expect a response
- make recommendations and expect a response from commissioners
- refer matters to the local council's Overview and Scrutiny Committee
- enter specific services and view the care provided

More information

To find out more, visit:

www.direct.gov.uk/localinvolvementnetworks

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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: 16 September 2008

Subject: Response to the Scrutiny Inquiry Report: The Localisation of Health and Social Care Services

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

1.0 Introduction

1.1 During the previous municipal year (2007/08), the Scrutiny Board (Health and Adult Social Care) undertook a scrutiny inquiry that considered 'The Localisation of Health and Social Care Services'. The final scrutiny inquiry report was published in May 2008. Copies of the final report have previously been circulated to members of the Scrutiny Board.

1.2 As previously reported, many of the recommendations identified in the inquiry report are cross-cutting, aimed at both health service and social care providers. It was also previously reported to the Scrutiny Board that given the context of the inquiry and the subsequent recommendations, it would perhaps be inappropriate and somewhat artificial to split the recommendations to report to the newly formed Scrutiny Boards for 'Health' and 'Adult Social Care' respectively.

1.3 With this above context in mind and given that the legislative powers for NHS Scrutiny rest with the Scrutiny Board (Health), it was agreed to incorporate tracking of all the recommendations within the work programme of the Health Scrutiny Board.

2.0 Report Issues

2.1 The initial response to the recommendations (attached at Appendix 1) is presented to the Scrutiny Board (Health) for consideration.

2.2 In recent years, Scrutiny Boards have adopted a more rigorous approach when monitoring progress against inquiry reports and/or statements. As a result, when tracking recommendations Scrutiny Boards consider progress against a standard set of criteria. These are presented in the form of a flow chart and attached at Appendix 2 to enable the Board to assess progress and any resulting actions arising.

2.3 The questions should help to decide whether a recommendation has been completed, and if not whether further action is required, allowing the Board to monitor progress and identify completed recommendations; those progressing to plan; and those where there is either an obstacle or progress is not adequate. The Board is then be able to take further action as appropriate

3.0 Recommendations

3.1 The Board is requested to consider the information provided in the attached report and determine:

3.1.1 What, if any, further action is necessary;

3.1.2 Any matters that require any further scrutiny;

3.1.3 Any specific matters to be referred to the Scrutiny Board (Adult Social Care) for action/ consideration

4.0 Background Papers

Scrutiny Board (Health and Adult Social Care) – May 2008: Inquiry Report – The Localisation of Health and Social Care Services
Scrutiny Board (Health) – 17 June 2008: Item 6 – Work Programming (Appendix 11: Outstanding/ potential items)
Scrutiny Board (Health) – 17 June 2008: Minutes of meeting
Scrutiny Board (Health) – 22 July 2008: Item 12 – Work Programme (Appendix 1: Draft work programme)

SCRUTINY BOARD INQUIRY INTO LOCALISATION OF HEALTH SERVICES: RESPONSE TO RECOMMENDATIONS

Recommendation 1:
That :

- ***a thematic group be developed for health and wellbeing, including adult social care, in each of the three new areas***
- ***the thematic groups work with the area committees to discuss and agree the nature and regularity of their dialogue in the future***

Response from Leeds Primary Care Trust (PCT)

The Primary Care Trust (PCT) and Adult Social Care support this recommendation and are working together to identify the most effective way to ensure implementation on a sustainable basis. This work includes gaining a better understanding of how other large urban areas work on a locality basis. A visit to Nottingham is planned for September 2008. The PCT and Adult Social Care recognise the need for dedicated officer time for each of the three new areas. This will ensure effective coordination and link the health and wellbeing programme to the officer coordination groups, area committees, local neighbourhoods and the Healthy Leeds Partnership. Proposals are being developed and will be presented to the Scrutiny Board by the year end.

Response from Adult Social Services

Area Management is represented on the Council's Strategic Leadership Team for Health and Wellbeing - providing a direct link between citywide and area concerns.

Development of a locality focus for health and wellbeing is included in the draft Adult Social Care service plan, as are plans to increase capacity to enable improved co-ordination around Health and Wellbeing for area committees and the development of local thematic groups.

Recommendation 2:
That the results of the PCT's review of minor surgery in Leeds be reported to this scrutiny board at the earliest opportunity.

Response from Leeds Primary Care Trust (PCT)

The PCT has concluded a review of current minor surgery facilities in primary care which shows areas of under utilisation. The PCT has set goals for increasing this uptake. We have completed a service specification for minor surgery to further encourage the use of local facilities.

Discussions are now taking place with Practice Based Commissioners about how we can work with providers to increase service options and choice for patients locally. We are also working with Leeds Teaching Hospitals NHS Trust (LTHT) to ensure that any new capacity will deliver faster access to services for patients (18 weeks).

Recommendation 3:
That Leeds PCT provides quarterly reports to this Board during 2008/9 regarding the development of services in the new LIFT financed health centres in Leeds.

Response from Leeds Primary Care Trust (PCT)

Background information regarding Local Improvement Finance Trust LIFT financed health centres in Leeds is provided in Annex A.

Update on progress
Since the localisation report was published the PCT has finalised arrangements for a number of additional clinical services to be either relocated or provide clinical sessions in LIFT buildings, these include:

- specialist Diabetes services at Middleton Health Centre;
- Yorkshire Ambulance Service – Rapid Response vehicle standby point at Wetherby Health Centre;
- Childrens' Disability Team at Armley Health Centre.

The relocation of two further services is almost finalised:

- Leeds Dental Institute, and Community Dental service at Beeston Hill; and
- Leeds Addiction Unit and Physiotherapy (hand) service at Middleton.

Discussions are also taking place with the following services:

- Primary Care Independent Contractors Services;
- Podiatric surgery;
- Hand surgery;
- Oversees Travellers Clinic;
- CAMHS (Child and Adolescent Mental Health Service);
- Weight Management Team;
- Drugs Team;
- Health Access Team;
- Health Promotion advice/information;
- Primary Care Mental Health Team;
- Children's Team;
- Speech and Language Service;
- Ear, Nose and Throat services outpatients;
- Audiology outpatients;
- Opthalmology outpatients;
- Diabetes services;
- Gynaecology outpatients;
- Dermatology outpatients;
- Urology outpatients; and
- Yorkshire Ambulance Service station relocation.

The PCT is keen to ensure the Scrutiny Board is kept up-to-date on these developments. Due to the length of time it takes to implement changes of this nature a further report to the Board is proposed in six months' time.

Recommendation 4:
That, during the summer of 2008, Leeds PCT carries out consultation to determine what services and opening times local people would like to see for their new Community Health Centres and reports the findings back to this Scrutiny Board at the October meeting.

Response from Leeds Primary Care Trust (PCT)

The PCT is committed to listening to the views of patients and the public when improving health services. Engagement/consultation on services and opening times for GP practices and health centres has been undertaken in the following ways:

- **City-wide engagement on GP-led health centre**
  During summer 2008 the PCT has consulted the public, patients and stakeholders about the development of a GP-led health centre in Burmantofts. This also includes views from across the city about what services and opening times people would like to see in their local GP practices and health centres. A full analysis of this feedback has been undertaken and will be available in September 2008. The information in this report will influence the services provided at the GP-led health centre in Burmantofts. It will also be taken forward through the PCT's primary care strategy which is currently being finalised.

- **GP Patient surveys and local questionnaires**
  The annual patient surveys commissioned by the PCT and the Department of Health ask a question about opening times for GP practices. This allows local practices to assess the local needs and wishes of their patients and respond appropriately.

  There are core opening times for all GP practices (8am to 6.30pm) and this year we have incentivised practices through a voluntary scheme (we pay them under Local Enhanced Service Payments) to open extended house in the evening and/or at weekends. As part of this agreement they are also required to carry out an additional patient questionnaire to find out what times the patients want practices to open. 60% of our practices already undertake such surveys and open extended hours. In our community centres, extended and weekend opening times is awaiting planning permission approval as this was not included in the original planning application.

- **Engagement on Joint Service Centres**
  The PCT is working in partnership with Leeds City Council to develop three Joint Service Centres in Chapeltown, Harehills and Kirkstall. Some engagement and consultation for these centres has already been undertaken and asked for feedback about the type of services people wanted to see in the centres. This will be used to influence what services are included in the centres.

- **Engagement on GP services in Rothwell, Middleton and Swillington**
  The PCT has carried out a range of engagement recently over changes to GP practices in south Leeds. This included asking patients what services they wanted to see in their local GP Practice/health centre and the opening times that would be convenient for them. This information has influenced the range of services provided locally and also played a key part in selecting the organisation to provide the service.

Recommendation 5:
That Leeds PCT keeps this Board informed of progress with the programme of refurbishment over the next municipal year.

Response from Leeds Primary Care Trust (PCT)

PCT Capital Programme
The PCT Board signed-off the capital investment programme for 2008/09 in July. The programme includes investment to enable the PCT to improve buildings by undertaking essential maintenance and statutory work (£1.1 million investment); and refurbishment and carbon-reducing opportunities (£0.8 million investment). The properties benefiting from this investment are:

- Bramley Clinic;
- Burmantofts Health Centre;
- Chapeltown Health Centre;
- Garforth Clinic;
- Gildersome Clinic;
- Halton Clinic;
- Holt Park Health Centre;
- Horsforth Clinic;
- Hunslet Health Centre;
- Kirkstall Health Centre;
- Meanwood Health Centre;
- Morley Health Centre;
- Otley Clinic;
- Pudsey Health Centre;
- Rothwell Health Centre;
- Seacroft Clinic;
- Swillington Clinic;
- Woodsley Road Health Centre

This year's refurbishment programme builds on schemes commissioned last year, such as Hunslet Health Centre which now benefits from:

- improved patient reception and waiting areas;
- disability accessible doors and toilets; and
- additional GP space to accommodate service improvements.

The programme for 2008/09 is currently out to tender and will be delivered by March 2009. One of the first schemes to be completed is the refurbishment of Burmantofts Health Centre which will host the GP-led Primary Medical Care service delivering essential healthcare services for the people of Leeds.

Other properties benefiting from the PCT Capital investment programme 2008/9 include:

- Morley Health Centre;
- Chapeltown Health Centre; and
- Hunslet Health Centre (on-going work from previous year).

Recommendation 6:
That the strategy for Wharfedale Hospital, due to be developed during early 2008, be presented to the first meeting of Scrutiny Board (Health and Adult Social Care) in the municipal year 2008/9.

Response from Leeds Primary Care Trust (PCT)

Leeds Teaching Hospitals Trust (LTHT) and the PCT are working closely together to develop proposals to ensure the best solution for the population of Leeds.

LTHT is presenting a separate paper to the September Board meeting to cover their Peripheral Hospitals Strategy.

Recommendation 7:
That Leeds Adult Social Services and Leeds PCT make arrangements to :

- ***Produce commissioning and procurement documentation in plain English***
- ***Offer personal contact for voluntary and community groups to explain tender documentation and procurement processes and report these arrangements back to this Scrutiny Board by December 2008.***

Response from Leeds Primary Care Trust (PCT)

The PCT is arranging plain English training for a range of staff responsible for producing documents for the public and other stakeholders (such as voluntary and community groups). This training will ensure our information is clear and concise. The PCT is also developing a 'style guide' to make sure that it has clear standards and expectations in place about how information should be produced.

Leeds PCT has a Patient Reader Group which comments on the design, layout, content and style of the PCT's patient leaflets and some corporate and public information documents. We are encouraging all services to make sure their patient leaflets are approved by this group before distribution. This ensures our information is logical, easy to understand and jargon free.

Leeds PCT regularly communicates with the Voluntary, Community and Faith sector (VCFs) groups and supports them in the procurement process by holding 'bidder' events to explain the process and ensure equity.

Response from Adult Social Services

The Chief Officer , Social Care Commissioning has been asked to prepare a separate report for the Adult Social Care Scrutiny Board on commissioning practice within adult social care. In this report attention will be drawn to a commissioning toolkit which has been developed for adult social care which provides advice and guidance to staff, including the use of plain English. This report is due to be consider by the Adult Social Care Scrutiny Board at its meeting on 17 September 2008.

Recommendation 8:
That Leeds PCT provides a report to the Scrutiny Board in July 2008, providing information about the funding received for, and money spent on, Choosing Health priorities in 2007/8.

Response from Leeds Primary Care Trust (PCT)

Leeds PCT spent its full 2006/2007 Choosing Health allocation of £1.67m in 2007/08 on the following areas:

Scheme/ Initiative	Funding
Sexual Health - including contraception services, HIV testing, new consultant in genito-urinary medicine	£374,000
Alcohol Harm Reduction – interventions in primary care	£140,000
Health Trainers - including training at Thomas Danby college	£135,000
Childhood Obesity – to help implement the Leeds Childhood Obesity Strategy	£264,000
Leeds Healthy Schools – to support Leeds schools programme	£225,000
Health advocate support for travellers	£35,000
Mental health and well being – including an Irish health outworker, domestic violence support	£78,000
Campaigns and promotion – including work with pharmacies	£55,000
Local initiatives (from former 5 PCTs) – e.g Neighbourhood Networks, exercise on referral, healthy walking, welfare rights	£326,000
Information post - this is a role involving Geographical Informatics Systems based with the Chief Information Officer. This is a long standing post now funded by Choosing Health.	£38,000
Total	**£1,670,000**

Recommendation 9:
That Leeds PCT gives consideration to replicating the out of hours dental provision at Lexicon House elsewhere in Leeds to provide better coverage for areas outside the city centre.

Response from Leeds Primary Care Trust (PCT)

Leeds PCT has tendered the provision of all urgent care, in-hours and out of hours. This is a competitive dialogue process, whereby the PCT does not set out how services will be delivered, but instead looks to the bidders to develop proposals as to how patients' needs would best be met, using information from the engagement process. The final specification for the urgent care service will be available in September and an update will be provided to the Health Proposals Working Group.

Recommendation 10:
That Leeds PCT gives an assurance to this Board that it intends to provide funding for the intermediate care beds at Middlecross home for older people in 2009/10.

Response from Leeds Primary Care Trust (PCT)

The Middlecross Care Home currently provides five beds within a total of 15 dementia Intermediate Care beds. All of the Partnerships for Older Peoples Projects (POPPs) pilots are subject to evaluation of their effectiveness in terms of both quality and finance and this information will influence the future sustainability to mainstream projects. It is also recognised through the development of the Leeds Intermediate Tier Strategy that provision for people with dementia is a priority but should be as part of the PCT's Care Closer to Home programme. These types of service will be developed as part of the commissioning plan to implement the Intermediate Tier Strategy; within that will be a plan to provide Intermediate Care Beds including the dementia beds where appropriate.

Response from Adult Social Services

The intermediate care provision within Middlecross Resource Centre has been funded for a further year (April 08 – March 09) with a combination of POPP Programme slippage, Adult Social Care and PCT funding. The activity and outcomes continue to be monitored against the service milestones by the POPP Performance management group.

The service continues to meet its activity targets and is developing new and innovative ways of providing hospital admission avoidance, early supported discharge and rehabilitation for older people with dementia and physical and social needs.

Plans for securing the long term sustainability of the service are in place with a Programme evaluation event planned for September 08. Following this event business plans will be developed and submitted for consideration by the commissioning teams within Adult Social Care and the PCT. This service will be considered alongside other POPP projects as part of a "whole system" package of interventions to improve the rehabilitation opportunities for older people with mental health needs.

Recommendation 11:
That the Director of Adult Social Services explores the possibility of instigating 'trial runs' at home for patients prior to discharge from Richmond House, to assess how well they will cope.

Response from Adult Social Services

Everyone in a CIC bed at Richmond House has a full assessment while they are there. This can include a home visit and certainly includes a full exploration of their needs in order to return home. Most people returning home from the CIC beds do so with the support of the Intermediate Care Team. They are then reassessed at home by a member of the Joint Care Management Team in conjunction with the ICT. If longer term services are required a Care Plan is presented to the West Gatekeeping Panel.

There are occasions when people return home and the return home does not succeed. In some cases people have then returned to a CIC bed at Richmond House. However, we are looking carefully at this practice in order to ensure that people whose need is for permanent residential care do not return to a CIC bed and wait there, possibly for several weeks, when a CIC bed is no longer required.

As these arrangements are flexible and can accommodate a number of uncertainties, it is felt that the introduction of a 'trial run' will only add a further unnecessary step in what is already a very thorough process.

Recommendation 12:
That progress with the development of Practice Based Commissioning in Leeds, particularly the arrangements for

- ***management support for the PBC Forum***
- ***patient and public involvement, and***
- ***the continuing discussions between Health and Adult Social Care colleagues of joint opportunities presented by PBC***

are monitored by this Scrutiny Board in 2008/9.

Response from Leeds Primary Care Trust (PCT)
Recent reconfiguration of the Practice Based Commissioning (PBC) Consortia in Leeds is outlined below:

Consortia	No. of practices	Population
H3+	31	276496
Leodis Healthcare	30	205093
North East Consortium	13	116277
Leeds Commissioning Collaborative	14	49828
The Wetherby & District Group	5	33155
Church Street Group	6	14964
Unaligned Practices	14	98265

The two largest consortia have fulfilled the requirements of "earned autonomy", demonstrating that they have robust governance and risk management arrangements in place, and have achieved against previous years' plans.

The PBC Governance Committee has approved ambitious strategic and operational plans for five of the consortia, and it is anticipated that remaining plans will be approved in September 2008. All PBC plans demonstrate a commitment to national and local priorities, to patient and public involvement and joint working with local authority and third sector organisations.

We anticipate that the number of unaligned practices will reduce as discussions are still taking place between some of these practices and the established PBC consortia. At least seven practices are implementing PBC as individual practices this year, and only two practices in the city have declined to participate in PBC at this stage.

Plans are being developed in partnership with the PBC Forum to establish a Commissioning Executive to ensure strategic connections between different strands of PCT commissioning and PBC. It is anticipated that the new arrangements will be in place in shadow form from October 2008.

The PCT has reviewed the management support for PBC. The dedicated PBC team provides direct support to PBC consortia and practices and facilitates support from other PCT departments, such as Finance, Information, Public Health, Patient and Public Involvement (PPI), and Commissioning. The PCT has invested in a dedicated PBC information system which enables activity and financial information to be made available to support commissioning.

PBC plans are required to describe arrangements for patient and public involvement in the development of commissioning plans and redesign proposals. All PBC consortia have completed a baseline audit of current PPI arrangements, and the PCT is providing support to develop more Patient Participation Groups at practice and consortium level. Some consortia have appointed or are currently appointing lay members to their Boards. The

PCT's PPI team supports the development of focus groups to inform the redesign of services. The Patient Advisory Group, with a wide membership from patient groups and community and voluntary organisations in Leeds, reviews all PBC proposals from a patient and public experience perspective and makes recommendations to the PBC Governance Committee.

Significant improvements in services have already been achieved through PBC – for example, practice based diagnostic services, admissions avoidance schemes, enhanced care for people in care homes, genital warts service for the student population, improvements to 18 week pathways – and in 2007/08 almost £2 million was freed up for reinvestment in local services.

As part of the establishment of partnership arrangements between the PCT and the Local Authority, PBC Consortia have been engaged in how they can make effective links with the Local Authority through partnerships at locality level. Practice based commissioners have been encouraged to establish links with Area Committees and agree areas of joint working on the delivery of Local Area Agreement priorities.

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Leeds NHS
Primary Care Trust

Local Improvement Finance Trust LIFT financed health centres in Leeds

Background

The Leeds Local Improvement Finance Trust (LIFT) Project Board was established in 2002 and oversaw the formation of Leeds LIFT Co. in 2003. The scope of Leeds LIFT Co. was to deliver significant changes in the quality and range of health & social care services delivered efficiently and effectively in the community. These settings should be modern, flexible and adaptable facilities. The company was set up not only to improve service delivery and the physical environment, but also to support public sector partnership work. Our local programme has seen the replacement of some of the worst quality buildings, in the poorest parts of the city; seven of the nine LIFT buildings are in the worst 10% Lower Super Output Areas. We now have operational buildings in:

- Armley;
- Woodhouse;
- Middleton;
- Beeston (Dewsbury Road);
- Beeston (Beeston Hill);
- Yeadon;
- Lower Wortley;
- Wetherby; and
- Osmondthorpe.

A wide range of services now operate out of state-of-the-art, purpose-built facilities. These include:

- **Primary Care:** GP and Dental Practices, Practitioners with a specialist interest (e.g. Dermatology, ENT, Gynaecology), Pharmacies;
- **Community Adult Services:** Mental Health, Physiotherapy, Podiatry, Anti-coagulant (Warfarin), Nursing, Smoking Cessation, Drug Addiction, Pulmonary Rehabilitation, Community Dental, Health Trainers;
- **Community Children's Services:** Baby Clinics, Parent & Toddler Groups, Contraception and Sexual Health, Child & Adolescent Mental Health, Speech & Language Therapy, Paediatrics, 0-16 Team, Audiology;
- **Other Community services:** Social Services, Sure Start, Early Years, WY Police (vulnerable victims), Citizens Advice Bureau, Eye Centre, Bereavement Counselling.

Many benefits have been realised including:

- **addressing inequalities** by targeting resources in areas of greatest need, improving life chances for children in low socio-economic groups, and providing services that respect and respond to diverse needs;
- **improving service and outcomes** by improving preventative care, up-skilling clinicians and health technicians, and exploiting new technology;
- **designing services around patients and users** by bringing services closer to people's homes, providing a wider range of services in one location, preventing hospital admissions, and extending self-help programmes to improve health and wellbeing.

As the LIFT programme has developed over the last six years, partners have addressed many challenges and have built on lessons learned. A key learning point from the first phase was the lack of signed under-lease agreements with third party tenants at the financial close. The consequence was GP practices declining to take up the accommodation designed and provided for them. All subsequent programmes have had these agreements in place increasing utilisation from day one. The next phase saw the spotlight on building design and increasing efficiencies in the amount of circulation space. There followed in the next phase a more comprehensive programme of user engagement allowing further development of the building designs. This saw a reduction in the lease costs.

The LIFT Project Board agreed that all new buildings would be designed and built with the expectation that they would have optimal utilisation within five years of opening. This allows for service developments and the outcome of the care closer to home programme to be accommodated. The PCT Strategy for 2008-2011 commits to address utilisation of any premises from where services are delivered. Optimal utilisation is assumed to be 80% of capacity which allows scope for flexibility and to avoid risks associated with over-crowding.

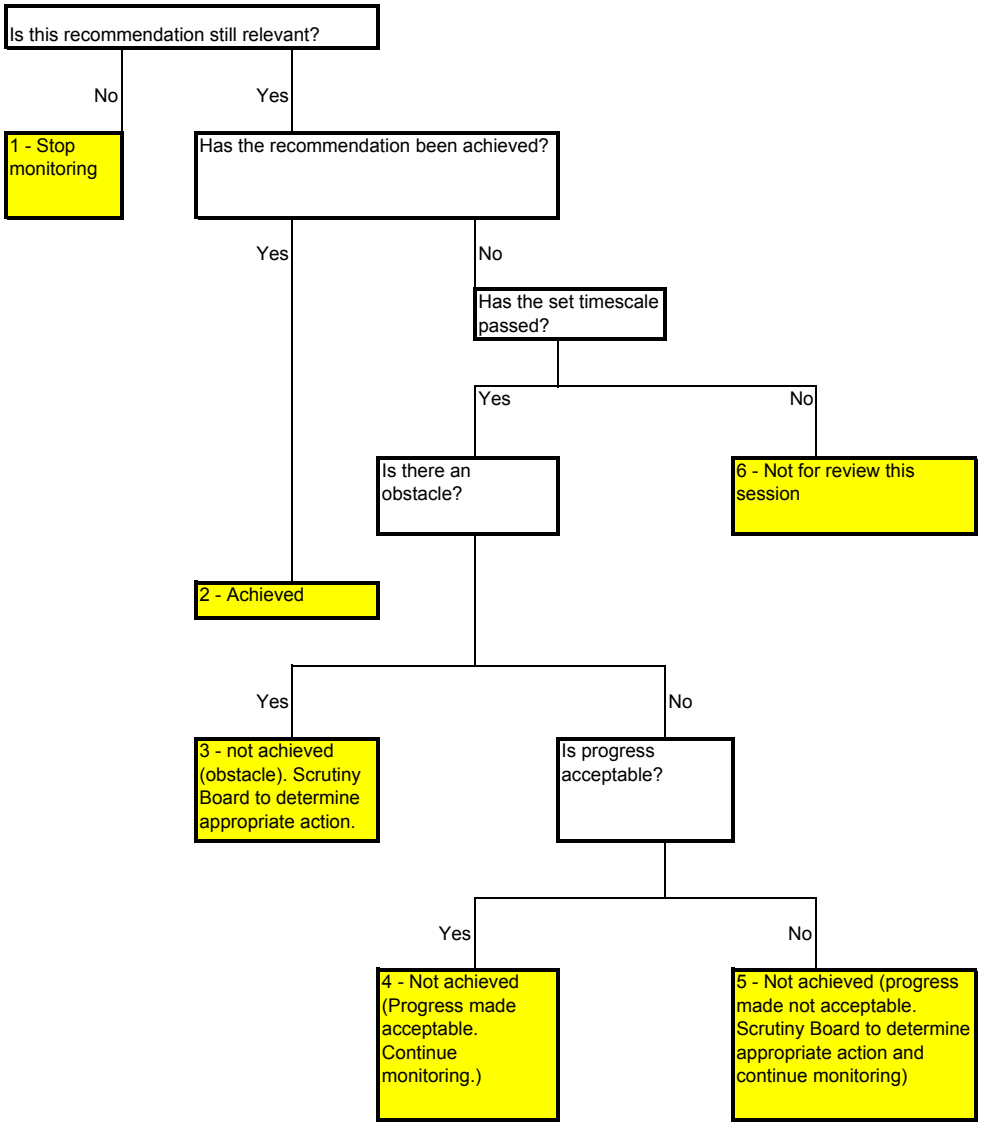
Status

We are currently reviewing our ratio of administration space to clinical space in LIFT buildings to ensure they are utilised in the best possible way. This will form part of the PCT Capital Strategy and Asset Management Plan.

Our current assessment:

Community Facility	Operational Date	Risk of not achieving optimal utilisation within 5 years.
Armley	2005	Low
Middleton	2005	Low
Woodhouse	2005	Low
Beeston (Dewsbury Road)	2006	Low
Beeston (Beeston Hill)	2007	Low
Yeadon	2007	Low
Wetherby	2008	Low
Wortley	2008	Low
Osmondthorpe	2008	Low

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



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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: 16 September 2008

Subject: Scrutiny Board (Health) – Work Programme and Draft Terms of Reference

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

1.0 INTRODUCTION

1.1 At its meeting in July 2008, the Board agreed its outline work programme. However, as the Board's work programme should be considered as an evolving document an updated version is attached as Appendix 1 for further consideration.

2.0 WORKING GROUPS

2.1 At its meeting in July 2008, the Board also established a number of working groups. Details for each group are considered below.

Health Proposals Working Group

2.2 Established to oversee future proposed service changes and make recommendations on the full Board's involvement, the group is yet to meet. Following the postponement of the initial meeting, a revised date is yet to be agreed and the Board will be provided with a progress update at the meeting.

2.3 At the meeting in July 2008, where the Board agreed the terms of reference for this working group, additional information hasd been provided regarding the legislative framework which determines the involvement of overview and scrutiny committees in proposed changes to the provision of health care services. These have now been included in the terms of reference (Appendix 2) and are provided for the Board's approval.

GP-led Heath Centres Working Group

2.4 The working group has met on two occasions, and has engaged with Leeds PCT regarding the proposals to establish a GP-led Health Centre in the Burmantofts area of Leeds. A summary of the proposals is provided at Appendix 3.

2.5 During discussions, the working group was advised that the public consultation had recently concluded and the results where in the process of being analysed. Members requested that the such results be presented to the Scrutiny Board at the earliest opportunity. This information is attached at Appendix 4.

2.6 In addition, Members of the working group requested to visit the current Burmantofts Health Centre (date to be confirmed), where it is initially planned for the new service to be located. Members also requested details of the proposed/ planned refurbishment works for the Health Centre.

Improving Sexual Health among Young People Working Group

2.7 Initially proposed to consider the issue of teenage pregnancy, the Board agreed to expand the scope of this inquiry to cover sexual health among young people in general. The revised terms of reference is attached at Appendix 5 for consideration.

2.8 The working group is scheduled to hold its first meeting on 9 September 2008. An update will be provided at the meeting.

3.0 OTHER WORK PROGRAMME ISSUES

3.1 At its meeting in July 2008, one of the substantive items discussed related to proposed changes to the structure of NHS Blood and Transplant and the specific implications of closing the blood testing and processing centre within Leeds and transferring its operation to other centres in the North of England. The Board is likely to need to re-consider the information provided to date and receive any additional information in order to agree its position on the proposals.

4.0 RECOMMENDATIONS

4.1 Members are asked to;

(i) Consider the updated work programme attached at Appendix 1 and agree / amend as appropriate:
(ii) Agree the revised terms of reference for the Health Proposals Working Group.
(iii) Consider the information provided in relation to the proposed GP-led Health Centre, and in particular the consultation analysis provided.
(iv) Agree the revised terms of reference for the inquiry into Improving Sexual Health among Young People.
(v) Note the position regarding the proposed changes to the structure of NHS Blood and Transplant and the specific implications of closing the blood testing and processing centre within Leeds.

5.0 BACKGROUND DOCUMENTS

Scrutiny Board (Health) – 17 June 2008: Item 6 – Work Programming (Appendix 11: Outstanding/ potential items)
Scrutiny Board (Health) – 17 June 2008: Minutes of meeting
Scrutiny Board (Health) – 22 July 2008: Item 12 – Work Programme (Appendix 1: Draft work programme)

Scrutiny Board (Health)
Work Programme 2008/09

Item	Description	Notes	Type of item
Meeting date – 16 September 2008			
Renal Services	To consider the current position regarding transportation of renal patients, in light of the issues highlighted by the previous Board.	Submissions from: ➢ Leeds Teaching Hospital NHS Trust ➢ Leeds PCT ➢ Yorkshire Ambulance Service ➢ Leeds Kidney Patients Association	Inquiry
Peripheral Hospitals Strategy Report	To consider the long-term strategy for peripheral hospitals in Leeds.	Report from Leeds Teaching Hospital NHS Trust will include issues around Wharfedale Hospital raised by the previous Board.	B/ MSR
Maternity Service / Neonatal Provision	To consider a report that sets out the current service provision in Leeds.	Report from Leeds Teaching Hospital NHS Trust to help the Board determine whether or not to undertake a more detailed inquiry.	B
Update on Leeds Local Involvement Network (LINk)	To provide the Board with an update and consider the Board's relationship with the host organisation.	May need some input from Legal regarding relationship issues. Possible input from Tim Gilling – Centre for Public Scrutiny Likely to be reported to the Adult Social Care Scrutiny Board.	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

Scrutiny Board (Health)
Work Programme 2008/09

Item	Description	Notes	Type of item
The Localisation of Health and Social Care Services – response to recommendations	To consider a composite response against report and each of the recommendations		MSR
Meeting date – 21 October 2008			
Performance Report	To consider the latest performance report considered by the Primary Care Trust Board alongside the outcome of that consideration.	Performance Report presented to the Primary Care Trust Board on 18 September 2008.	PM
Performance Management	Quarter 1 information for 2007/08 (April - June)	All Scrutiny Boards receive performance information on a quarterly basis	PM
Joint Strategic Needs Assessment (JSNA) - update	To consider an update in the development of a joint assessment that identifies the future needs of the populous of Leeds and any identified service changes/ reconfigurations	Also likely to be reported to the Adult Social Care Scrutiny Board. Need to consider the timing, potential role and activity of the Board and that of the Health Scrutiny Board.	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

Scrutiny Board (Health)
Work Programme 2008/09

Item	Description	Notes	Type of item
Mental Health Legislation Implementation	To consider the impact, implications and proposed response to legislative changes regarding: • The Mental Health Act • Mental Capacity	A coordinated report to help the Scrutiny Board assess the readiness of all key partners. The need for this report was identified during a recent discussion between the Chair and Leeds Partnership Foundation Trust (LPFT).	
Meeting date – 18 November 2008			
Children's Hospital Services and Clinical Services Reconfiguration: full business case	To consider an update on the full business case for the proposed service reconfiguration.		
Meeting date – 12 December 2008			
Performance Report	To consider the latest performance report considered by the Primary Care Trust Board alongside the outcome of that consideration.	Performance Report presented to the Primary Care Trust Board on 20 November 2008.	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

Scrutiny Board (Health)
Work Programme 2008/09

Item	Description	Notes	Type of item
Performance Management	Quarter 2 information for 2008/09 (July-Sept)	All Scrutiny Boards receive performance information on a quarterly basis	PM
Recommendation Tracking	This item track progress with previous Scrutiny recommendations on a quarterly basis	Unlikely to feature on the agenda given the nature of the Board's work to date.	MSR
Meeting date – 20 January 2009			
Meeting date – 17 February 2009			
Performance Report	To consider the latest performance report considered by the Primary Care Trust Board alongside the outcome of that consideration.	Performance Report presented to the Primary Care Trust Board (to be confirmed).	PM
Recommendation Tracking	This item track progress with previous Scrutiny recommendations on a quarterly basis		MSR

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

Scrutiny Board (Health)
Work Programme 2008/09

Item	Description	Notes	Type of item
Meeting date – 24 March 2009			
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 to be confirmed	PM
Meeting date – 28 April 2009			
Performance Report	To consider the latest performance report considered by the Primary Care Trust Board alongside the outcome of that consideration.	Performance Report presented to the Primary Care Trust Board (to be confirmed).	PM
Performance Management	Quarter 3 information for 2008/09 (Oct-Dec)	All Scrutiny Boards receive performance information on a quarterly basis	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

Scrutiny Board (Health)
Work Programme 2008/09

Item	Description	Notes	Type of item
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

Scrutiny Board (Health)
Work Programme 2008/09

Working Groups			
Working group	**Membership**	**Progress update**	**Dates**
Health Proposals	Cllr Grahame Cllr Lamb Cllr McKenna Eddie Mack (TBC)	*TBC*	*8 Sept. 2008*
GP-led Health Centres	Cllr Grahame Cllr Kirkland Cllr Illingworth Eddie Mack	*TBC*	*19 Aug. 2008* *21 Aug. 2008*
Young Peoples Sexual Health	Cllr Grahame Cllr Monaghan Cllr Kirkland Cllr McKenna Somoud Saqfelhait	*TBC*	*9 Sept. 2008*

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

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**
Continuing Care Implementation	To consider the local impact and future activity associated with implementing the national framework for continuing NHS care, further to the report presented to the Executive Board in October 2007.	Lead Officer – Dennis Holmes. Need to consider format and timing of any report, the potential role and activity of the Board and that of the Adult Social Care Scrutiny Board.
Leeds Teaching Hospitals NHS Trust – foundation status	To consider the process and implications of the Leeds Teaching Hospitals NHS Trust bid to achieve foundation hospital status.	

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

APPENDIX 2

SCRUTINY BOARD (HEALTH)

HEALTH PROPOSALS WORKING GROUP

TERMS OF REFERENCE

1.0 Background

1.1 The initial legislative background regarding scrutiny's consideration of NHS Trusts proposals for changes to local health services was set out in the Health and Social Care Act (2001) (the 2001 Act). This could be summarised as follows:-

- The 2001 Act sets out a series of statutory requirements for the NHS in relation to patient and public involvement.
- Section 11 of the 2001 Act places a duty on the NHS to involve and consult patients and the public in planning services, developing and considering proposals for changes in the way those services are provided, and in decisions that affect how those services operate.
- Section 7 of the 2001 Act requires NHS organisations to consult the Scrutiny Board (Health and Adult Social Care) on any proposal for a **substantial** development or variation to health services.
- The 2001 Act further provides powers for Scrutiny Board (Health and Adult Social Care) to refer issues, on which they have been consulted under the "substantial variation" clause, to the Secretary of State for Health either where they believe that consultation with patients, the public and other stakeholders has not been satisfactory or where they consider that a proposal of an NHS body is not in the interests of the health service in the area.

1.2 The duties to involve and consult, as set out in Sections 7 and 11 of the 2001 Act, have subsequently been developed and brought together into the NHS Act (2006). This can be summarised as:

- **Section 242 (2)**, **NHS Act 2006** places a statutory duty on all NHS organisations to make arrangements to involve and consult people in:
  - Planning services they are responsible for;
  - Developing and considering proposals for changes in the way those services are provided;
  - Decisions to be made that affect how those services operate.

- **Section 244 (2), NHS Act 2006** requires NHS Trusts to consult the local Overview and Scrutiny Committee (OSC) on any proposal for "substantial development or variation of the health service".

2.0 Scope

2.1 The levels of change are not defined in legislation and it is widely acknowledged that the definition of 'substantial' development or variation of health services is subjective, with proposals often open to interpretation. As such, through discussions with the Scrutiny Board, Leeds PCT has developed local definitions and examples, covering four levels of change.

2.2 The definitions of change (detailed in Appendix 1) are based on guidance included in the scrutiny guide, *Substantial Variations and Developments of Health Services*[1], and are summarised in Table 1 (below).

[1] Published by the Centre for Public Scrutiny, December 2005

Table 1: Summary of levels of change

Degree of variation	Colour code	Contact with Scrutiny
Category 1 – substantial variation (e.g. introduction of a new service)	Red	Consult
Category 2 – significant change (e.g. changing provider of existing services)	Orange	Inform
Category 3 – minor change (e.g. change of location within same hospital site)	Yellow	Inform
Category 4 – ongoing improvement (e.g. proposals to extend or reduce opening hours)	Green	No

2.3 The purpose of the Working Group is to allow local NHS bodies to inform Scrutiny of future proposals for service changes at an early stage to allow the Working Group to discuss and agree the status and resulting actions for such proposals.

2.4 However, as the statutory duty to consider substantial changes will remain with the full Scrutiny Board, the remit of the Working Group will be to:

- Agree whether a proposal amounts to a substantial variation and needs to be considered by the full Board.
- Consider whether the Trust's plans for consultation with patients, the public and other stakeholders seems satisfactory.
- Consider whether the proposal is in the interests of the health service in the area.

2.5 In the case of substantial changes, the view of the Working Group on bullet points two and three will assist the full Board in coming to a decision about whether further scrutiny is necessary.

3.0 Frequency of meetings

3.1 It is initially proposed that the Working Group will meet on a bi-monthly basis, commencing in September 2008.

3.2 However, it is planned that the Working Group will adopt a flexible approach to meeting dates and, as such, may choose to meet outside a bi-monthly timetable.

4.0 Membership

4.1 The membership of the Health Proposals Working Group for the duration of the current municipal year (2008/09) is as follows:

- Councillor Pauleen Grahame
- Councillor Andrea McKenna
- Councillor Alan Lamb
- Eddie Mack (Co-opted member)

5.0 Key stakeholders

5.1 The following key stakeholders have been identified as likely contributors to the Working Group:

- Leeds Primary Care Trust (PCT)
- Leeds Teaching Hospitals NHS Trust (LTHP)
- Leeds Partnership Foundation Trust (LPFT)
- Director of Adult Social Services

6.0 Monitoring arrangements

6.1 The full Scrutiny Board (Health) will be kept appraised of the activity of the Working Group and regular updates will be provided.

September 2008

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)
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	Information & evidence base
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	Information & evidence base	
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	Information & evidence base		

OSC involved

OSC may be involved

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

Scrutiny Inquiry – GP-led Health Centres
Working Group meeting – 19 August 2008

Summary of information provided by Damian Riley, Director of Primary Care, Leeds Primary Care Trust.

General matters

- In Leeds, the term 'GP led Health Centres' is being used rather than 'polyclinics'.
- There are currently already over 100 GP practice contracts in place covering all practices in Leeds PCT.
- These practices range in size, from 1000 – 30,000 registered patients, and provide a range of additional services at a local level.

Current developments

- There is a proposal for one further GP provider outlet – in the Burmantofts area of Leeds as part of a new GP-led Health Centre. It is anticipated this will register any patients who wish to join the practice, and the list size will grow steadily to provide services for an estimated 1000 registered patients by end of year 1.
- There will be a formal procurement and evaluation process to establish a reputable , quality provider of this service, who will provide a range of services from 8:00am-8:00pm, 7 days per week all year round.
- There is strong evidence that there are significant health needs within and around the Burmantofts area of Leeds.
- In addition, the closure of the Dr. Potts practice has also increased the need for additional capacity in that area of the city.
- Furthermore, the centre will be well placed to meet the needs of patients who otherwise feel inclined to attend Accident and Emergency services
- The proposed centre will be procured as an NHS contract (i.e. not a private service) and will remain free at the point of use for patients.
- Details of such proposals were discussed at the Service Reconfiguration Sub-Group (as part of the arrangements under the former Scrutiny Board (Health and Adult Social Care) in December 2007 and March 2008.
- Leeds PCT launched a public consultation for people to give us their views about the plans to provide a new GP-led health centre in Burmantofts. The consultation ran from 19th May to 8th August.

Additional Information

Since April 2008, Leeds PCT has been offering a voluntary incentive scheme aimed at all GP practices in Leeds. The scheme provides an additional payment (£2.95 per head of population on the registered list) in return for the provision of additional surgery hours (30 minutes/ week for every 1000 head of population on the registered list).

This expenditure represents additional funding with a current take-up rate exceeding 50% of practices.

19 August 2008

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APPENDIX 4

Leeds NHS
Primary Care Trust

Proposal for a new GP-led Health Centre in Leeds

Analysis report

August 2008

Leeds Primary Care Trust

1 Introduction
2 Patient and stakeholder consultation
3 Ongoing process
4 Responses and feedback
5 Responses by local authority wards
6 Contact Information

Appendix 1 Original consultation document (separate document)
Appendix 2 Comments form (separate document)
Appendix 3 Stakeholder list

1 Introduction

Between 19th May 2008 and 11th August 2008, Leeds Primary Care Trust (PCT) carried out a process of patient, public and stakeholder consultation about the plans to open a new GP-led health centre in Leeds.

By the 26th August, 193 comments forms and four letters had been received by the PCT and this report highlights some of these responses and key themes.

Of the four letters received, one letter is from a local group recognising the potential benefits of a GP-led health centre but also raises concerns around a potential loss of doctor-patient relationship and the location. The second is from a larger political group which has consulted with 100+ of its members and states that there is overwhelming support from its members for the introduction of a GP-led health centre in Leeds. The third and fourth are from individuals with a number of comments about the contents of the original documentation; a significant number of these comments are included within this document.

The outcomes of this report will be used to in formal discussion with potential providers and shape the services that are delivered at the GP-led health centre.

Further details about the consultation process can be found in the original consultation document attached as Appendix 1.

2 Patient and stakeholder consultation

Process and extent of consultation

- Leeds Patient Advice and Liaison Service (PALS) was identified as a central point of contact for members of the public for enquiries via their freephone number. The consultation document, comments form and poster were posted on the PCT website (www.leedspct.nhs.uk) to download.
- Leeds PCT staff were made aware of the proposals by information in the trust e-bulletin, poster distribution and at a series drop-in events.
- Discussions were held with key stakeholders including the Leeds Local Medical Committee (LLMC).
- Consultation document (Appendix 1), comments forms (Appendix 2) and posters advertising the drop-in events were provided to all Leeds independent contractors - GP practices, pharmacies, dentists and opticians - for display in waiting rooms.

- Consultation documents were distributed across Leeds through a variety of NHS, voluntary sector organisations and distribution networks including One-Stop centres and libraries. A full list of stakeholders is included in Appendix 3.

- Consultation documents and comments forms were sent to all MPs and local ward councillors.

- The consultation document and comments form were posted on the PCT website on 19th May 2008: http://www.leedspct.nhs.uk/?pagepath=Home%20Page/Consultations

Drop-in Events

- Eleven public drop-in events were arranged across the city of Leeds to give people the opportunity to voice opinions or concerns, ask questions and give feedback.

- Information about the consultation and drop-in events was published in the local press and further posters were distributed for display at community venues across Leeds.

- Open drop-in events were considered the most appropriate, accessible and effective way of holding the events and a variety of venues were used. The PCT also responded to specific requests for locality based events. In addition to this the consultation included involvement in the PCT's NHS 60th anniversary event in Millennium Square and a stall in Kirkgate market, Leeds City Centre.

- The majority of drop-in events were well attended and found to be an effective method of consultation.

- The details of the drop-in events are as follows:

Monday 2 June	6.00 pm – 7.30 pm	North West House, Boardroom
Saturday 14 June	1.00 pm – 5.00 pm	Committee Rooms 6 & 7, Leeds Civic Hall
Monday 23 June	12.00 pm – 2.00 pm	Yeadon Health Centre
Tuesday 1 July	12 pm – 2.00 pm	Chapeltown Health Centre
Thursday 3 July	10.00 am – 4.00 pm	Millennium Square event
Friday 4 July	10.00am – 2.30 pm	Leeds Kirkgate Market
Tuesday 8 July	9.00 am – 12.00 pm	Kirkstall Health Centre
Friday 11 July	2.00 pm – 4.00 pm	Beeston Hill Health Centre
Friday 18 July	10.00am – 2.30 pm	Armley Health Centre
Tuesday 22 July	9.30 am – 8.00pm	White Rose Shopping Centre
Monday 28 July	9.00 am – 12.00 pm	Morley Health Centre
Friday 1 August	9.00am – 12.00 pm	Burmantofts Health Centre
Tuesday 5 August	10.00 am – 12.00 pm	Wetherby Health Centre

The outcomes of this consultation process will be used in formal discussions with potential providers throughout the procurement process. Key themes and patient views, where appropriate, will be fed into the service requirements and ultimately the overall service model for the health centre. This document tells us more about how and why patients will access the GP-led health centre and what services they would like to see within the health centre.

As part of the overall procurement process bidders have been asked to address how they intend to engage with patients and the public throughout the contractual service period and also how they will ensure services reflect the differing patient cultures within Leeds. These answers will be evaluated and scored.

The PCT has established a Patient Advisory Group from those who expressed an interest through the consultation process. This group will support and advise the PCT on specific areas relating to patient experience. In addition to this the Patient Advisory Group has selected one of its members to participate in the evaluation panel and input into the selection of the service provider.

4 Responses and Feedback

The comments form is attached as Appendix 2.

By the 26th August, 193 comments forms and four letters had been received. Of these, 12 are from patients already registered with GP practices in the Burmantofts area.

Questions 1 and 2

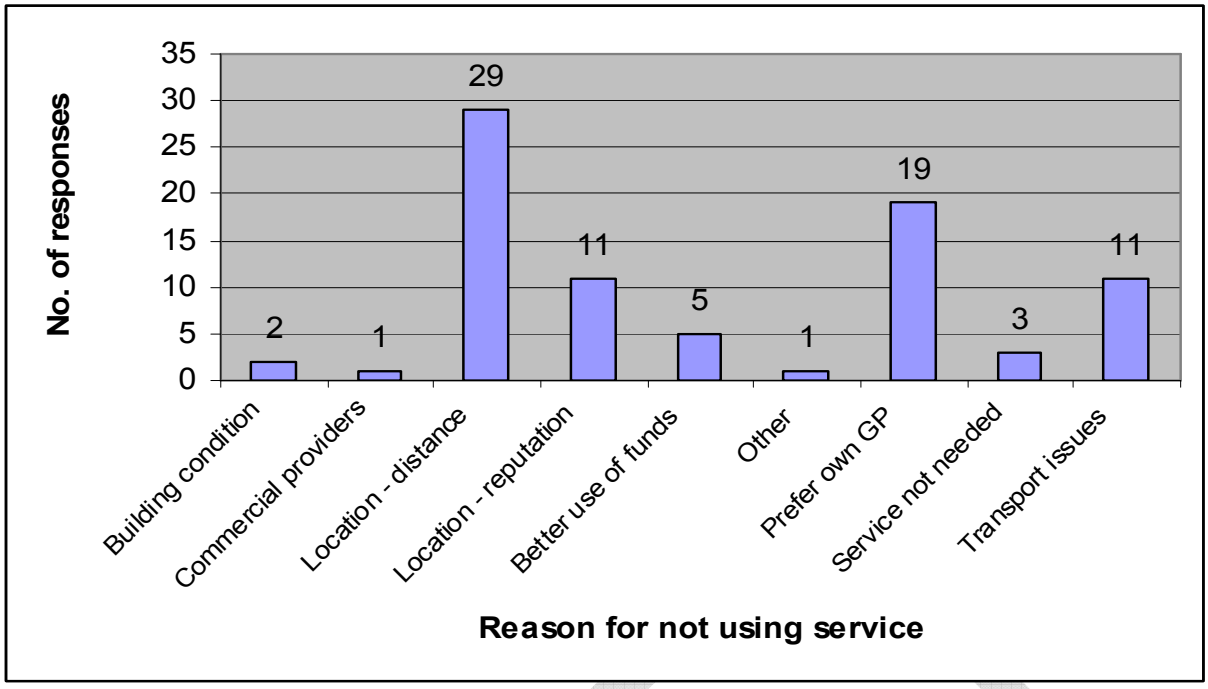
Of the people who stated that they are not registered with a GP practice in the Burmantofts area, 56% stated that they would consider accessing the services available at the GP-led health centre as a non-registered patient.

Comments were received around the accessibility of Burmantofts to all the patients of Leeds. This was balanced with positive feedback on the element of the extended opening times, especially the opportunity to access services on a Saturday and Sunday.

Question 3

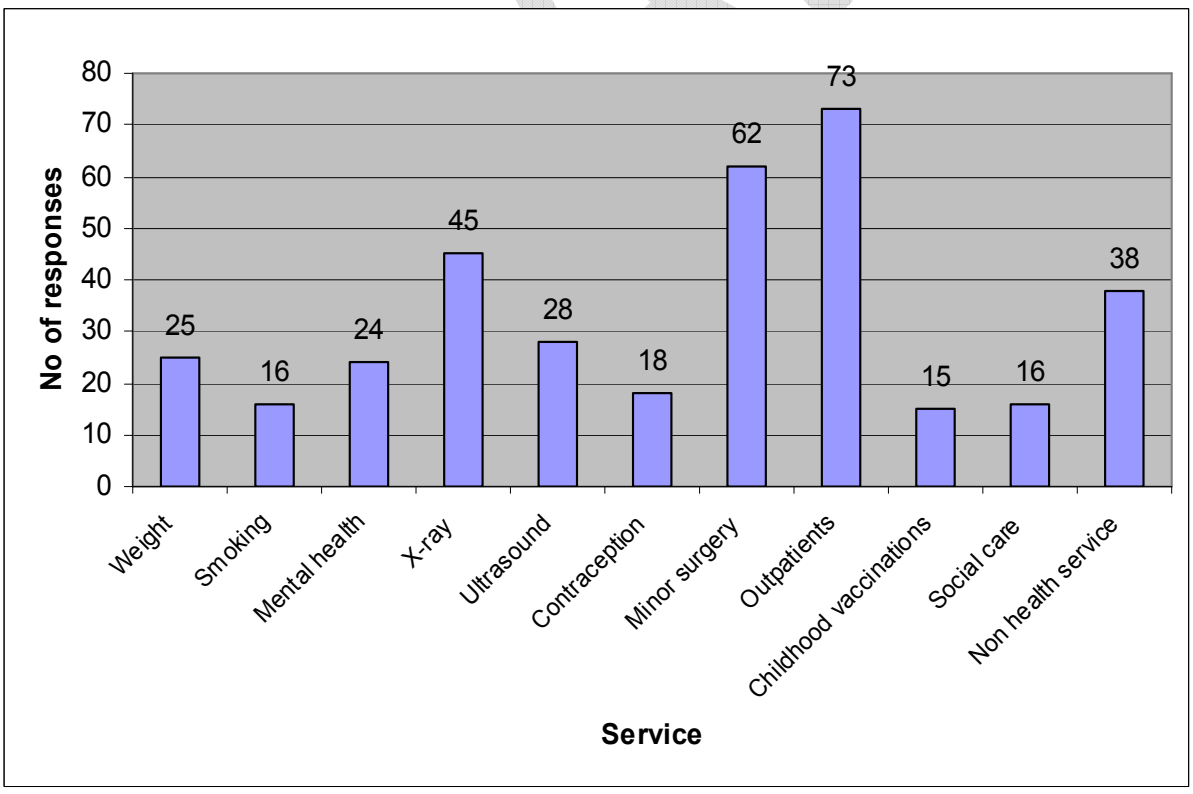
Question 3 asked respondents, “If you are not registered in the Burmantofts area, would you utilise the services at the GP-led health centre and if not, why not?”

Of the responses, 79 people stated that they were not registered in the Burmantofts area and would not use the services. A summary of comments can be found on the following page.



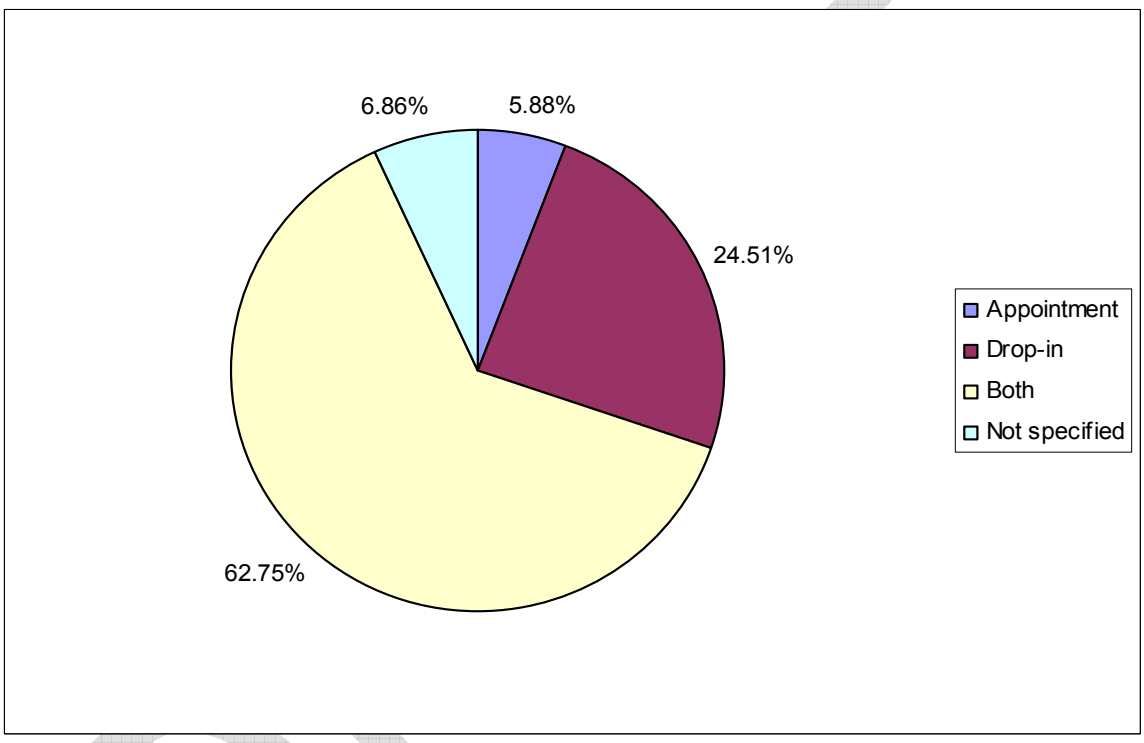
Question 4

"If you used the GP-led health centre, which services (listed in Appendix 2) would you be likely to use?" 102 people stated that they would use the GP-led health centre. A summary of the services people would use is shown below:

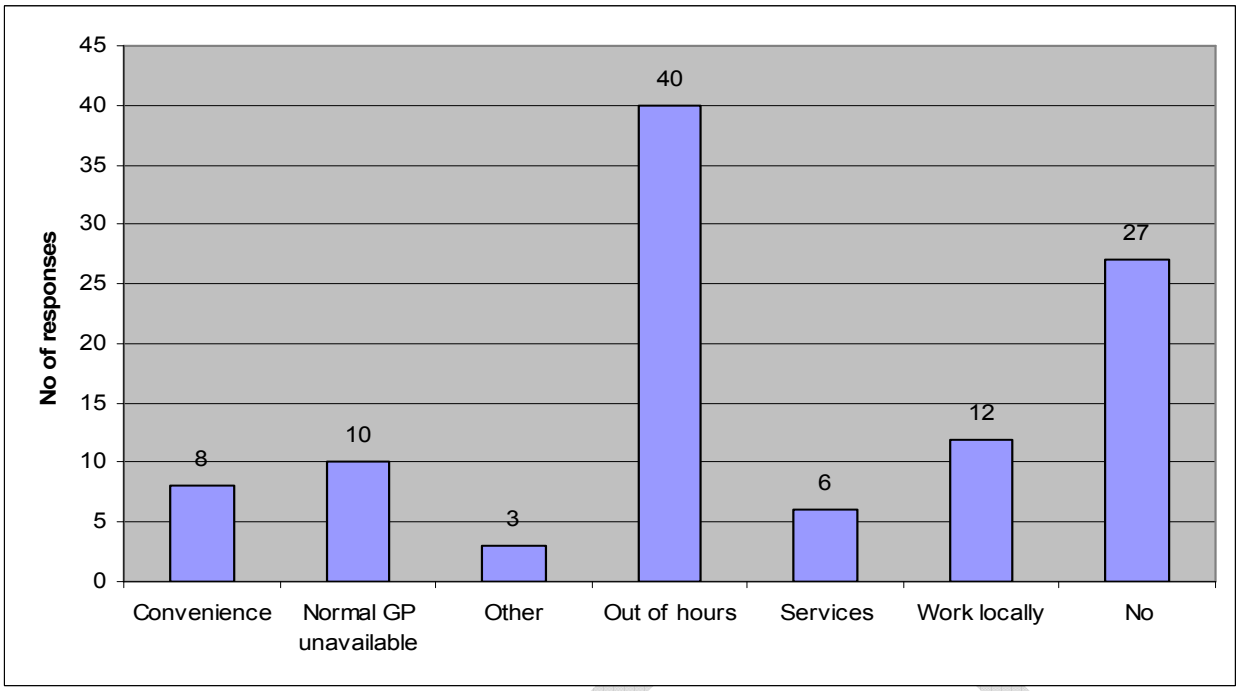


Question 5
"Would you prefer to make an appointment to access the service you require, or access services on a drop in basis?" Of the 101 responses, results are detailed below:

Preferred option	Number of responses	% of responses
Appointment	6	5.88%
Drop-in	25	24.51%
Both	66	62.75%
Not specified	7	6.68

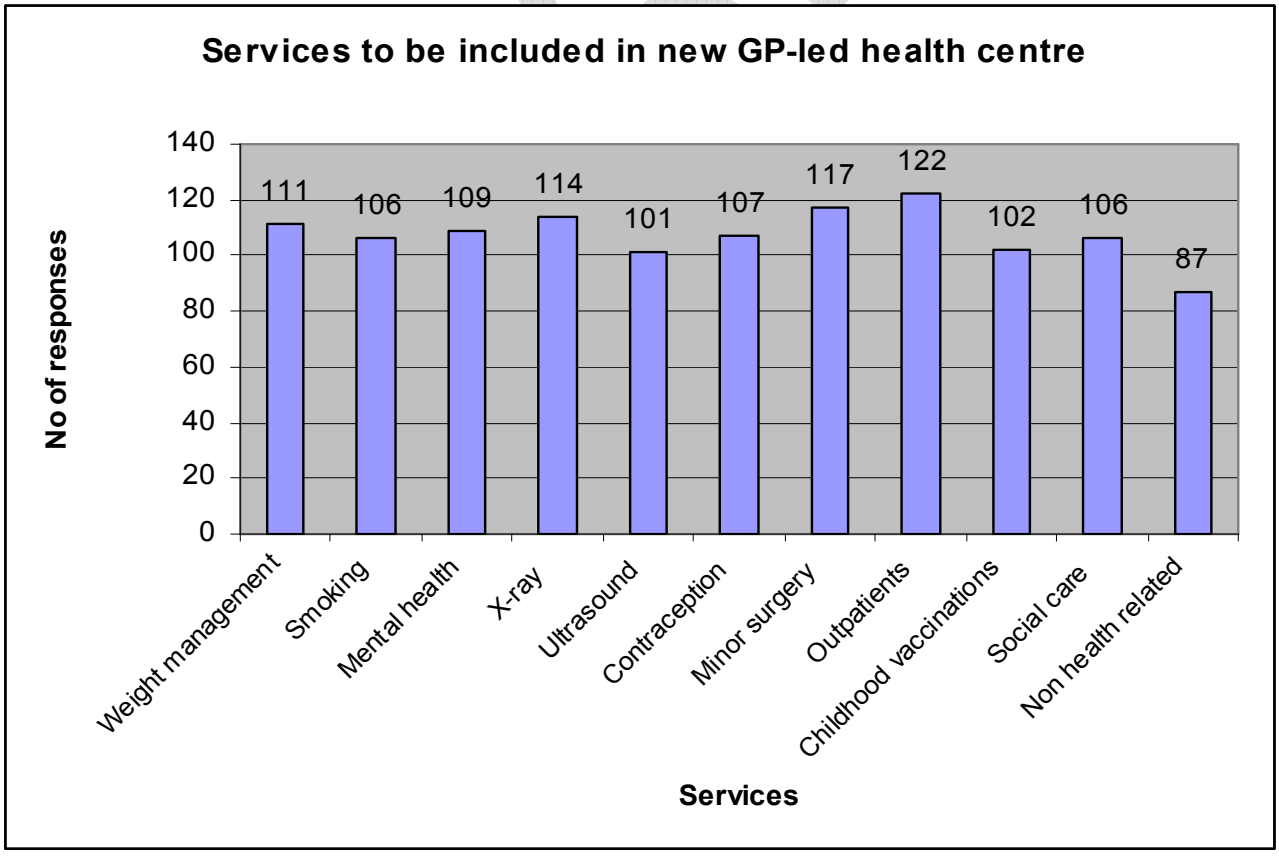


Question 6
"If you would choose to access services from the GP-led health centre as an unregistered patient, are there any reasons for using this service instead of the GP practice you are currently registered with?" A summary of the results is detailed on the following page.

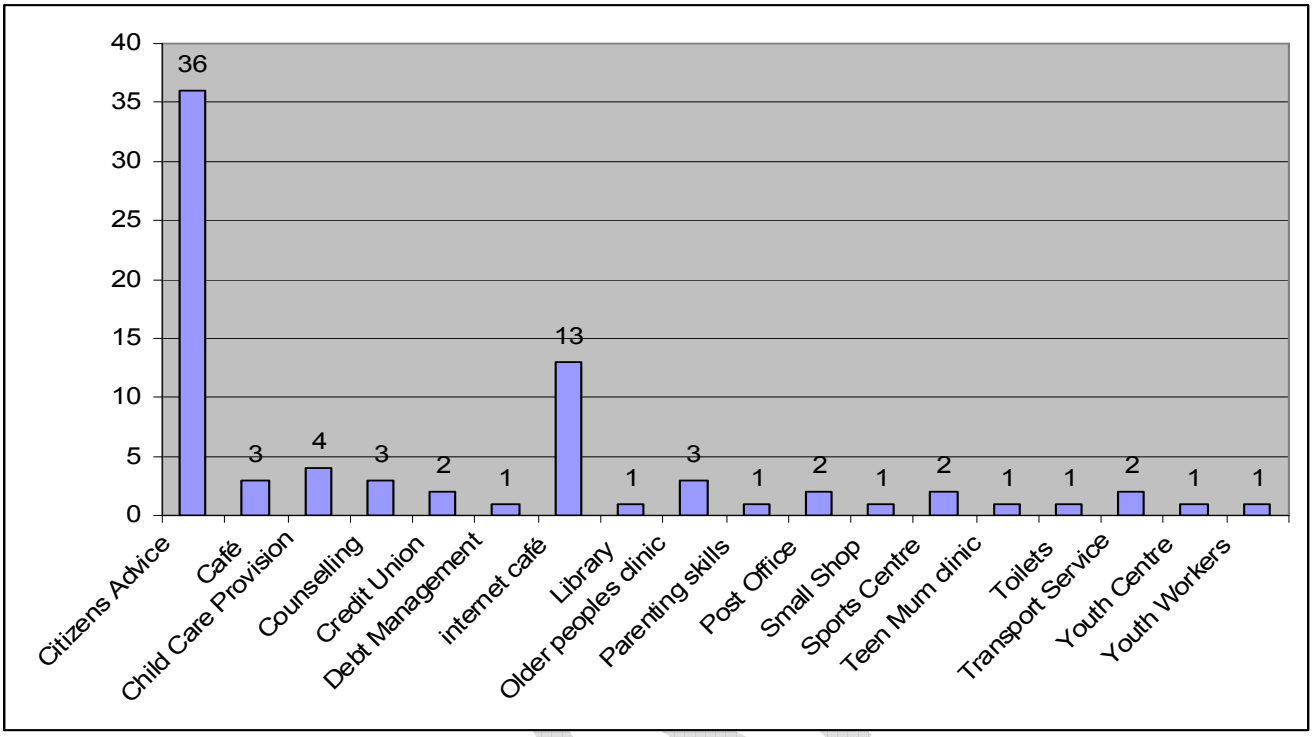


Question 7

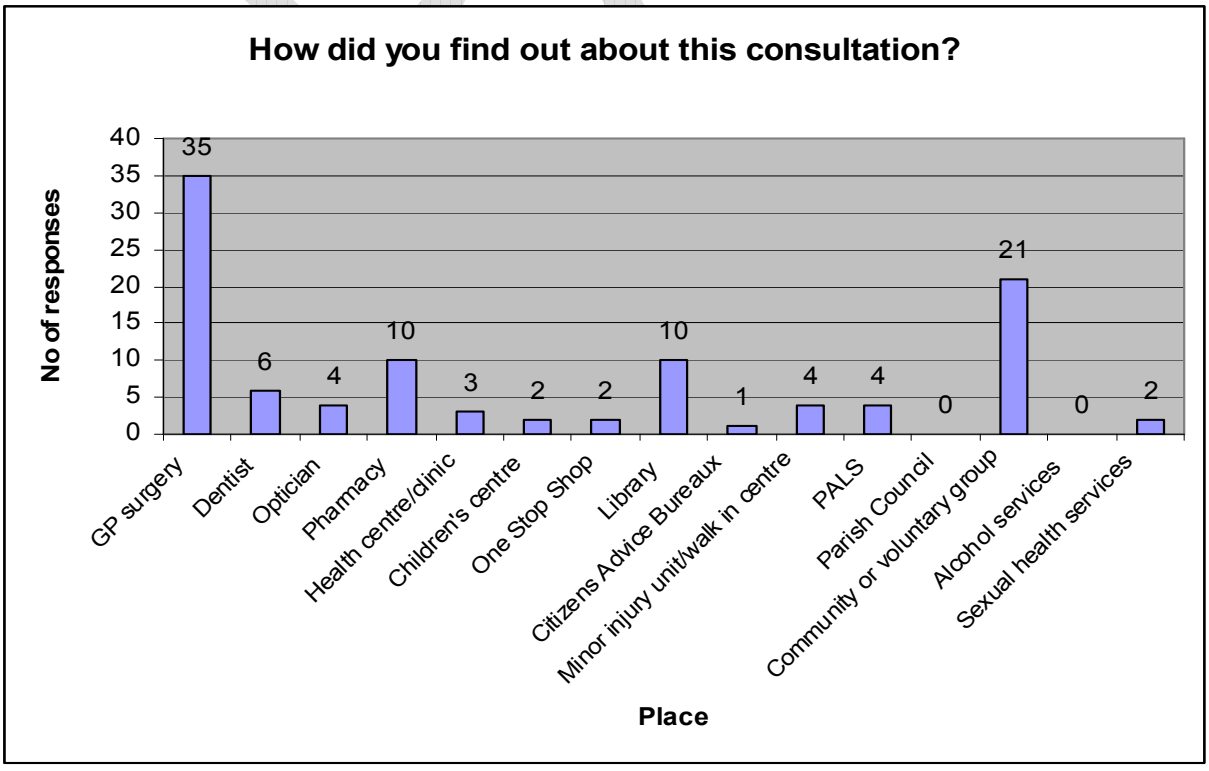
"What services do you think should be included in the new GP-led health centre (even if you would not use them)?" Of those that listed health-related services, a summary of the results is detailed below:



Question 7 continued
87 people said they felt non health-related services should be included in the GP-led health centre. The summary details are listed below:



Question 8
"We are constantly trying to improve how we share information with people. How did you find out about this consultation?" A summary of the results is detailed below:



5 Responses by local authority ward

Adel and Wharfedale & Alwoodley				**LS17**
Total replies	14	Would use the centre	10	Would not 4
Accessing the service The majority would access the service either by drop-in **or** scheduled appointment.				
Summary of comments: a) Convenient access out of hours (2 responses) b) Too far to travel (3 responses)				

Ardsley and Robin Hood				**WF2, WF3**
Total replies	4	Would use the centre	2	Would not 2
Accessing the service Half would access the service on a drop-in basis and half either by drop-in **or** scheduled appointment.				
Summary of comments: a) Convenient access out of hours (4 responses) b) Prefer own GP (1 response)				

Armley				**LS12**
Total replies	9	Would use the centre	8	Would not 1
Accessing the service Half would choose to access the service either by drop-in **or** scheduled appointment.				
Summary of comments: a) Convenient access out of hours (6 responses) b) Too far to travel (1 response)				

Beeston and Holbeck & Middleton Park				**LS10, LS11**
Total replies	13	Would use the centre	5	Would not 8
Accessing the service The majority would access the service either by drop-in **or** scheduled appointment.				
Summary of comments: a) Convenient access from work (2 responses) b) Difficult to access (3 responses) c) Too far to travel (3 responses)				

Bramley and Stanningley				**LS13**
Total replies	5	Would use the centre	3	Would not 2
Accessing the service The majority would access the service either by drop-in **or** scheduled appointment.				
Summary of comments: a) Convenient access out of hours (2 responses) b) Convenient access from work (1 response) c) Need disabled friendly access (1 response)				

Burmantofts and Richmond Hill				**LS9**
Total replies	32	Would use the centre	20	Would not 12
Accessing the service The majority would access the service either by drop-in **or** scheduled appointment.				
Summary of comments: a) Wider choice of services (2) b) Convenient access from work (4 responses) c) Convenient access out of hours (5 responses)				

Calverley and Farsley & Otley and Yeadon				**LS19, LS21**
Total replies	9	Would use the centre	1	Would not 8
Accessing the service The majority would access the service either by drop-in **or** scheduled appointment.				
Summary of comments: a) Convenient access from work (4 responses) b) Convenient access out of hours (1 response) c) Too far to travel (6 responses)				

Chapel Allerton				**LS7**
Total replies	6	Would use the centre	3	Would not 3
Accessing the service Half would choose to access the service on a drop-in basis and half either by drop-in **or** scheduled appointment.				
Summary of comments: a) Convenient access out of hours (2 responses) b) Own GP adequate (2 responses)				

City and Hunslet				**LS1, LS3**
Total replies	3	Would use the centre	3	Would not 0
Accessing the service The majority would access the service either by drop-in **or** scheduled appointment.				
Summary of comments: a) Convenient access out of hours (1 response)				

Cross Gates and Whinmoor & Temple Newsam				**LS15**
Total replies	5	Would use the centre	1	Would not 4
Accessing the service The majority would access the service on a drop-in basis.				
Summary of comments: a) Convenient access out of hours (1 response) b) Convenient access from work (1 response) c) Location is not reputable (1 response) d) Building is too old (1 response)				

Garforth and Swillington & Kippax and Methley				**LS25**
Total replies	4	Would use the centre	3	Would not 1
Accessing the service The majority would access the service either by drop-in **or** scheduled appointment.				
Summary of comments: a) Convenient access out of hours (2 responses) b) Convenient access from work (1 response) c) Too far to travel (1 response)				

Gipton and Harehills				**LS8**
Total replies	6	Would use the centre	3	Would not 3
Accessing the service Half would choose to access the service on an appointment basis.				
Summary of comments: a) Convenient access out of hours (1 response) b) Convenient access from work (1 response) c) Location is not reputable (1 response)				

Guiseley and Rawdon					**LS20**
Total replies	4	Would use the centre	2	Would not	2
Accessing the service The majority would access the service either by drop-in **or** scheduled appointment.					
Summary of comments:	a) Convenient access from work (2 responses) b) Convenient access out of hours (1 response) c) Location is not reputable (1 response)				

Hyde Park and Woodhouse & Headingley					**LS6**
Total replies	2	Would use the centre	1	Would not	1
Accessing the service Half would access the service on a drop-in basis.					
Summary of comments:	a) Convenient access out of hours (1 response) b) Too far to travel (1 response)				

Horsforth					**LS19**
Total replies	7	Would use the centre	5	Would not	2
Accessing the service The majority would access the service either by drop-in **or** scheduled appointment.					
Summary of comments:	a) Convenient access out of hours (1 response) b) Wider choice of services (1 response) c) Too far to travel (1 response) d) Location is not reputable (1 response)				

Killingbeck and Seacroft					**LS14**
Total replies	10	Would use the centre	6	Would not	4
Accessing the service The majority would access the service either by drop-in **or** scheduled appointment.					
Summary of comments:	a) Convenient access out of hours (2 responses) b) Prefer own GP (1 response) c) Too far to travel (1 response)				

Kirkstall					**LS4, LS5**
Total replies	5	Would use the centre	4	Would not	1
Accessing the service The majority would access the service either by drop-in **or** scheduled appointment.					
Summary of comments:	a) Convenient access out of hours (1 response) b) Location is not reputable (1 response)				

Roundhay, Moortown & Weetwood					**LS16**
Total replies	14	Would use the centre	5	Would not	9
Accessing the service The majority would access the service either by drop-in **or** scheduled appointment.					
Summary of comments:	a) Convenient access out of hours (1 response) b) Wider choice of services (1 response) c) Too far to travel (1 response) d) Location is not reputable (1 response)				

Morley North & Morley South				**LS27**
Total replies	7	Would use the centre	4	Would not 3
Accessing the service The majority would access the service either by drop-in **or** scheduled appointment.				
Summary of comments: a) Convenient access from work (2 responses) b) Convenient access out of hours (1 response) c) Prefer own GP (2 responses) d) Too far to travel (1 response)				

Pudsey & Farnley and Wortley				**LS28**
Total replies	3	Would use the centre	0	Would not 3
Accessing the service Half would access the service on a drop-in basis and half either by drop-in **or** scheduled appointment, half would access on an appointment basis.				
Summary of comments: a) Too far to travel (2 responses)				

Rothwell				**LS26, WF4**
Total replies	10	Would use the centre	7	Would not 3
Accessing the service The majority would access the service either by drop-in **or** scheduled appointment.				
Summary of comments: a) Convenient access out of hours (4 responses) b) Too far to travel (2 responses)				

Wetherby & Harewood				**LS22**
Total replies	1	Would use the centre	1	Would not N/A
Accessing the service Would access the service either by drop-in **or** scheduled appointment.				

6 Contact Information

Call: Leeds Patient Advice and Liaison Service (PALS)
0800 0525 270 or from their website

See: **www.leedspals.nhs.uk** or **www.leedspct.nhs.uk**

Write to: PALS
Leeds Primary Care Trust
2nd Floor Stockdale House
Headingley Business Park
Victoria Road
Leeds LS6 1PF

If you have special communication needs or would like this information on audio tape or in a different language, please contact us or ask a carer or friend to telephone on your behalf. Our number is 0800 0525 270.

APPENDIX 1: Overview of stakeholders for engagement

In alphabetical order

- GPs across Leeds
- Leeds Dental Committee
- Leeds Local Medical Committee
- Leeds Optometry Committee
- Leeds Partnerships NHS Foundation Trust
- Leeds Pharmacy Committee
- Leeds Teaching Hospitals NHS Trust
- Libraries
- Local businesses
- Local children's centres
- Local community and voluntary groups
- Local councillors and MPs
- Local faith leaders
- Local high schools
- Local independent contractors, e.g. pharmacists, dentists, optometrists
- Local Involvement Network (LINkS) preparatory group
- Local media
- Local parish/town councils
- NHS staff
- Overview and Scrutiny Committee
- Patient Advice Liaison Service (PALS)
- Patient representative
- Public
- Registered patients
- Social Services
- Union representatives
- Yorkshire & Humber Strategic Health Authority

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Proposal for a new GP-led health centre in Leeds

Comments Form

Leeds Primary Care Trust values the views and opinions of patients and the local communities in Leeds. Please use this form to outline any thoughts or comments you may have about the new GP-led health centre which have been described in this document. Please use an extra sheet if necessary.

If you would like us to write to you with the outcome of the consultation please let us have your name and address. If you would prefer not to give us these details, it would be helpful if you let us have your postcode as the GP-led health centre is for the benefit of all Leeds residents and employees.

Name:	
Address:	
Contact number:	

If you are interested in the work of the PCT and would like to be involved in future patient involvement work please indicate below.

	Yes	No
I would like to be contacted about future patient involvement	☐	☐

		Yes	No
1	Are you already registered with a practice in the Burmantofts area?	☐	☐
2	If not, would you consider accessing any of the services available from the Burmantofts GP-led health centre as a non registered patient?	☐	☐

3 If **No**, why not?

.....

.....

.....

4 If **Yes**, which services would **You** be likely to use? Please tick below:

Weight management	☐	Outpatients clinics	☐
Stop smoking services	☐	Childhood vaccinations	☐
Mental health	☐	Social care services	☐
X-ray	☐	Non health-related services e.g.Citizens Advice Bureaux, Internet Café	☐
Ultrasound	☐		
Contraception services	☐		
Minor surgery	☐		

5 Would you prefer to make an appointment to access the service you require, or access services on a drop in basis? Please tick:

	appointment		drop-in		both
☐		☐		☐	

6 If you would choose to access services from this health centre as an unregistered patient, are there any reasons for using this service instead of the practice where you are currently registered?

.....

.....

7 What services services do you think should be included in the new GP-led heath centre even if you would not use them? Please tick below:

Weight management	☐
Stop smoking services	☐
Mental health	☐
X-ray	☐
Ultrasound	☐
Contraception services	☐
Minor surgery	☐
Outpatients clinics	☐
Childhood vaccinations	☐
Social care services	☐

Please also include non health-related services such as Citizens Advice Bureaux, Internet Café and any other, please specify:

.....

.....

8 We are constantly trying to improve how we share information with people. How did you find out about this consultation. Please circle all that apply:

GP surgery • Dentist• Optician • Pharmacy • Health centre/clinic • Children's centre • One stop shop • Library Citizens Advice Bureaux • Minor injury unit/walk-in centre PALS • Parish council • Community or voluntary group Alcohol services • Sexual health services

Do you have any suggestion as to how we could further improve how we share information?

.....

.....

.....

.....

.....

.....

If you would like more copies of this document for your household or family please contact

PALS on: 0800 05225 270

Thank you for taking the time to complete this feedback form, could you please send it to the address below by 11 August 2008.

FREEPOST RLSJ-BXBH-HZRL
FAO:
GP-led health centre
Leeds
LS16 6QG

SCRUTINY BOARD (HEALTH)

INQUIRY INTO IMPROVING SEXUAL HEALTH AMONG YOUNG PEOPLE

TERMS OF REFERENCE

1.0 Introduction

1.1 In April 2008, the Health and Adult Social Care Scrutiny Board (as it was then known), published a statement on Teenage Pregnancy. This was the product of a one-off 'task and finish' working group which had been established to consider the issue.

1.2 The working group was established following the publication of performance data during 2007 which showed that Leeds was repeatedly failing to make progress in reaching government targets on reducing teenage conception. The issue was also identified by the Audit Commission as part of their Comprehensive Performance Assessment of the Council.

1.3 The working group considered the following areas:

- The facts and figures around teenage pregnancy in Leeds
- The findings from a recent report on the situation in Leeds produced by the Teenage Pregnancy National Support Team (TPNST)
- The action being taken to reduce teenage conceptions in the city
- The options open to young women to complete their studies or access training after childbirth
- Whether the Board might make recommendations to assist the work around reducing teenage pregnancies in Leeds
- Whether any further scrutiny should be undertaken in the next municipal year in the form of a full inquiry.

1.4 The statement produced by the group concluded that, while there were excellent services in Leeds to support teenage parents, there was still much work to be done around reducing teenage conceptions and improving sexual health services.

1.5 The main recommendation of the working group was that a further inquiry be carried out during the coming municipal year, into the issue of reducing teenage conceptions. The working group also recommended that the inquiry involve members of both the Children's Services and Health Scrutiny Boards, and that young people be co-opted as members for the inquiry, as they had made a very valuable contribution to the working group.

1.6 At the July meeting of the Health Scrutiny Board, it was agreed to broaden the terms of reference for the inquiry to cover sexual health among young people in general, as well as teenage conceptions. This was in line with advice received from the Director of Adult Social Care,

and also reflected the concerns raised by Members and young people during the initial working group.

2.0 Scope of the inquiry

2.1 The Teenage Pregnancy working group made a number of recommendations around the terms of reference for a future inquiry. These have been combined with comments from officers to produce the following scope for the inquiry:

- an investigation of the links between teenage pregnancy and low aspiration
- consistency of Sex and Relationship Education (SRE) for both males and females in primary and secondary schools, and other education settings
- consistency of SRE in non-education settings
- the availability of access to contraception/family planning for young males and females in the city, outside standard school/working days, and in on-site education and training settings, including further education
- the rise in conception rates in under 15s

2.2 It is planned that young people from the Youth Sexual Health Action Group (YSHAG) will be involved in the inquiry, either as coopted members, or as witnesses.

3.0 Comments of the relevant Director and Executive Member

3.1 In line with Scrutiny Board Procedure Rule 12.4 the views of the relevant Directors and Executive Members have been sought and have been incorporated where appropriate into these Terms of Reference. Full details are available on request from the Scrutiny Support Unit.

4.0 Structure of the Inquiry

4.1 It is proposed that a range of approaches to evidence gathering are used in this Inquiry, including the one or more of the following:

- A working group of the Scrutiny Board to consider some evidence and question key witnesses
- Full meetings of the Scrutiny Board to consider some evidence and question key witnesses
- Discussion with key stakeholders
- Visits to selected establishments, as appropriate, to engage with service users and staff

- Visits to other authority areas and/or areas of best practice, as appropriate

4.2 The Inquiry will conclude with the publication of a report, or statement, and recommendations by the Scrutiny Board that will be submitted to the appropriate forum.

5.0 Timetable for the inquiry

5.1 It is initially planned that the Inquiry will take place over three sessions with a view to issuing a final report or statement during the 2008/09 municipal year.

5.2 The length of the Inquiry is subject to change.

6.0 Submission of evidence

6.1 The following formal evidence gathering sessions are scheduled:

6.2 **Site visits – dates to be confirmed**

6.3 **Session one – (date to be confirmed)**

The purpose of this session will be to consider background information on Teenage Conceptions and Sexual Health Services in Leeds, in particular:

- Current Sexual Health provision in Leeds, particularly that aimed at young people
- The final report of the Teenage Pregnancy National Support Team on the situation in Leeds
- The most recent statistical information on teenage pregnancy and sexual health, including Chlamydia screening rates and HIV infection rates
- SRE (Sex and Relationship Education) policy in Leeds
- The availability of contraception/family planning for young people
- The role of Primary Care in promoting good Sexual Health

Towards the end of the session, consideration will be given to any further and/or specific information required as part of the inquiry.

6.2 **Session two - (date to be confirmed)**

During the second session of the inquiry the board will look at the wider situation and examples of best practice from other authorities. In particular the board will consider:

- Possible methods for reducing the number of teenage conceptions and improving sexual health amongst young people
- The evidence for a link between low aspiration and teenage pregnancy
- The prevalence of teenage pregnancy amongst certain social groups – for example, Looked After Children
- Exploring ways in which the Council can contribute to the Leeds Sexual Health Strategy.

Towards the end of the session, consideration will be given to any further and/or specific information required as part of the inquiry.

6.3 **Session three - (date to be confirmed)**

Subject to any additional information being identified, consideration will be given to the content and recommendations of a draft final report or statement.

7.0 Witnesses

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

- Leeds PCT
- Director of Children's Services
- Members of YSHAG
- Leeds Youth Service
- Education Leeds
- Leeds Teenage Pregnancy and Parenthood Partnership
- Representative from the Teenage Pregnancy National Support Team
- Representatives from other authority areas
- Representatives from any community or voluntary organisations providing services and advice to young people on sexual health and/or parenthood issues.

8.0 Post inquiry report monitoring arrangements

8.1 Following the completion of the Scrutiny inquiry and the publication of the final inquiry report and recommendations, the implementation of the agreed recommendations will be monitored. The Scrutiny Board will determine those arrangements at the end of the Inquiry.

8.2 The final inquiry report will include information on the detailed arrangements for how the implementation of recommendations will be monitored.

9.0 Measures of success

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

9.2 The Board will look to publish practical recommendations.

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