Public Document Pack

Leeds CITY COUNCIL

Supplementary Agenda

SCRUTINY BOARD (HEALTH)

Meeting to be held in Civic Hall, Leeds, LS1 1UR on
Tuesday, 26th April, 2011 at 10.00 am

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

MEMBERSHIP

Councillors

S Armitage	-	Cross Gates and Whinmoor;
M Dobson (Chair)	-	Garforth and Swillington;
P Ewens	-	Hyde Park and Woodhouse;
P Harrand	-	Alwoodley;
A Hussain	-	Gipton and Harehills;
J Illingworth	-	Kirkstall;
G Kirkland	-	Otley and Yeadon;
G Latty	-	Guiseley and Rawdon;
J Matthews	-	Headingley;
E Taylor	-	Chapel Allerton;

Co-opted Members (Non-Voting)

Position Vacant - Leeds LINk
Emma Stewart - Leeds LINk

Please note: Certain or all items on this agenda may be recorded

Agenda compiled by:
Stuart Robinson
Governance Services
Tel: 24 74360

Principal Scrutiny Advisor:
Steven Courtney
Tel: 24 74707

Produced on Recycled Paper

A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
7			**DERMATOLOGY SERVICES IN LEEDS** To consider a report of the Head of Scrutiny and Member Development. **(Report attached)**	1 - 20
8			**LEEDS ALCOHOL HARM REDUCTION PLAN: 2011-15 - CONSULTATION** To consider a report of the Head of Scrutiny and Member Development. **(Report attached)**	21 - 40
9			**NATIONAL REVIEW OF CHILDREN'S CONGENITAL HEART SERVICES - PROGRESS REPORT** To consider a report of the Head of Scrutiny and Member Development. **(Report attached)**	41 - 50
10			**RECOMMENDATION TRACKING** To consider a report of the Head of Scrutiny and Member Development to provide a progress update on the Board's previous scrutiny inquiries and recommendations. **(Report attached)**	51 - 66
11			**SCRUTINY BOARD (HEALTH) - OUTLINE ANNUAL REPORT 2010/11** To consider a report of the Head of Scrutiny and Member Development. **(Report attached)**	67 - 70

Item No	Ward/Equal Opportunities	Item Not Open		Page No
12			**WORK PROGRAMME - UPDATE** To receive and consider a report from the Head of Scrutiny and Member Development outlining the Scrutiny Board's work programme for the remainder of the current municipal year. **(Report attached)**	71 - 104

This page is intentionally left blank

Agenda Item 7

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 26 April 2010

Subject: Dermatology Services in Leeds

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

1.0 Purpose of this Report

1.1 The purpose of the report is to present the Scrutiny Board (Health) with an updated position regarding the proposed development of dermatology services within Leeds.

1.2 It highlights some concerns identified by the Leeds Dermatology Patients Panel and the Skin Care Campaign. Leeds Teaching Hospitals NHS Trust (LTHT) have been invited to address such concerns and provide an update to the Scrutiny Board (Health).

2.0 Background

November 2009

2.1 At its meeting on 24 November 2009, the previous Scrutiny Board (Health) received and considered a range of information associated with proposed changes to dermatology services, particularly in terms of in-patient provision on ward 43 at Leeds General Infirmary (LGI).

2.2 At that meeting, the Board was made aware of some pubic concern around proposed changes to the dermatology service and the need to maintain a dedicated in-patient service for those patients suffering acute episodes that required hospital admission. Members also heard that patients and the British Association of Dermatologists (BAD) had significant concerns around the consultation process – highlighting that staff and patients needed to be engaged and consulted before any decision to change services currently provided on ward 43.

2.3 At the same meeting in November 2009, members of the Scrutiny Board (Health) were advised by LTHT that consideration was being given to re-providing dermatology

services elsewhere within the Trust and an options appraisal was being undertaken. Members were assured by LTHT that there had always been an intention to engage and consult with staff and patients, and that further work around engaging and involving key stakeholders would be undertaken in an open and transparent manner.

2.4 Following consideration of the issues presented and discussed at the meeting, the Scrutiny Board raised a number of concerns and communicated these by way of a letter to the Trust's Chief Executive. This included the lack of effective patient involvement and engagement in developing the proposals.

March 2010

2.5 The concerns raised in November 2009 and the associated response from LTHT were reported to the previous Scrutiny Board in March 2010. At that meeting, LTHT's Directorate Manager (Speciality Medicine) advised the Scrutiny Board that:

- LTHT intended to continue to provide dedicated Dermatology inpatient beds;
- The continued need for dedicated inpatient beds and the need for skilled nursing staff was recognised and there was no proposal to change the level of service or support provided;
- LTHT was seeking to re-provide the inpatient beds to another ward location within the Trust;
- There had been on-going discussions with patients, consultants and the nursing team about the proposed re-provision of dermatology beds from Ward 43 LGI to another ward location within LTHT;
- A lead Matron had been dedicated to the project and, in close liaison with patients, consultants and the nursing team, a draft options paper had been produced for further comments by key stakeholders before completion.

2.6 In addition, at the same meeting in March 2010, the Leeds Dermatology Patient Panel (LDPP) representative advised the previous Scrutiny Board that:

- As the panel was newly formed and still evolving, its main aim was to contribute to the planned re-provision of Ward 43 dermatology services and to ensure a focus on maintaining current levels of high quality patient;
- The panel had established links with a number of representative groups within LTHT and were continuing to receive support from a range of national dermatology groups and organisation, such as The Skin Care Campaign and The British Association of Dermatologist;
- The panel also included a committee member of the Leeds Local Involvement Network (LINks);
- The panel had been very active with input into the completion of the option appraisal work, including compiling a comparison list between Ward 43 at LGI and a proposed Ward 2 at Chapel Allerton Hospital (CAH);
- During the last three months, LTHT had been very helpful, open and transparent at the panel's meetings.
- The next stage would be around the more formal consultation processes.

2.7 At that meeting the Chair stated that the main aim of the Scrutiny Board had been to help ensure the retention of high quality, dedicated medical and nursing care for the benefit of patients; and to facilitate an on-going dialogue between patients and the Trust in this regard. Noting the Scrutiny Board's pivotal role, the Chair went on to state how pleasing it was to hear how patients were being actively involved in the planned re-provision of dermatology services.

Post March 2010

2.8 Since the Scrutiny Board meeting in March 2010, proposals where brought forward by the Trust to relocate Dermatology inpatient services to Chapel Allerton Hospital. The Trust undertook a consultation exercise, in part through the Leeds Dermatology Patient Panel (LDPP) and the LDPP has continued to have some involvement in the planning and preparation works for the proposed move.

2.9 In early September 2010, having been informed of the proposed timescales for the move of inpatient services, members of the LDPP raised concerns with LTHT. Such concerns were reported and discussed at the Scrutiny Board (Health) meeting in October 2010. In November 2010, Members of the Scrutiny Board (Health) attended a tour of the in-patient facilities at Chapel Allerton Hospital.

2.10 In March 2011, the Chair of the Scrutiny Board met with representatives from the LDPP, who raised a number of ongoing concerns in relation to the proposed move of the Dermatology Outpatients Service to Chapel Allerton Hospital, which included:

- Capacity of the proposed hospital site;
- Proposed location and associated proximity of the various elements that make up the outpatients service;
- Availability of information and involvement of all members of the LDPP; and,
- Unrealistic timescales.

2.11 These matters were identified at the Board's meeting in March 2011 and were subsequently communicated with LTHT and a brief report requested. In addition, a request was made to ensure that no plans were finalised until the Scrutiny Board (Health) and explored this matter further.

3.0 Dermatology Services in Leeds

3.1 LDPP have subsequently provided an outline of some areas of progress (Appendix 1) and the main issues / concerns that remain in relation to both in-patient and out-patient services (Appendix 2). Representatives from LDPP have been invited to attend the Scrutiny Board meeting to outline these concerns in more detail and address any questions the Board may have, as appropriate.

3.2 Furthermore, additional concerns identified by the Skin Care Campaign have recently been brought to the attention of the Chair. These concerns, outlined in the letter attached at Appendix 3, have been forwarded to LTHT for comment. As outlined in the attached letter, the Skin Care Campaign will not be represented at the meeting.

3.3 Representatives from Leeds Teaching Hospitals NHS Trust (LTHT) have been invited to attend the meeting to present a brief report addressing the concerns raised by LDPP and the Skin Care Campaign. A copy of this report will be provided as soon as practicable.

4.0 Recommendation

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

4.1.1 Identify and determine any specific action the Board may wish to take;

4.1.2 Identify any matters that require further scrutiny and/or any recommendations the Board may wish to make.

5.0 Background Papers

- Provision of Dermatology Services – Scrutiny Board (Health), 24 November 2009
- Provision of Dermatology Services – Scrutiny Board (Health), 16 March 2010
- Provision of Dermatology Services – Scrutiny Board (Health), 26 October 2010

APPENDIX 1

CHANGES in THE DERMATOLOGY OUTPATIENT PLANS EITHER MADE BEFORE or FOLLOWING A. MEETING ON MARCH 25TH WITH SYLVIA CRAVEN (head of estates) and other MANAGEMENT COLLEAGUES, CONSULTANTS, NURSES and 4 PATIENT PANEL REPRESENTATIVES

1. The theatre and laser areas have been moved from the top floor (of the wing adjacent to the likely new Dermatology outpatients) to the ground floor. Because of the layout of CHA, which is on a slope, although the main outpatients and theatre/laser areas are both on the ground floor, the areas are separated by one floor. However this move is a very good move as it does put the two distinct parts of the department much closer together

2. The consulting rooms for the patients have been significantly modified to the benefit of patients in that the majority of them will have an adjacent consulting room and examination room. This will allow most patient to get undressed with dignity in the adjacent examination room while at the same time that Doctor can interview another patient. The door between the consulting and examination room is relatively soundproof

3. We are pleased to hear that there will be one more theatre

4. The paediatric waiting room and paediatric consulting rooms are no longer on the main hospital corridor. They have been moved into the major part of the outpatient department

5. A much more appropriate area has been provided for medical student teaching. This was very much needed since from next year there will always be 8 medical students in the department at any one time. On the whole we as patients are very happy to be seen by medical students but do not like to be kept waiting unnecessarily. Furthermore it is possible that by the major teaching room there will be a room in which a patient could be "undressed", but in a dressing gown waiting to be seen by the students

This page is intentionally left blank

APPENDIX 2

URGENT INPATIENT CONCERNS 13/04/2011					
ISSUE/CONCERNS	**COMMENTS BY LDPP.**	**HOW THIS ISSUE EFFECTS WARD 2 PATIENTS**	**REQUESTED/ACTION BY THE LDPP FROM THE TRUST**	**LIKELY PERSON RESPONDING ON BEHALF OF THE TRUST**	**DATE BY WHICH WE WOULD LIKE A RESPONSE**
RISK ASSESSMENT	Concerns over whether a full risk assessment was performed prior to Dermatology moving from the Infirmary	If not done then this could have contributed to circumstances on the ward which has put patients at risk	Was a risk assessment done? If so we request a copy of that assessment If not, why wasn't this done despite the LDPP suggesting it should be	Judith Lund	April 21 2011
LACK of INFECTION CONTROL	Infection control on the ward is inadequate	This lack of appropriate infection control has put patients at risk and has had a demoralizing effect on some patients on the ward	That appropriate policies and procedures are put in place	Amanda Dean	Currently in progress.Update required by APRIL 21 2011
RELATIVE LACK of TRAINING OF RHEUMATOLOGY NURSES & VISA VERSA		Has affected patients care	What plans are there to provide adequate training and supervision to ensure that nurses are skilled enough to give good care?	Amanda Dean and Penny McSorley	Being acted upon. Update required by APRIL 21 2011
REDUCED NURSES MORALE	Number of staff per shift is not consistent	Does affect patients care and when they receive treatment.	What is being done to improve staff morale?	Amanda Dean and Penny McSorley	Being acted upon Update required by APRIL 21 2011

APPENDIX 2

URGENT INPATIENT CONCERNS 13/04/2011					
ISSUE/CONCERNS	**COMMENTS BY LDPP.**	**HOW THIS ISSUE EFFECTS WARD 2 PATIENTS**	**REQUESTED/ACTION BY THE LDPP FROM THE TRUST**	**LIKELY PERSON RESPONDING ON BEHALF OF THE TRUST**	**DATE BY WHICH WE WOULD LIKE A RESPONSE**
INADEQUATE LABELING of THE WARD & PATIENTS (male and female) TOILETS and BAYS	Could have been done 6 months ago ;it is a requirement on mixed sex wards	Does affect patients as different sexes are using same sanitary facilities(not dignated)	What is the Trust policy for Ward 2 with reference to DSSA Principles 2010.03.02 Ver 2.0 (item 1-18)	Judith Lund / Chief Nurse	Update required by APRIL 21 2011
DECISION as to which PATIENTS receives PREVENTATIVE anticoagulant treatment	Clearly this is essential	Maybe some patients have received it inappropriately?		Amanda Dean / Dr Goodfield/Dr Wilkinson	Update required by APRIL 21 2011
APPROPRIATENESS OF ADMISSION & ADMISSION TO SINGLE ROOMS		If inappropriate would be dangerous to patients		Amanda Dean	Update required by APRIL 21 2011

APPENDIX 2

URGENT INPATIENT CONCERNS 13/04/2011					
ISSUE/CONCERNS	**COMMENTS BY LDPP.**	**HOW THIS ISSUE EFFECTS WARD 2 PATIENTS**	**REQUESTED/ACTION BY THE LDPP FROM THE TRUST**	**LIKELY PERSON RESPONDING ON BEHALF OF THE TRUST**	**DATE BY WHICH WE WOULD LIKE A RESPONSE**
FAILURE TO COMPLETE NEW WARD CHANGES	Current facilities are inadequate for even good basic care to be possible eg: gel, soap, towel and glove dispenser are still not attached to the treatment room walls and there are at times no waste bins.	We consider that there has been more than enough time to have got this right and failure to provide proper facilities does increase risk to patients	For a lot of reasons – infection control, poor lighting, lack of adequate cleaning, lack of nursing expertise etc patients are being put at risk – what risk assessment has been done by the trust to try to prevent this? (see request above)	Julie McFarlane / Judith Lund	April 21 2011
BETTER PATIENT BED SIDE LIGHTING for PATIENTS & STAFF	Current lighting is inadequate	Inadequate lighting will impair proper examination and some treatments increasing risk to patients Once again the LDPP consider that the trust has had more than enough time to get this right	To install upgraded lighting to suit patient and clinical requirements.	Julie McFarlane	April 21 2011

APPENDIX 2

URGENT INPATIENT CONCERNS 13/04/2011					
ISSUE/CONCERNS	**COMMENTS BY LDPP.**	**HOW THIS ISSUE EFFECTS WARD 2 PATIENTS**	**REQUESTED/ACTION BY THE LDPP FROM THE TRUST**	**LIKELY PERSON RESPONDING ON BEHALF OF THE TRUST**	**DATE BY WHICH WE WOULD LIKE A RESPONSE**
RISK OF PATIENTS OR STAFF SLIPPING IN SHOWER OR BATHROOM RESULTING IN INJURY	This has already occurred	Creams and emollients on floor making it slippery. Patients at risk of falling (fracture to limbs)	A proper policy and procedure needs to ne developed before more patients and staff are put at risk	Amanda Dean	Currently in progress Update required by APRIL 21 2011
PATIENT WARD LEAFLET	Needs better coordination	Patients not fully informed about their inpatient stay	To organise a co ordinated meeting	Amanda Dean	April 20 2011

APPENDIX 2

URGENT OUTPATIENT CONCERNS 13/04/2011					
ISSUE/CONCERNS	**COMMENTS BY LDPP.**	**HOW THIS ISSUE EFFECTS DERMATOLOGY PATIENTS**	**REQUESTED/ACTION BY THE LDPP FROM THE TRUST**	**LIKELY PERSON RESPONDING ON BEHALF OF THE TRUST**	**DATE BY WHICH WE WOULD LIKE A RESPONSE**
GENERAL ISSUES ***Failure of the Trust to abide by (in England) section 242 of the consolidated NHS act 2006***	We have asked the trust on at least 3 occasions if they have signed up to this legal requirement. Most, if not all of the trust staff with whom we have had discussions do not know of this act	There should be a two-month period of public consultation for any major move. Patients and the scrutiny board might request public consultation if it seems that the dermatology outpatient will not be fit for our purpose	Please confirm whether or not middle-management are familiar with this act and are procedures and engagement documents available. If available then forward them to us so that we can see how public consultation is implemented by the Trust..	Judith Lund	April 21 2011
Failure of the Trust to be signed up to the patient engagement charter	This is a legal requirement and all patients should have access to it	The charter should be on the trust website. We cannot find it	Please confirm if the trust has produced a "Patient Engagement Charter" and that it is on their website.	Judith Lund	April 21
Patients have not seen any plans since March	Thus we cannot adequately comment	Lack of such knowledge will reduce our patient	Could we see the latest plans, including the office	Julie McFarlane	April 21, 2011

APPENDIX 2

URGENT OUTPATIENT CONCERNS 13/04/2011					
ISSUE/CONCERNS	**COMMENTS BY LDPP.**	**HOW THIS ISSUE EFFECTS DERMATOLOGY PATIENTS**	**REQUESTED/ACTION BY THE LDPP FROM THE TRUST**	**LIKELY PERSON RESPONDING ON BEHALF OF THE TRUST**	**DATE BY WHICH WE WOULD LIKE A RESPONSE**
25	on the current plans	experience and medical care	accommodation for medical and nursing staff		
SIZE OF CONSULTING ROOMS	Some of the rooms especially for paediatric patients are likely to be too small if patient comes with 3/4 relatives + buggy		Request to see plans with chairs etc. in place	Julie McFarlane	April 21, 2011
SPLIT LOCATIONS : If consultant offices are not close to the clinic		This will impair our medical experiences and could put patients at risk	Confirmation as to where the consultant offices are to be positioned	Julie McFarlane	April 21, 2011
SPLIT LOCATIONS : If registrars offices are not adjacent to the clinic	To have registrars close to the clinic would be great for patients	Likely to affect the treatment and care of some patients ie when registrar called to see patient in clinic ie patient with leg ulcer, phototherapy, acute skin rash, patient in nurse led clinic .Patients would also like registrars to see as many relevant "interesting" patients as possible to enhance their training and expertise	We still do not understand why the 4 offices near reception cannot be used for the specialist registrars. Yes, it would mean moving up to? 4 non-Dermatology staff. **The outpatient move to chapel A involves 55,000 patients. This is a sizable number of patients compared to 4 individuals**	Julie McFarlane / Sylvia Craven	April 21, 2011

APPENDIX 2

URGENT OUTPATIENT CONCERNS 13/04/2011					
ISSUE/CONCERNS	**COMMENTS BY LDPP.**	**HOW THIS ISSUE EFFECTS DERMATOLOGY PATIENTS**	**REQUESTED/ACTION BY THE LDPP FROM THE TRUST**	**LIKELY PERSON RESPONDING ON BEHALF OF THE TRUST**	**DATE BY WHICH WE WOULD LIKE A RESPONSE**
SPLIT LOCATIONS: If sisters office is not within the outpatients	We frequently see sister being needed by other members of the MDT in order to help us	No sister within the clinic will impair our overall experience and put patients at risk	Has sister Mousa got such a room in the clinic arena?	Julie McFarlane	April 21, 2011
PATIENT WAITING	We are told that in no way could a waiting area be built by reception in the courtyard We are told that drainage access prohibits any such building in the courtyard	We have not seen in writing that there will be a nursing / admin desk in the largest waiting area Patients waiting will effectively be along 2 corridors This area is relatively windowless, with very little natural light	In the long term could some of the courtyard (a large area) be used for additional Dermatology facilities To make the largest waiting area much more pleasant for patients could reasonable sized windows be placed to overlook the courtyard	Julie McFarlane	April 21
ACCESSIBILITY/CAR PARKING	The move to CAH will result in an extra 140 cars per day	Car parking will be an issue for all patients. Hospital car parking will	We are told that staff would use the Sikh temple area. Is this correct? Does the trust have a long-term contract with the Sikh & Polish centers? Has the Trust consulted with the local authorities as access	Judith Lund Bob Bilton Judith Lund	April 21th April 21

URGENT OUTPATIENT CONCERNS 13/04/2011					
ISSUE/CONCERNS	**COMMENTS BY LDPP.**	**HOW THIS ISSUE EFFECTS DERMATOLOGY PATIENTS**	**REQUESTED/ACTION BY THE LDPP FROM THE TRUST**	**LIKELY PERSON RESPONDING ON BEHALF OF THE TRUST**	**DATE BY WHICH WE WOULD LIKE A RESPONSE**
		also affect people who live around CAH	changes may be required etc.	Bob Bilton	
	A significantly large number of patients will find it more difficult (**about 15,000 patients visits pa**) & costly, as well as having greater difficulty in getting time off work when they need multiple treatments over several weeks	This will impact on safety of certain treatments. There is really however nothing can be done about this. The move to CAH is set in stone			
PAEDIATRIC PROBLEMS	We have to accept that in contrast to the current service the paediatric service will operate as a split site service; the doctors / nurses /other therapists working at both sites We were pleased to hear from sister Mousa that bloodletting for children is available at chapel A Children's general	The doctors dealing with paediatric issues may not be in the right place at the right time and so a child will have to be given an alternative appointment On the admittedly infrequent occasions a paediatric dermatology inpatient may have to visit chapel A for treatment Transport waiting can be	Has Dr. Clark got any further information How will transport be arranged for inpatient treatment to becarried out at CAH?	Dr. Clark / Dr. Wilkinson Judith Lund	April 21,

APPENDIX 2

URGENT OUTPATIENT CONCERNS 13/04/2011					
ISSUE/CONCERNS	**COMMENTS BY LDPP.**	**HOW THIS ISSUE EFFECTS DERMATOLOGY PATIENTS**	**REQUESTED/ACTION BY THE LDPP FROM THE TRUST**	**LIKELY PERSON RESPONDING ON BEHALF OF THE TRUST**	**DATE BY WHICH WE WOULD LIKE A RESPONSE**
	anaesthetic Laser treatment is still at the LGI	very stressful	Whereabouts in the LGI?		
NURSING CONCERNS	We are told that at the time of the move 1 nurse will retire & 1 nurse may opt not to move to CAH	Certain treatments are not currently available to us because of nurse shortage.	If effectively 3 nurses are lost would they be replaced and if so will this reflect their knowledge and expertise? If not replaced then services will be cut?	Amanda Dean	April 21,
ADEQUACY OF SUPPORT SERVICES *PHOTOGRAPHY*	We are told that 600 of us are photographed each year Dr. Stables reported that ideally each patient with skin cancer should be photographed. This we think will considerably increase the number of patients to be photographed	Currently all patients are photographed at the LGI If 600+ patients have to go to the LGI to be photographed this would definitely reduce our hospital experience and certainly not be a one-stop visit	We get different answers from different staff members about this issue. Could we please have an answer	Judith Lund/Julie McFarlane	April 21
PHARMACY	Skin patients frequently receive 3+ items on a prescription	For a one stop visit we would like to receive our outpatient treatment at CAH and not have to wait for it to come from the LGI	What is the trusts plan to expand pharmacy facilities	Judith Lund	April 21

APPENDIX 2

URGENT OUTPATIENT CONCERNS 13/04/2011					
ISSUE/CONCERNS	**COMMENTS BY LDPP.**	**HOW THIS ISSUE EFFECTS DERMATOLOGY PATIENTS**	**REQUESTED/ACTION BY THE LDPP FROM THE TRUST**	**LIKELY PERSON RESPONDING ON BEHALF OF THE TRUST**	**DATE BY WHICH WE WOULD LIKE A RESPONSE**
PORTERING	This is currently excellent at chapel A	**55,000 patient visits** is bound to require more porters	What is the trusts plan about ensuring that portering is maintained at the service level provided now?	Judith Lund	April 21
FUTURE CARE OF DERMATOLOGY PATIENTS IN LEEDS	Patients in Leeds deserve an excellent Dermatology service	If the system and facilities are not as good as other teaching hospitals such as Newcastle and Manchester then Leeds will not be able to attract the best doctors.. This would reduce patients access to new treatments as they are being developed Prof. Emery has an excellent rheumatology setup with a massive infrastructure at chapel A (&University)	Is the trust willing to provide/support/infrastructure for clinical Dermatology research	Dr. Belfield. We need a reply from a medical professional person	April 21

APPENDIX 2

URGENT OUTPATIENT CONCERNS 13/04/2011					
ISSUE/CONCERNS	**COMMENTS BY LDPP.**	**HOW THIS ISSUE EFFECTS DERMATOLOGY PATIENTS**	**REQUESTED/ACTION BY THE LDPP FROM THE TRUST**	**LIKELY PERSON RESPONDING ON BEHALF OF THE TRUST**	**DATE BY WHICH WE WOULD LIKE A RESPONSE**
RISK ASSESSMENT	After the very disappointing patient experiences with the Ward move we have concerns over the outpatient move	A full risk assessment, including infection control, should be carried out on the outpatient move so that patient safety is not at risk	Could you trust confirm that risk assessment has been done for the outpatients If not when will it be done?	Judith Lund	April 21
WHAT WILL HAPPEN TO THE 55,000 PATIENTS IF MONEY IS NOT AVAILABLE FOR WHAT WE CONSIDER IS OUR MINIMUM REQUIREMENT		This would reduce patients experience and quality of care	The LDPP would request a public inquiry (as per the NHS Act 2006 and seek MPs advice re: the possibility of a parliamentary adjournment) debate	Judith Lund / Sylvia Craven	April 21

This page is intentionally left blank

Cllr Mark Dobson
Chairman
Scrutiny Board (Health)
Leeds City Council

12th April 2011

Dear Councillor Dobson

Re: TREATMENT, CARE and SUPPORT of PATIENTS with SKIN DISEASES in LEEDS

I am writing following a recent hospital trust and patient group meeting about the continued problems experienced by patients following the move of adult in-patient dermatology services from Leeds General Infirmary to Chapel Allerton Hospital and the growing concerning of patients about the proposed move of out-patient services.

As expressed previously I was dismayed at the lack of planning and strategic decision making the trust had invested in the move of the ward; especially, considering the outcomes from previous scrutiny committee meetings and the year in which the hospital trust has had to plan for this significant change in service delivery. At a recent meeting of the Leeds Dermatology Patient Panel it was alarming to hear that despite the delays and previous reassurances from the trust patients were experiencing significant problems with the in-patient service, inc:

- infection control and consequent patient safety issues – with very poor management of potentially infectious patients and the facilities needed to contain any infection from infecting other patients
- incomplete building works including inadequate lighting and incomplete essential fixtures and fittings
- the inadequate level of experience and knowledge of the staff not from a dermatology background to provide the specialist treatment, care and support needed.

In my opinion if the move had have been properly planned, with appropriate strategic plans and clinical risk assessments, all of these could have been avoided and patients would not have been put at risk.

Once again it was noteworthy that the patient's at the meeting compromised a great deal on what they ideally wanted and what they will get. Unfortunately, however, confidence in the trust is very low and consequently patients are feeling that any move of out-patient services does not bode well – this may, however, be improved if the trust can produce strategic plans and clinical risk assessments that can be implemented to ensure a much smoother and safer transfer of out-patient services from the infirmary to Chapel Allerton Hospital.

I am sorry I cannot attend the OSC meeting where you will discuss this but please do not hesitate in contacting me if I can be of any further support.

Yours sincerely

Andrew Langford
Chief Executive.

Skin Care Campaign
St. James House
13 Kensington Square
London W8 5HD
t: 07810564913 e: alangford@skincarecampaign.org w: www.skincarecampaign.org

This page is intentionally left blank

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 26 April 2011

Subject: Leeds Alcohol Harm Reduction Plan (2011 – 2015) – consultation

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

1.0 Purpose

1.1 The purpose of this report is to provide members of the Scrutiny Board (Health) with the opportunity to comment on the draft Alcohol Harm Reduction Plan (2011-2015).

2.0 Background

2.1 Alcohol plays an important role in society, being consumed by the majority of adults and making an important contribution to the economy. However, the consumption of alcohol has health and social consequences borne by individuals, their families and the wider community. As previously reported, the cost of alcohol in Leeds (to the NHS alone) has been estimated to be in excess of £20 million per year.

2.2 At its meeting in January 2011, the Scrutiny Board (Health) received and considered a report on the economic and social costs of alcohol-related harm in Leeds (2008/09). At that meeting, the Board was advised by the Joint Director of Public Health that the report was being used to inform the development of a revised strategy/ action plan that would focus on:

- Leadership
- Reducing consumption
- Reducing crime and disorder
- Reducing alcohol related ill-health
- Impact of alcohol on children and young people

2.3 At that meeting, the Board agreed to consider the draft action plan prior to its completion.

3.0 Leeds draft Alcohol Harm Reduction Plan (2011-2015)

3.1 Leeds draft Alcohol Harm Reduction Plan (2011-2015) is attached at Appendix 1 for consideration of the Scrutiny Board (Health). It details proposed actions to address the following priority areas:

- Partners working across the City of Leeds prioritise effective actions that tackle the different ways that alcohol Impacts on local people and communities
- More people of all ages who consume alcohol do so within nationally recognised safe limits
- Fewer people experience alcohol-related violent crime and Anti-Social Behaviour in our Communities
- Fewer people experience alcohol-related ill health
- Fewer children and young people's whose lives are adversely affected by their parents drinking including neglect, physical and emotional abuse
- Fewer under 18 year olds who develop drinking habits which impact on their health, personal safety and offending behaviour

3.2 The draft action plan was launched for consultation on 21 March 2011, which runs until 13 May 2011.

3.3 This report provides members of the Scrutiny Board (Health) with an opportunity to comment on and provide a formal consultation response, with regard to the proposed Alcohol Harm Reduction Plan (2011-2015). A consultation response form is attached at Appendix 2.

4.0 Recommendations

4.1 Members are asked to consider the details presented in this report and appendices, and, if/ where appropriate, agree any specific matters to be highlighted as part of the Board's formal consultation response.

5.0 Background Documents

- The economic and social costs of alcohol-related harm in Leeds (2008/09) – Scrutiny Board (Health), 25 January 2011

A Consultation Document

Leeds Alcohol Harm Reduction Plan: 2011-15

CONSULTATION

NHS Leeds

Leeds City Council

West Yorkshire Trading Standards Service
West Yorkshire Joint Services

Draft version 21

Introduction

Leeds alcohol harm reduction plan builds on the Leeds Alcohol Harm Reduction Strategy 2007-10. Much has been achieved under the last strategy. However there is a need to review our actions to ensure that in times of restricted investment in statutory services that we can work together to halt the increase and reduce the harm caused by the misuse of alcohol across the City.

All our investment in interventions to reduce alcohol harm must be cost effective and there is the added incentive that savings can be made by reducing the hidden cost of alcohol for many agencies working in Leeds. This cost has been presented in the 2010 report: The Economic and Social Cost of alcohol-related harm in Leeds 2008-09[1]. It is now even more important that we achieve co-ordinated, integrated and best value action across the private, public and voluntary sectors and within communities to ensure that we reduce alcohol harm.

This action plan has been developed by the Leeds Alcohol Management Board with the aim of achieving a comprehensive and feasible from 2011 to 2015. The plan should be read in conjunction with the 2011 Leeds alcohol needs assessment, NHS Leeds Alcohol Admissions Data Analysis[2] and the Leeds Economic and Social Cost of alcohol-related harm report. It complements and reflects City Priority plans and other strategic plans where alcohol is identified as a key issue.

Strategic Framework

The Leeds City Council Health Improvement Board (health and wellbeing) and Safer Leeds have shared the leadership of the last Alcohol Strategy. However it is recognised that alcohol harm is a common issue that has an impact across the Leeds Initiative strategic priorities

- Safer and Stronger Communities
- Health and wellbeing
- Children and Young People
- Sustainable Economy and Culture
- Regeneration.

An Alcohol Management Board will include representation from across the strategic priorities and with other key stakeholders. Establishment of accountability arrangements are to be determined.

CONSULTATION

[1] Jones L. Bates G et al. The Economic and Social Cost of alcohol-related harm in Leeds 2008-09. 2010. NHS Leeds
[2] Reynolds B. Alcohol Admissions Data Analysis. 2010. NHS Leeds

Overall Outcome

People living and working in Leeds will experience a reduction in the harm caused by alcohol. They will see improvements in the delivery of services and a co-ordinated and comprehensive approach by key stakeholders and agencies.

Our Priorities

Over the next four years we will focus on achieving the following strategic priorities:

1. Partners working across the City of Leeds prioritise effective actions that tackle the different ways that alcohol Impacts on local people and communities

2. More people of all ages who consume alcohol do so within nationally recognised safe limits

3. Fewer people experience alcohol-related violent crime and Anti-Social Behaviour in our Communities

4. Fewer people experience alcohol-related ill health

5. Fewer children and young people's whose lives are adversely affected by their parents drinking including neglect, physical and emotional abuse

6. Fewer under 18 year olds who develop drinking habits which impact on their health, personal safety and offending behave

CONSULTATION

Priority 1: Partners working across the City of Leeds prioritise effective actions that tackle the different ways that alcohol impacts on local people and communities	Accountable Director – Ian Cameron
Working in partnership has been identified by government as a high impact intervention.	

Performance Indicators	Targets	
	2011-12	2012-13
• Political leaders commit to prioritise alcohol harm reduction in Leeds • Key stakeholders and organisations commit to achieving the Leeds Alcohol Harm Reduction Plan • Each of the Leeds City priority plans include action to reduce alcohol harm • Alcohol Harm reduction plan 2011-15 milestones are achieved		

Priority Actions

Action	Targeting	Action Owner	Contributing Officers	Milestone or Target
Meet political leaders to identify a political 'champion', achieve the vision and seek commitment to take forward the action plan	Political Leaders	Director of Public health	Director of Adult Social Care, Director of Childrens Trust, NHS Commissioners	Alcohol-use disorder prevention is prioritised as an 'invest to save 'measure
Complete a comprehensive alcohol harm reduction needs assessment	Key Stakeholders agencies	NHS Leeds/LCC		May 2011
A consultation process is completed leading to an agreed Leeds Alcohol Harm Reduction Action plan 2011-15	All partners across Leeds working in alcohol field	Leeds Initiative	Consultant in Public Health: healthy living and health inequalities	May 2011
Agreed governance arrangements established				July 2011

CONSULTATION

Priority 2: More people of all ages who consume alcohol do so within nationally recognised safe limits	Accountable Director – Ian Cameron

Performance Indicators	Targets	
	2011/12	2012/13
• Key identified organisations have workplace alcohol policies based on recognised good practice implemented • Levels of reported Alcohol consumption amongst young people is reduced– monitored via the annual Every Child Matters survey • More increasing and higher risk drinking population are offered identification and brief interventions from skilled staff or volunteers each year • Reduction in prevalence of binge drinking		

Priority Actions

Action	Targeting	Action Owner	Contributing Officers	Milestone or Target
Implement workplace alcohol polices and promote a healthy and safe consumption of alcohol; for the children's workforce ensure that underage drinking is not condoned.	Workplaces LCC Police NHS	Consultant in Public Health: healthy living and health inequalities	Workplace health lead officers: LCC, Police and NHS	
Implement and evaluate a research programme to challenge exaggerated beliefs about normal alcohol consumption habits of other young people (social norms)	Secondary schools/WNW Locality	Consultant in Public Health: healthy living and health inequalities	Education Leeds School Improvement Service, Leeds University	
Implement a partnership communications campaign to give people the help and advice they need to adopt a healthy and safe drinking behaviour	Population of Leeds	Consultant in Public Health: healthy living and health inequalities	Communications Officers from LCC, NHS Leeds, Police, Ambulance, Fire & Rescue, PubWatch	

CONSULTATION

Partners officially endorse the introduction of a minimum price per unit of alcohol, as soon as practicable	Senior management of partner agencies	Consultant in Public Health: healthy living and health inequalities		
Introduce a skills development programme so that staff are competent to identify d hazardous drinking and alcohol dependence; and to initially assess the need for an intervention	Frontline staff in Primary and secondary health, and children and adults social care services	Consultant in Public Health: healthy living and health inequalities	NHS Leeds Public health, LCC Adult Social Care, Childrens services and NHS commissioners	Increase in the number of people at risk of an alcohol related problem and those whose health and wellbeing is being damaged by alcohol who are identified and offered support

CONSULTATION

Priority outcome 3: Fewer people experience alcohol-related violent crime and disorder	Accountable Director: Simon Whitehead

Performance Indicators	Targets	
	2011/12	2012/13
• Reduce the level of alcohol related violent crime • Reduce number of people with alcohol-related harm attending NHS Accident and Emergency Departments		

Priority Actions

Action	Targeting	Action Owner	Contributing Officers	Milestone or Target
Design and deliver tailored responses to assaults, wounding and alcohol fuelled violence	City centre District centres, localities of concern	Divisional Commanders Head of Safety and Safeguarding	Operational Group NHS	• Incorporate actions into DCSP plans (2011-2014) - by April 2011 • Actions reviewed quarterly during 2011 • Work with A&E to share non-confidential information with Safer Leeds – during 2011
Encourage business improvement districts i.e. defined areas within which businesses pay a fee to a collective budget in order to fund improvements leading to reduction in alcohol harm within the district's boundaries.	Localities with high rates of violent crime and /or alcohol harm			
Develop Locality based action plans to resolve alcohol harm at community level	Localities of concern	Area leaders	Public Safety Manager, LCC Community Safety; Chief Inspector, Police	Production of quarterly and annual strategic intelligence products

CONSULTATION

Evaluate the Headingly Street Angels project and if successful roll out to other localities with high rates of violent crime	Localities with high rates of violent crime	Area Leaders	Public Safety Manager, LCC Community Safety	
Explore all funding options to extend taxi marshalling based on intelligence around location and hotspot periods	Localities with high rates of violent crime	LCC Community Safety: Public Safety Manager	Chief Inspector City NPT City Centre Manager	
Committed partnership working and sharing of resources to achieve actions set out in the Leeds City Centre Evening and Night Time Economy strategy	City Centre	LCC Community Safety: Public Safety Manager	City Centre Manager Chief Inspector City NPT	Night time Economy Plan signed approved by Safer Leeds Executive by March 2011 Plan in place by April 2011
Increase targeted support for vulnerable licensed premises	City centre District town centres Localities of concern	C&H Divisional Lead Head of Safety and Safeguarding	Operational Group PubWatch Scheme; Section Head: LCC Entertainment Licensing	• Increase numbers of premises involved in PubWatch, best bar none and similar schemes – during 2011 • Target problematic premises – Increased test purchase operations – during 2011 • Explore opportunities to utilise ASB tools – Responsible Retail Orders – April 2011
Explore all funding options to introduce a triage centre to provide on-the-scene medical attention to people out in the city	City centre	NHS Leeds Consultant in Public Health:	LCC Community Safety: Public Safety Manager;	

CONSULTATION

from 8pm to 4am		healthy living and health inequalities	Chief Inspector City NPT	
Monitor progress of the Police Reform & Social Responsibility Bill and engage responsible authorities in the development of new Statement of Licensing Policy.	Entertainment Licensing	Nicola Raper, LCC Entertainment Licensing	LCC Entertainment Licensing: Principal Project Officer	Consultation on the draft Statement Of Licensing Policy early 2012 dependant on the progress of the Police, Reform & Social Responsibility Bill.
Maintain the arrest referral screening and brief intervention provision within the DIP Main Grant to integrate Drug and Alcohol Arrest Referral	Criminal Justice Services	Safer Leeds	Commissioning and Development, Drug Interventions Programme, Safer Leeds	To be in place by December 2011

CONSULTATION

Priority 4: Fewer people experience alcohol-related ill health	Accountable Director: Ian Cameron

Performance Indicators	Targets	
	2011/12	2012/13
• Alcohol-related hospital admissions are reduced • Alcohol-specific hospital admissions are reduced • Number of specialist alcohol treatment slots increased towards 1 in 7 dependent drinkers (in line with 'Signs for improvement'.) • Planned discharge rates for drinkers entering commissioned treatment services are superior to the national average (currently 51%) • Monitor and respond to drunk under 18 year olds presenting at A and E mental		

Priority Action

Action	Targeting	Action Owner	Contributing Officers	Milestone or Target
Increase provision of high quality treatment services available to the increasing and higher risk groups, dependant drinkers and alcohol misusing offenders (in line with NICE guidelines)[3].	Dependant Drinkers	Diane Powell, NHS Leeds	NHS and LCC alcohol treatment service commissioners	• Increased provision of treatment services • Higher number of people accessing services October 2011
Review service level agreements with treatment service providers to increase the number of high quality evidence based specialist alcohol treatment slots and to ensure performance is measured	ADS LAU Alcohol Hospital Service St Annes	Diane Powell, NHS Leeds	NHS alcohol treatment service commissioners	• SLAs in place • Increased number of evidence based treatment slots

[3]NICE. Alcohol Use disorders: preventing the development of hazardous and harmful drinking. Public Health Guidance 24. June 2010

CONSULTATION

				available May 2011
Develop comprehensive referral pathways to a stepped care treatment approach[4] including offenders	Dependent Drinkers	Diane Powell, NHS Leeds	NHS and LCC alcohol treatment service commissioners	Comprehensive referral pathway developed and implemented August 2011
Establish a robust model of multi-agency working to support those highly vulnerable people identified as 'frequent flyers' attending the acute trust.	Frequent flyers/attendees of the acute trust	Diane Powell, NHS Leeds	NHS and LCC alcohol treatment service commissioners; Safer Leeds	Model for multi-agency working developed and implemented January 2012
Ensure a sustainable access to treatment services following alcohol arrest referral	Offenders	Diane Powell NHS Leeds	NHS and LCC alcohol treatment service commissioners; Safer Leeds	Ongoing
Work with statutory; third sector and service user and carer organisations to ensure access to treatment services for hard to reach vulnerable groups.	Identified hard to reach and vulnerable	Diane Powell NHS Leeds	Carers Leeds service	Access to treatment services by hard to reach vulnerable groups November 2011
Assess the feasibility of tendering a whole treatment system for alcohol		Diane Powell, NHS Leeds	NHS and LCC alcohol treatment service commissioners	December 2011
Include identification and brief advice on alcohol into the Leeds Healthy Livings interventions programme: Leeds Lets Change	At risk drinkers	Heather Thomson, NHS Leeds	NHS Leeds public health and commissioners of Staying Healthy Services	An increase in appropriate referrals March 2012

[4] Department of Health (2006) Models of care for alcohol misusers (MOCAM). London: Department of Health.

CONSULTATION

Priority 5: **Fewer children and young people's lives are adversely affected by their parents drinking including neglect, physical and emotional abuse** **Priority 6:** **Fewer under 18 year olds develop drinking habits which impact on their health, personal safety and offending behaviour**	**Accountable Director: Nigel Richardson**

Performance Indicators	**Targets**	
	2011/12	**2012/13**
• Percentage of retailers who illegally sell alcohol reduces (using test purchasing) • Number and proportion of child protection cases where parental alcohol misuse is a factor • Rate of fixed period alcohol related exclusions from school • Levels of alcohol related offending by young people		

Priority Action

Action	**Targeting**	**Action Owner**	**Contributing Officers**	**Milestone or Target**
Build on the Trading Standards Test Purchase project in Middleton and Armley to reduce the supply of alcohol to young people in other target areas of the City	Localities identified as having high levels of health and ASB issues associated with illegal sales to young people	Trading Standards	NHS Leeds public health and NHS Commissioners	Reduction in illegal sales in targeted areas
Develop and implement a short educative programme on alcohol use for children and young people entering the Youth Offending Service.	Young people entering the youth justice system	Louise Atherton – LCC Young People's substance use	Youth Offender Service, Young People's substance use service commissioners	

CONSULTATION

		commissioner		
Develop and implement a robust pathway and model to ensure the delivery of appropriate, evidence based interventions and support for children & young people who attend A&E with alcohol as a contributory factor.	Children and young people entering A&E	ICT Children & Families – Julie Stafford	Leeds Teaching Hospital Trust; Leeds Community Health Care; LCC Young People's substance use commissioner; CAF team Children and young people's social care	
Roll out the implementation of one drug and alcohol screening tool applicable to all children's services settings. The tool will promote early identification of drug and alcohol related issues, advice giving and referral when appropriate.	Vulnerable groups of young people, including looked after children, truants, young people excluded from school, young offenders	Young People's substance use Commissioned services	NHS Leeds Young People's substance use commissioner Workforce development	
Implement protocols between adult alcohol treatment providers and children's services about parental alcohol use to prevent potential harm to dependent children and young people in the household.	Children of problematic drinkers	Safer Leeds and LCC Children's Services	Adult treatment providers; Safer Leeds; Platform; CAF team; Children and young people's social care	
Ensure relevant workers are skilled in identifying parental drug and alcohol misuse, risk assessment and harm reduction approaches	Adult treatment providers	LCC Adult and children social care commissioners of	Commissioning and Development: Safer Leeds; NHS Leeds	

CONSULTATION

		substance misuse services		
Ensure that parents who are drinking too much are able to access parenting programmes and other support in order to reduce the harm experienced by dependent children	Parents whose drinking impacts on parenting capacity	LCC Adult and children social care commissioners of substance misuse services	Children Leeds Panels Family Intervention Programmes	
Encourage schools to plan for the substance misuse priority when engaging with the healthy school behaviour change model (enhancement) and develop a consistent approach to drugs and alcohol education across schools	All children and young people	Healthy Schools Team Manager	Head teachers LCC Youth service	

CONSULTATION

APPENDIX 2

Healthy Leeds

Leeds Alcohol Harm Reduction Action Plan - Consultation

The Leeds Alcohol Harm Reduction Action Plan 2011 – 2015 is out for consultation until Friday 13th May 2011. You are invited to comment on each of our strategic priorities, which are listed below. To view the specific actions for each of the strategic priorities please refer to the Alcohol Action Plan. You can also fill this online at www.leedsinitiative.org/alcoholconsultation.

1. **Partners, working across the City of Leeds, prioritise effective actions which tackle the different ways that alcohol impacts on local people and communities.**

2. **More people of all ages who consume alcohol do so within nationally recognised safe limits.**

3. **Fewer people experience alcohol-related violent crime and anti-social behaviour in our communities**

Please return to Katherine Yu, the Leeds Initiative, Civic Hall, Leeds, LS1 1UR or email leeds.initiative@leeds.gov.uk

APPENDIX 2

Healthy Leeds

4. **Fewer people experience alcohol-related ill health.**

5. **Fewer children and young people whose lives are adversely affected by their parents drinking including neglect, physical and emotional abuse.**

6. **Fewer under 18 year olds who develop drinking habits which impact on their health, personal safety and offending behaviour:**

7. **Any further comments?**

Please return to Katherine Yu, the Leeds Initiative, Civic Hall, Leeds, LS1 1UR or email leeds.initiative@leeds.gov.uk

APPENDIX 2

Healthy Leeds

8. **Contact details – please write your name, organisation and contact details here if you are happy to do so:**

Please return to Katherine Yu, the Leeds Initiative, Civic Hall, Leeds, LS1 1UR or email leeds.initiative@leeds.gov.uk

This page is intentionally left blank

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 26 April 2011

Subject: National Review of Children's Congenital Cardiac Services – progress report

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

1.0 Purpose

1.1 The provide the Scrutiny Board (Health) with an update around the national review of children's congenital heart services and the associated work of the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) – the regional scrutiny body specifically formed to consider the proposals.

2.0 Background

2.1 In 2008 the NHS Medical Director requested a review of Children's Congenital Heart Services in England. The aim of the review was to develop and bring forward recommendations for a *Safe and Sustainable* national service that has:

- Better results in surgical centres with fewer deaths and complications following surgery
- Better, more accessible assessment services and follow up treatment delivered within regional and local networks
- Reduced waiting times and fewer cancelled operations
- Improved communication between parents/ guardians and all of the services in the network that see their child
- Better training for surgeons and their teams to ensure the service is sustainable for the future
- A trained workforce of experts in the care and treatment of children and young people with congenital heart disease
- Surgical centres at the forefront of modern working practices and new technologies that are leaders in research and development
- A network of specialist centres collaborating in research and clinical development, encouraging the sharing of knowledge across the network

2.2 As part of the above review programme, members of Leeds City Council's Scrutiny Board (Health) were formally made aware of the review of Children's Cardiac

Surgery Services across England in September 2009 and advised that 11 centres across England were providing Children's Cardiac Surgery Services, with around 3,800 procedures being undertaken each year..

2.3 Since that time, the Board has received a number of updates outlining progress of the review and key milestones. Throughout the review process, the Board has been reminded that Leeds Teaching Hospitals NHS Trust is the only provider of such surgical services in the Yorkshire and Humber region and that one of the issues being considered centred around a smaller number of larger centres, each undertaking a higher number of surgical procedures.

Review process

2.4 On behalf of the ten Specialised Commissioning Groups in England, and their constituent local Primary Care Trusts, the *Safe and Sustainable* review team (at NHS Specialised Services) has managed the review process. This has involved:

- Engaging with partners across the country to understand what works well at the moment and what needs to be changed
- Developing standards – in partnership with the public, NHS staff and their associations – that surgical centres must meet in the future
- Developing a network model of care to help strengthen local cardiology services
- An independent expert panel assessment of each of the current surgical centres against the standards
- The consideration of a number of potential configuration options against other criteria including access, travel times and population.

2.5 At a meeting of the Joint Committee of Primary Care Trusts (JCPCT) – the national body established to agree the review recommendations – held on 16 February 2011, the following recommendations and options for consultation were presented and agreed:

- Development of Congenital Heart Networks across England that would comprise all of the NHS services that provide care to children with Congenital Heart Disease and their families, from antenatal screening through to the transition to adult services.
- Implementation of new clinical standards that must be met by all NHS hospitals designated to provide heart surgery for children
- Implementation of new systems for the analysis and reporting of mortality and morbidity data relating to treatments for children with Congenital Heart Disease.
- A reduction in the number of NHS hospitals in England that provide heart surgery for children from the current 11 hospitals to 6 or 7 hospitals in the belief that only larger surgical centres can achieve true quality and excellence.
- The options for the number and location of hospitals that provide children's heart surgical services in the future are:

  Option A: Seven surgical centres at:
  - Freeman Hospital, Newcastle
  - Alder Hey Children's Hospital, Liverpool
  - Glenfield Hospital, Leicester
  - Birmingham Children's Hospital
  - Bristol Royal Hospital for Children
  - 2 centres in London[1]

[1] *The preferred two London centres in the four options are Evelina Children's Hospital and Great Ormond Street Hospital for Children*

Option B: Seven surgical centres at:

- Freeman Hospital, Newcastle
- Alder Hey Children's Hospital, Liverpool
- Birmingham Children's Hospital
- Bristol Royal Hospital for Children
- Southampton General Hospital
- 2 centres in London[1]

Option C: Six surgical centres at:

- Freeman Hospital, Newcastle
- Alder Hey Children's Hospital, Liverpool
- Birmingham Children's Hospital
- Bristol Royal Hospital for Children
- 2 centres in London[1]

Option D: Six surgical centres at:

- Leeds General Infirmary
- Alder Hey Children's Hospital, Liverpool
- Birmingham Children's Hospital
- Bristol Royal Hospital for Children
- 2 centres in London[1]

2.6 A period of public consultation has commenced and will run until 1 July 2011.

3.0 Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber)

3.1 At its meeting in December 2010, and in line with the Regional Joint Health Scrutiny Protocol, Leeds City Council's Scrutiny Board (Health) nominated its representatives towards establishing a Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber).

3.2 Since the announcement of the consultation options, Health Overview and Scrutiny Committees from other authorities across the region indicated their desire to form a joint scrutiny committee and confirmed their nominations accordingly. In line with the Regional Joint Health Scrutiny Protocol, Leeds City Council is providing the Chair and support to the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber). With all 15 authorities participating in such arrangements, membership of the joint committee is based on one member per authority and is as follows:

- Barnsley MBC – Cllr. Janice Hancock
- Bradford MDC – Cllr. Elaine Byrom
- Calderdale Council – Cllr. Ruth Goldthorpe
- City of York Council – Cllr. Sandy Fraser
- Doncaster MBC – Cllr. Georgina Mullis
- East Riding of Yorkshire Council – Cllr. Barbara Hall
- Hull City Council – Cllr. John Hewitt
- Kirklees Council – Cllr. Liz Smaje
- Leeds City Council – Cllr. Mark Dobson (Chair)
- North East Lincolnshire Council – Cllr. Peggy Elliot
- North Lincolnshire Council – Cllr. Trevor Barker
- North Yorkshire County Council – Cllr. Jim Clark
- Rotherham MBC – Cllr. Shaukat Ali

- Sheffield City Council – Cllr. Ian Saunders
- Wakefield Council – Cllr. Betty Rhodes

3.3 The joint committee held its first meeting on 14 March 2011, where it agreed it terms of reference and received a presentation, giving a broad outline of the proposals, from representatives of Specialised Commissioning Group (Yorkshire and the Humber). The joint committee will consider the options presented and the likely implications across the Yorkshire and Humber region. This will include consideration of the:

- Review process and formulation of options presented for consultation;
- Projected improvements in patient outcomes and experience;
- Likely impact on children and their families (in the short, medium and longer-term), in particular in terms of access to services and travel times;
- Views of local service users and/or their representatives;
- Potential implications and impact on the health economy and the economy in general, on a local and regional basis;
- Any other pertinent matters that arise as part of the Committee's inquiry.

3.4 At its second meeting, 29 March 2010, the joint committee received an initial response to the proposals from Leeds Teaching Hospitals NHS Trust and met with senior representatives from the Trust – including the Chief Executive and senior clinicians.

3.5 Following discussions at the meeting, the joint committee identified some concern with both the process of the public consultation and with its timing. As such, the joint committee agreed to seek a 3-month extension to the consultation exercise, to allow sufficient time for it to complete its review and issue its report and any recommendations. Members of the national review team have been made aware of this outcome and a formal report is currently being drafted in this regard.

3.6 The joint committee also agreed an outline/ indicative action plan to undertake its review. This is attached at Appendix 1. The next meeting date of the joint committee has not yet been confirmed.

4.0 Recommendations

4.1 Members of the Board are asked to note the update provided and identify any specific matters for consideration by the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber).

5.0 Background Documents

- A New Vision for Children's Congenital Heart Services in England: Consultation Document – March 2011
- Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) – Terms of Reference (agreed March 2011)
- Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) – agenda and reports – 14 March 2011
- Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) – agenda and reports – 29 March 2011

APPENDIX 1

JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (YORKSHIRE AND THE HUMBER)

RECONFIGURATION OF CHILDREN'S CONGENITAL HEART SERVICES IN ENGLAND

PROPOSED ACTION PLAN AND TIMETABLE

Purpose

To provide a draft action plan and indicative timetable for the work of the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) in:

- Considering the proposed reconfiguration of children's congenital heart surgery services in England; and,
- Producing a consultation response and/or scrutiny report in relation to the proposed reconfiguration of children's congenital heart surgery services in England;

Background

At its previous meeting on 14 March 2011, the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) agreed it terms of reference for considering the proposed reconfiguration of children's congenital heart surgery services in England. The main actions within the terms of reference include consideration of the:

- Review process and formulation of options presented for consultation;
- Projected improvements in patient outcomes and experience;
- Likely impact on children and their families (in the short, medium and longer-term), in particular in terms of access to services and travel times;
- Views of local service users and/or their representatives;
- Potential implications and impact on the health economy and the economy in general, on a local and regional basis;
- Any other pertinent matters that arise as part of the Committee's inquiry.

At that same meeting, the Joint Committee was advised that current public consultation exercise was seeking to establish views across four specific areas, namely:

- Clinical Standards – the proposed new clinical standards that must be met by all NHS hospitals designated to provide heart surgery for children.
- Clinical Networks – the development of Congenital Heart Networks across England that would comprise all of the NHS services that provide care to children with Congenital Heart Disease and their families.
- Surgical Centres – a proposed reduction in the number of NHS hospitals in England that provide heart surgery for children.
- Measuring Quality – proposed new systems for the analysis and reporting of outcomes (i.e. mortality and morbidity data) relating to treatments for children with Congenital Heart Disease.

DRAFT

APPENDIX 1

Outline timetable

Action	Input from	When	How
Review process and formulation of options presented for consultation;	Specialised Commissioning Group (Yorkshire and the Number)	March – June 2011	Written reports/ briefings and attendance at appropriate meetings of the Joint HOSC. Response to written questions (where appropriate)
	Leeds Teaching Hospitals NHS Trust (LTHT)	March – June 2011	
	Safe and Sustainable Team	April – June 2011	
	Joint Committee of Primary Care Trusts	April – June 2011	
Projected improvements in patient outcomes and experience;	Specialised Commissioning Group (Yorkshire and the Number)	March – June 2011	Written reports/ briefings and attendance at appropriate meetings of the Joint HOSC. Response to written questions (where appropriate)
	Leeds Teaching Hospitals NHS Trust (LTHT)	March – June 2011	
	Safe and Sustainable Team	April – June 2011	
	Joint Committee of Primary Care Trusts	April – June 2011	
	Yorkshire and the Number Congenital Cardiac Network	April – June 2011	
	Embrace Yorkshire and Humberside Infant and Children Transport Service	April – June 2011	
	GP Consortia / local Primary Care Trusts	April – May 2011	Invitation to provide written response / comments
	Hospital Trusts across the region	April – June 2011	
	Directors of Public Health	April – June 2011	
	Professional bodies	April – June 2011	
	Alder Hey Children's Hospital, Liverpool	*April – June 2011*	*Invitation to provide written response / comments – TBC*
	Freeman Hospital, Newcastle	*April – June 2011*	

DRAFT

APPENDIX 1

Action	Input from	When	How
Likely impact on children and their families (in the short, medium and longer-term), in particular in terms of access to services and travel times;	Specialised Commissioning Group (Yorkshire and the Number)	March – June 2011	Written reports/ briefings and attendance at appropriate meetings of the Joint HOSC. Response to written questions (where appropriate)
	Leeds Teaching Hospitals NHS Trust (LTHT)	March – June 2011	
	Safe and Sustainable Team	April – June 2011	
	Joint Committee of Primary Care Trusts	April – June 2011	
	Yorkshire and the Number Congenital Cardiac Network	April – June 2011	
	Embrace Yorkshire and Humberside Infant and Children Transport Service	April – June 2011	
	GP Consortia / local Primary Care Trusts	April – May 2011	Invitation to provide written response / comments
	Hospital Trusts across the region	April – June 2011	
	Directors of Public Health	April – June 2011	
	Professional bodies	April – June 2011	
	Local Involvement Networks	April – June 2011	
	Parents/ parent groups (including Children's Heart Surgery Fund)	March – June 2011	Invitation to provide written response / comments. Attendance at appropriate meetings of the Joint HOSC.
	Alder Hey Children's Hospital, Liverpool	*April – June 2011*	*Invitation to provide written response / comments – TBC*
	Freeman Hospital, Newcastle	*April – June 2011*	
Views of local service users and/or their representatives;	Local Involvement Networks	April – June 2011	Invitation to provide written response / comments

DRAFT

APPENDIX 1

Action	Input from	When	How
	Parents/ parent groups (including Children's Heart Surgery Fund)	March – June 2011	Invitation to provide written response / comments. Attendance at appropriate meetings of the Joint HOSC.
Potential implications and impact on the health economy and the economy in general, on a local and regional basis;	Specialised Commissioning Group (Yorkshire and the Number)	March – June 2011	Written reports/ briefings and attendance at appropriate meetings of the Joint HOSC. Response to written questions (where appropriate)
	Leeds Teaching Hospitals NHS Trust (LTHT)	March – June 2011	
	Yorkshire and the Number Congenital Cardiac Network	April – June 2011	
	Embrace Yorkshire and Humberside Infant and Children Transport Service	April – June 2011	
	GP Consortia / local Primary Care Trusts	April – June 2011	Invitation to provide written response / comments
	Local MPs	April – June 2011	
	Local Authorities (Leaders, Relevant Executive Board Members, Chief Executives, other Appropriate senior officers)	April – June 2011	

Action	Input from	When	How

DRAFT

APPENDIX 1

Action	Input from	When	How
Any other pertinent matters that arise as part of the Committee's inquiry.			
(1) Patient and public involvement and engagement	Safe and Sustainable Team	April – June 2011	Written reports/ briefings and attendance at appropriate meetings of the Joint HOSC. Response to written questions (where appropriate) Particular reference to: (1) The CHF commissioned focus group and survey work – outcomes, robustness, interpretation and use (2) Consultation plan/ strategy
	Joint Committee of Primary Care Trusts	April – June 2011	
	Children Heart Federation	April – June 2011	

DRAFT

DRAFT

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 26 April 2011

Subject: Recommendation Tracking

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

1.0 Purpose

1.1 The purpose of this report is to provide a progress update on the Board's previous scrutiny inquiries and recommendations.

2.0 Background

2.1 In December 2006, the Overview and Scrutiny Committee agreed to adopt a new, more formal system of recommendation tracking, to ensure that scrutiny recommendations were more rigorously followed through.

2.2 As a result, each Scrutiny Board now receives regular reports on its recommendations from previous inquiries which have not yet been completed. This allows the Scrutiny 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 Scrutiny Board will then be able to take further action as appropriate.

2.3 A standard set of criteria has been produced, to enable the board to assess progress. These are presented in the form of a flow chart at Appendix 1. The questions should help the Scrutiny Board to determine whether a recommendation has been completed and identify any further action required.

3.0 Recommendation tracking

3.1 A progress update for the previous scrutiny inquiry, *Promoting Good Public Health: The role of the Council and its partners* is attached at Appendix 2. This includes a draft assessment of the status of appropriate recommendations, based on the update information provided and the flow chart attached at Appendix 1.

3.2 For each outstanding recommendation, a progress update is provided. In some cases there may be several updates, as the Scrutiny Board monitors progress over a period of time.

3.3 The Scrutiny Board is asked to:

- Consider the updates provided;
- Determine whether or not progress is satisfactory;
- Determine whether or not any additional work in required.

3.4 Specific officers have not been invited to attend the meeting for this item. As such, where the Scrutiny Board requires additional information, the appropriate officer will be requested to provide a full written response on such matters.

3.5 In deciding whether to undertake any further work, members will need to consider and balance other aspects of the Board's work programme.

4.0 Recommendations

4.1 Members are asked to consider the progress updates provided against the Scrutiny Board's previous recommendations and:

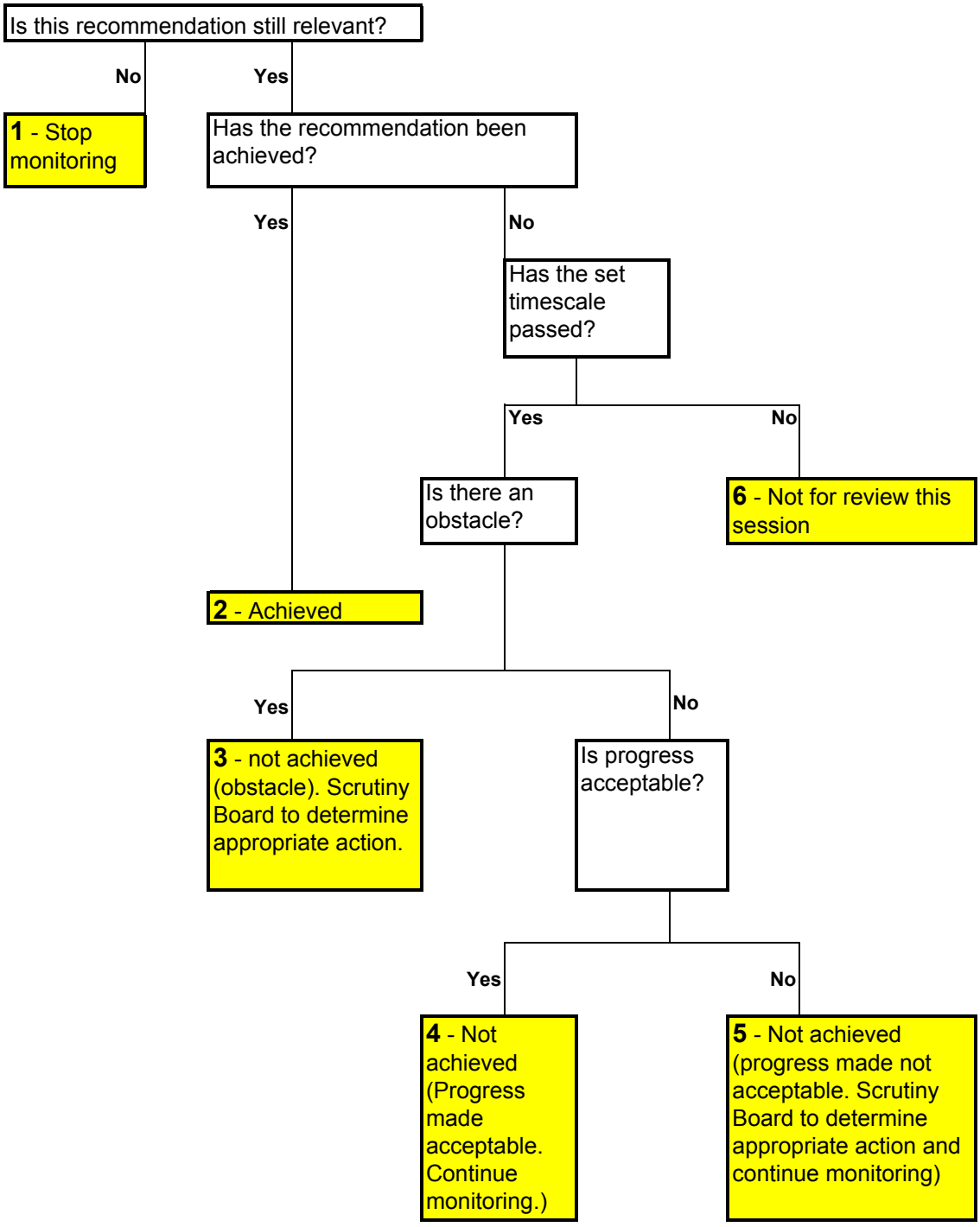
4.1.1 Agree or amend the draft assessment of the status of recommendations, as detailed in Appendix 2; and,

4.1.2 Identify any recommendations where progress is unsatisfactory and determine any action the Scrutiny Board may wish to take.

5.0 Background Papers

- Scrutiny Inquiry Report – Promoting Good Public Health: The role of the Council and its Partners

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



This page is intentionally left blank

APPENDIX 2

INQUIRY: Promoting Good Public Health: the role of the Council and its Partners.	PUBLISHED: May 2010	LAST UPDATE RECEIVED: December 2010

	Recommendation / progress / update	Stage	Complete
1	**That the Head of Scrutiny and Member Development continues to work with the membership of the Scrutiny Board (Health), or its successor body, to ensure that future public health issues in Leeds, particularly where there are significant health inequalities, are incorporated into the annual work programme from June 2010/11.**		
	<u>September 2010</u> This recommendation is agreed; however it should be noted that the development of Scrutiny Board work programmes rests with members of the Board alone. Nonetheless, the role of the Board's Principal Scrutiny Advisor is to provide guidance to the Chair and Board Members as to what that work programme might include. The analysis and review of Public Health issues are of great importance and a fundamental remit of the Health Board, therefore advise from officers will continue to ensure such work is appropriately incorporated into the annual work programme. This might include the Board undertaking specific scrutiny inquiries and/or maintaining an overview through regular performance monitoring. **<u>December 2010</u>** At the June and July 2010 meetings, the Scrutiny Board received contributions from a number of key stakeholders in terms of its future work programme. These included the Chairs and Chief Executives of NHS Leeds (as the primary care trust), Leeds Teaching Hospitals NHS Trust and Leeds Partnerships NHS Foundation Trust. The Board also heard from the Director of Public Health and representatives from the Council's Adult Social Services Directorates. At that time, the new coalition government had just published its proposed vision for the NHS – *Equity and Excellence: Liberating the NHS* – which outlined some major proposals for NHS reforms. More recently, the government has set out its proposed strategy for public health services in England through the White Paper – *Healthy Lives, Healthy People*. The Board will be considering the proposals in more detail, alongside the potential impact for Leeds, in early 2011. It should be noted that the Board maintains an overview of public health priorities through the regular quarterly performance monitoring reports. The Board also considers its work programme on a monthly basis, which allows members to identify and, where appropriate, amend the work programme to reflect any emerging issues and changes in priorities.		

APPENDIX 2

INQUIRY: Promoting Good Public Health: the role of the Council and its Partners.	PUBLISHED: May 2010	LAST UPDATE RECEIVED: December 2010

	Recommendation / progress / update	Stage	Complete
	April 2011 update This action in complete. Nonetheless, as in previous years, at the first meeting of the Board in the new municipal year (likely to be June 2011), a range of key stakeholders will be invited to contribute to the development of the Board's future work programme. While agreeing the work programme of the Board currently rests with the Board itself, public health matters are likely to part of this consideration.	**2 – achieved**	**YES**
2	**That, by December 2010, in collaboration with the Director of Public Health, the Director of Adult Social Services (as the lead for Health):** **(a) Makes an assessment of the extent to which all NICE public health guidance and recommendations (as they relate to local authorities) have been disseminated and used to inform the delivery of services, either directly or through appropriate policies, across the Council.** **(b) (b) Designs and implements a robust assurance process to ensure the appropriate distribution and consideration of any future NICE guidance, appropriate to the Council.**		
	September 2010 This recommendation is agreed. The Scrutiny Board (Health) has noted the important role of NICE in providing national evidence of effectiveness on the promotion of good health and the prevention and treatment of ill health. As part of the Governments White Paper on the NHS and the subsequent review of arms length bodies, the future role of NICE has been seen as crucial, and will be put on an even firmer statutory footing by establishing it in primary legislation. Its role will expand scope to include social care standards. A member of the NHS Leeds Public Health Directorate will take forward the recommendation from September 2010, working closely with LCC staff. The intention is to complete this work by December 2010. A Public Health trainee has been identified to take forward this work which will commence in September, with completion by December 2010 **December 2010** Options have now been developed and are under discussion, within NHS Leeds and LCC. The preferred option requires additional resources, which have not been identified at this stage. 1. Dissemination of NICE guidance to NHS Leeds, LCC and VCS contacts (i.e. not a full assurance process). 2. Dissemination with a piloted assurance process in one area (possibly alcohol guidance).		

APPENDIX 2

INQUIRY: Promoting Good Public Health: the role of the Council and its Partners.	PUBLISHED: May 2010	LAST UPDATE RECEIVED: December 2010

	Recommendation / progress / update	Stage	Complete
	3. Full assurance process for implementing and monitoring NICE guidance, supported by a new NICE Public Health Group as dedicated support officer. A report outlining these options in full has been drafted and will be considered by the Health Improvement Board shortly.		
	April 2011 update The options presented in the November 2010 report: 'NICE Public Health guidance: An assurance process proposal for NHS Leeds and Leeds City Council' will be discussed at the next meeting of the Health Improvement Board in May 2011.	**4 – not achieved. Progress acceptable. Continue monitoring**	**NO**
3	**That, by September 2010, the Director of Public Health works collaboratively to ensure an agreed Sexual Health Strategy is in place and signed up to by all key partners.**		
	September 2010 The sexual health modernisation team was re-established in May 2010 with representation from our clinical, statutory and voluntary sector partners. It was agreed by this group in June that the sexual health strategy be amended in light of the current political changes. The revised version sets out the commissioning priorities for NHS Leeds from 2010 to 2012. The strategy is currently being circulated to all members of the modernisation team for final comments. Once agreed an action plan to support the strategy will be developed. The process of engagement with Practice Based commissioner (PBC) consortia around NHS Leeds commissioning intentions is underway. **December 2010** A meeting has been arranged for January to agree the final strategy and begin the development of the action plan to support the strategy. The process of engagement with Practice Based commissioner (PBC) consortia around NHS Leeds commissioning intentions is underway.		
	April 2011 update The Sexual Health Strategy was presented to the Scrutiny Board (Health) in February 2011 where it was well received. The strategy outlined key commissioning intentions for the city and provided an overview of where service changes and modernisation will be focused. The board was advised on the expected new	**2 – achieved**	**YES**

INQUIRY: Promoting Good Public Health: the role of the Council and its Partners.	PUBLISHED: May 2010	LAST UPDATE RECEIVED: December 2010

	Recommendation / progress / update	Stage	Complete
	national Sexual Health strategy due out in spring 2011 and was assured that the Leeds strategy could be adapted as needed to reflect the direction of the national strategy. Action plans are in development to support the implementation of the strategy.		
4	**That, as soon as practicable, the Director of Children's Services writes to the appropriate Minister and Government Department in an attempt secure a national direction for the delivery of consistent and high quality Sex and Relationship Education (SRE) in local schools.**		
	September 2010 This recommendation is agreed. A report is being prepared for presentation at a future meeting of the Children's Trust Board. The report will cover a number of issues relating to Sex and Relationship Education in schools. There is an existing national campaign, which is also aimed at the government setting minimum standards for Sex and Relationship Education. The Leeds Children's Trust Board will be invited to add its support to the campaign.		
	April 2011 update Progress to be confirmed.	**TBC**	**TBC**
5	**That, as part of the overall Leeds Development Framework and prior to formal submission, the Director of City Development and the Director of Public Health ensure that the public health agenda and relevant NICE recommendations are appropriately addressed and reflected in the Core Strategy.**		
	September 2010 This recommendation is agreed. NHS Leeds Public Health Directorate and LCC City Development have each identified a lead officer to jointly progress a strategic approach to improving health through City Development work streams that include spatial planning; transport; sport and leisure; and libraries, arts and culture. A City Development Health & Wellbeing group has been formed and two workshops have made the first steps in developing key actions for transport and leisure and for libraries, leisure, arts and culture. These have been cross-referenced with NICE guidance and will feed into the process for deciding the Health and Well-being priorities of the Leeds Strategic Plan 2011 -14.		

APPENDIX 2

INQUIRY: Promoting Good Public Health: the role of the Council and its Partners.	PUBLISHED: May 2010	LAST UPDATE RECEIVED: December 2010

	Recommendation / progress / update	Stage	Complete
	December 2010 Awaiting publication of the draft Local Development Framework.		
	April 2011 update The draft Local Development Framework is almost complete. Lead Officers from Health and LCC are meeting in early May to agree the process for ensuring public health is addressed and reflected in the Core Strategy. Rationale and programme to carry out a rapid Health Impact Assessment on the Core Strategy has been outlined in previous discussions between partners. Broader work between NHS Leeds Public Health Directorate and LCC City Development to develop key actions will be further progressed once the City Priorities are signed off, to enable action plans to reflect and deliver those key priorities	**4 – not achieved. Progress acceptable. Continue monitoring**	**NO**
6	**That the Director of Public Health, in conjunction with other Chief Officers, actively identifies and assesses best practice examples from across the country, aimed at limiting or reducing the number of fast-food outlets across the City and improving access to good quality food: In this regard, a progress report be provided to the Scrutiny Board (Health) by January 2011.**		
	September 2010 This recommendation is agreed. NHS Leeds Staying Healthy Commissioning Team along with the Council's Environmental Services have mapped data on of the distribution of hot food takeaways across Leeds. NHS Leeds is currently collating examples of good practice from across the UK to form recommendations that may be taken forward. A first draft will be shared with the DPH end August 2010. **December 2010** NHS Leeds has collated examples of good practice from across the UK and formed the following two recommendations: 1. Explore the impact of the adoption of supplementary planning guidance to control the opening of hot food takeaways in Leeds. 2. Look at opportunities to develop work with businesses to improve the nutritional content of takeaway meals, and ways of raising public awareness of takeaways which provide healthier options and food preparation practices Preliminary meetings with Trading Standards and Environmental health are taking place to scope the possibilities of taking forward recommendation 2 before the New Year.		

APPENDIX 2

INQUIRY: Promoting Good Public Health: the role of the Council and its Partners.	PUBLISHED: May 2010	LAST UPDATE RECEIVED: December 2010

	Recommendation / progress / update	Stage	Complete
	April 2011 update 1. Work between NHS Leeds Public Health Directorate and LCC City Development to develop key actions supplementary planning guidance to control the opening of hot food takeaways in Leeds will be further progressed once the City Priorities are signed off, to enable action plans to reflect and deliver those key priorities 2. NHS Leeds, West Yorkshire Trading Standards and Environmental Health have developed a joint project proposal to work with 20 takeaways across two targeted localities for 1 year. The aim is to reduce the fat and salt content of selected dishes by 10%. Achievement of this will be rewarded by a recognition scheme linked to scores on the doors. Funding of £8000 is required to deliver the proposal. We are currently looking for funding avenues to enable this work.	**4 – not achieved. Progress acceptable. Continue monitoring**	**NO**
7	**That, as soon as practicable, the Director of Public Health and the Head of Licensing and Registration, jointly write to the appropriate Minister and Government Department in an attempt to secure changes to the current licensing legislation, that would result in 'public health' considerations becoming material consideration within the licensing application process.**		
	September 2010 This recommendation is agreed. A national consultation on empowering individuals, families and local communities to shape and determine local licensing 'Rebalancing the Licensing Act' ran for 6 weeks from 28 July to the 8 September 2010 and covered England and Wales, where proposals apply. The consultation document sets out the Government's proposals for overhauling the current licensing regime to give more power to local authorities and the police to respond to local concerns about their night-time economy, whilst promoting responsible business. There are implications for public health, NHS commissioning and provider organisations. Officers from both NHS Leeds public health and LCC Licensing and Registration attended a Home Office consultation workshop and it was agreed to collaborate and forward separate responses to strengthen the Leeds position. A call for health harm as a licensing objective was among the many responses that were agreed and forwarded by both NHS Leeds and Leeds City Council.		

APPENDIX 2

INQUIRY: Promoting Good Public Health: the role of the Council and its Partners.	PUBLISHED: May 2010	LAST UPDATE RECEIVED: December 2010

	Recommendation / progress / update	Stage	Complete
	December 2010 Recently, the government set out its proposed strategy for public health services in England through the White Paper – *Healthy Lives, Healthy People*. As part of the White Paper, it is stated that the Home Office will seek to overhaul the Licensing Act to give local authorities and the police stronger powers to: • Refuse and/or remove licences from any clubs, bars and pubs that are causing problems; • Close any shop or bar found to be persistently selling alcohol to children; and, • Charge more for late-night licences This is likely to include publication of the government's response to the consultation on *'Rebalancing the Licensing Act'* and a further publication on 'Alcohol pricing and taxation'. In early 2011, the Scrutiny Board will be considering the overall proposals for public health in more detail, alongside the potential impact for Leeds.		
	April 2011 update A call for health harm as a licensing objective was among the many responses to the 2010 consultation paper: Rebalancing the Licensing Act that were agreed and forwarded by both NHS Leeds and Leeds City Council. The consultation paper set out the Government's proposals for overhauling the current licensing regime to give more power to local authorities and the police to respond to local concerns about their night-time economy, whilst promoting responsible business. The Police Reform and Social Responsibility Bill is going through parliamentary process and is set to "Rebalance" the Licensing Act once this is completed in 2012. Among other actions it will increase fines and sanctions for those selling alcohol to those who are under age and include health as a responsible authority for licensing decisions.	**4 – not achieved. Progress acceptable. Continue monitoring**	**NO**
8	**That, by July 2010, the Department of Health (in collaboration with any other appropriate Government Department) be strongly urged to work towards the introduction of a minimum price per unit of alcohol, as soon as practicable: This may include, but should not be restricted to, a review of current competition laws and regulations, as appropriate.**		
	September 2010 This recommendation is agreed. The national consultation on empowering individuals, families and local communities to shape and determine local licensing 'Rebalancing the Licensing Act' requested responses		

INQUIRY: Promoting Good Public Health: the role of the Council and its Partners.	PUBLISHED: May 2010	LAST UPDATE RECEIVED: December 2010

	Recommendation / progress / update	Stage	Complete
	on action to ban below cost sales. NHS Leeds and Leeds City Council have both responded in support of legislation to introduce minimum price per unit of alcohol and of the review of alcohol pricing and taxation. The Core Cities Health Improvement Collaborative is building advocacy for legislation to be passed before April 2011 prohibiting the sale of alcohol for less than 50p per unit of alcohol. The NHS Leeds Board has formally endorsed this action. **December 2010** Plans are progressing to launch an updated Leeds Alcohol Strategy action plan in January, along with a report, commissioned by the Healthy Leeds Partnership into the economic impact of harmful alcohol consumption within the city. The national campaign on minimum unit pricing appears to have run into opposition from the government, although the national alcohol strategy is to be revised and re-launched in early 2011, when it is anticipated that the government's policy position on this issue will be clarified.		
	April 2011 update The Coalition has unveiled plans to introduce legislation to ban retailers from selling alcohol below the rate of duty plus VAT. The Director of Public Health issued a press release recognising this as a positive step but that it will only have an impact on the price of a small percentage of alcoholic drinks. We await publication of the national alcohol strategy during 2011 before deciding any further action on advocacy for introduction of a minimum price per unit of alcohol.	**4 – not achieved. Progress acceptable. Continue monitoring**	**NO**
9	**That, in finalising the arrangements and terms of a joint Director of Public Health (DPH) appointment, the Council's Chief Executive consider the issues raised in this report, specifically in terms of ensuring the full and active role of the DPH – both as a member of the Corporate Leadership Team and within decision-making across the Council in general.**		
	September 2010 This recommendation is agreed. NHS Leeds and Leeds City Council aim to confirm the joint appointment of the Director of Public Health this October. A Memorandum of Understanding, which is in draft form at present, confirms that the Joint Director Of Public Health will be a member of the Council's Corporate Leadership Team and will be expected to take a lead on all health related issues across the Council. The joint post will be accountable to the Chief Executives of both organisations. The recently published NHS White Paper, Equity and Excellence; Reforming the NHS, sets out an intention to establish the public health		

INQUIRY: Promoting Good Public Health: the role of the Council and its Partners.	PUBLISHED: May 2010	LAST UPDATE RECEIVED: December 2010

	Recommendation / progress / update	Stage	Complete
	director as a statutory post, employed directly by local authorities, but with joint accountability to the proposed Public Health Services. These new arrangements are scheduled for implementation by 2012. **December 2010** The joint appointment of the Director of Public Health was formally announced on the 1st November 2010. From that date Ian Cameron has been a full member of the Council's Corporate Leadership Team, and has now established formal accountability arrangements with the Chief Executive. **April 2011 update** This action is complete.	**2 – achieved**	**YES**
10	**That, under the direction of Executive Board, the Assistant Chief Executive (Corporate Governance) review current decision-making guidance and pro-forma, with a view to ensuring appropriate consideration of public health implications within all decisions by December 2010.**		
	September 2010 This recommendation is broadly agreed. Whilst the recommendation was proposed prior to the publication of the NHS White Paper, the proposals set out in that document, include legislative change that would place statutory responsibility for improving the health of the population with local authorities. Shadow arrangements for this new statutory function are being proposed at present, and its implications for policy as well as service delivery are under review. While it is likely that a report on the wider issues will be presented to the Scrutiny Board (Health) in the next few months, it should also be recognised that the Council has a legal duty to consider a range of different matters as part of its decision-making framework. These legal duties are then overlain by the Council's own policies. Good corporate governance can be considered against three fundamental aspects relating to the decision-making arrangements in place within an organisation. Specifically that the arrangements: • are current and fit for purpose; • have been effectively communicated; • are embedded and routinely complied with. The current report writing guidance captures the range of competing demands and considerations that are		

INQUIRY: Promoting Good Public Health: the role of the Council and its Partners.	PUBLISHED: May 2010	LAST UPDATE RECEIVED: December 2010	
	Recommendation / progress / update	**Stage**	**Complete**
	placed upon the Council. Specifically, under section 4.0 (Implications For Council Policy And Governance), this guidance makes reference to a range of considerations that report authors should be seeking to address. A number of considerations relate to public health matters, such as: • milestones identified in the Leeds Strategic Plan – these currently include significant Public Health issues; • plans and policies included in the Council's Budget and Policy Framework as listed in Article 4 of the Constitution – Article 4 includes a range of plans which are required by the Local Authorities (Functions and responsibilities)Regulations, and have been voluntarily adopted by the Council. Many, if not all, are of relevance to this inquiry; • such other plans and policies as may be appropriate to the service area(s) affected by the report; • the Council's Narrowing the Gap agenda – again of which Public Health is a significant component. One of the roles of Directors and Chief Officers (in whose name reports are written) is to challenge draft reports to ensure that all relevant considerations are incorporated into final reports submitted for Committee decision and officer delegated decision. In this regard, and to help improve compliance with the guidance, opportunities for further training and development for staff will be explored during the Municipal year. In addition, as the Council regularly reviews its Corporate Governance arrangements, there is scope to ensure and maintain that the guidance and report writing template remain fit for purpose and relevant.		
	<u>April 2011 update</u> Existing report writing guidance was initially produced in August 2006, and was last revised in March 2010. To ensure the guidance is fit for purpose and reflects the Council's current decision making procedures, a thorough review of the guidance has been undertaken. As a result, the guidance has been amended to more closely reflect the decision making requirements in the Constitution and to focus on the current risk areas to the Council's decision making, such as equality and diversity and cohesion and integration. The revised guidance also makes specific reference to considerations of how proposed actions contribute to the targets and priorities in the Council's Policy Framework – which from the new Municipal Year will incorporate a Health and Wellbeing City Priority Plan . A report on the revised guidance and proposed report template (which is proposed to come into effect from the start of the 2011/12 municipal year) will be presented to the Council's Corporate Governance and Audit Committee on 18 April 2011. This will seek comments of that committee on the revised report writing guidance and proposed report template.	**2 – achieved**	**YES**

APPENDIX 2

This page is intentionally left blank

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 26 April 2011

Subject: Scrutiny Board (Health) – Annual Report 2010/11

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

1.0 Purpose of the report

1.1 The purpose of this report is to seek comment from Members of the Scrutiny Board (Health) regarding the content of the Board's Annual Report for 2010/11.

2.0 Introduction

2.1 Members will be aware that the operating protocols for Scrutiny Boards require the publication of an Annual Report to Council: This is the Board's opportunity to contribute to that Annual Report by identifying specific matters that have been considered over the duration of the current year.

3.0 Annual Report 2010/11

3.1 The proposed format of the Annual report will follow a similar format to previous years and provide the following information:

- Details of membership of the Scrutiny Board during 2010/11;
- Details of the main inquiries/ areas of work undertaken;
- A summary of other areas of work undertaken;
- A summary of progress on recommendations made in 2009/10;
- A summary of the Board's full work programme for 2010/11.

3.2 Reflecting the significant NHS Reform initially announced in June 2010, much of the Board's work during 2010/11 has focused on such, alongside the anticipated local impact / progress. This represents a slight departure from previous years, as the Board has not undertaken any specific inquiries or published any reports / recommendations.

3.3 In addition to the focus on proposed NHS Reforms, the Board has considered a wide range of other issues and topics – as demonstrated by the summary of the full work programme, presented at Appendix 1.

3.4 Given the Board's slightly different focus during the course of the year, Members of are asked to consider the full work programme summary (Appendix 1) and agree any matters to be specifically highlighted within the Board's Annual Report for 2010/11.

4.0 Recommendation

4.1 That Members of the Scrutiny Board (Health):

4.1.1 Identify and agree any matters to be specifically highlighted within the Board's Annual Report for 2010/11.

4.1.2 Agree that, in consultation with the Chair, the detailed content of the Board's Annual report be finalised by the Principal Scrutiny Adviser and circulated to members of the Board for comment.

5.0 Background Papers

- Scrutiny Board (Health) – Agendas and minutes: June 2010 – March 2011

The Board's full work programme 2010/11

Requests for scrutiny

- Garforth Squash and Leisure Centre – health considerations

Review of existing policy / services

- Pharmaceutical Needs Assessment
- Provision of Dermatology Services
- Vascular Services – regional review and consultation on proposed changes
- Health Service Developments Working Group – examining service change proposals
- Health Service Direct Discharge

Development of new policy

- Equity and Excellence: Liberating the NHS – White Paper
- Healthy Lives, Healthy People – the Public Health White Paper
- Leeds Sexual Health Strategy

Monitoring scrutiny recommendations (from previous inquiry reports)

- Promoting Good Public Health: The role of the Council and its Partners
- Kirkstall Joint Service Centre

Performance management

- Joint performance quarterly reports

Briefings

- Appointment of co-opted Members
- Constitutional changes
- Leeds Local Involvement Network (LINk) – Annual Report (2009/10)
- Kirkstall Joint Service Centre
- Vision for Leeds (2011 – 2030)
- Developing Leeds Community Healthcare
- National Review of Children's Congenital Cardiac Services
- Economic and Social Cost of Alcohol in Leeds (2008/09)
- Mental health Partnership Integration Project
- NHS Operating Framework 2011/12
- Quality Accounts (2010/11)
- Strategic Plans (2011-15)

Presentations

- NHS Leeds
- Leeds Teaching Hospitals NHS Trust (LTHT)
- Leeds Partnerships NHS Foundation Trust (LPFT)
- National Institute for Clinical Excellence (NICE)

Regional Joint Scrutiny

- Impact of the National Review of Children's Congenital Cardiac Services

This page is intentionally left blank

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 26 April 2011

Subject: Updated Work Programme 2010/11

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

1.0 Purpose

1.1 The purpose of this report is to present and update members on the current activity across a number of work areas. As this is the last scheduled meeting during the current municipal year, the Board is also asked to identify specific matters, currently listed as 'unscheduled items', to be highlighted for consideration by the new Board following the Annual Council Meeting in May 2011.

2.0 Background

2.1 At its meetings on 25 June 2010 and 27 July 2010, the Board received a number of inputs to help members consider the Board's priorities during the current municipal year. This included specific inputs from:

- Executive Board Member for Adult Health and Social Care
- Deputy Director (Adult Social Services)
- NHS Leeds – Chair and Chief Executive
- Leeds Teaching Hospitals NHS Trust (LTHT) – Chair and Chief Executive
- Leeds Partnerships Foundation Trust (LPFT) – Chair and Chief Executive
- Leeds Director of Pubic Health

2.2 At those meetings a number of potential work areas were identified by members of the Board and were subsequently confirmed in an outline work programme. However, members will be aware that the work programme should be regarded as a 'live' document, which may evolve and change over time to reflect any in-year change in priorities and/or emerging issues.

2.3 As such, and as in previous years, the work programme, including any emerging issues, will continue to be routinely presented to the Scrutiny Board for consideration, amendment and/or agreement: The work programme was most recently presented and agreed at the Scrutiny Board meeting held on 22 March 2010, and an updated version is now presented at Appendix 1 for consideration.

3.0 Update on specific work areas and associated activity

3.1 This section of the report seeks to provide a more detailed update on specific activities and elements of the Board's work programme.

NHS proposed reforms

3.2 The Board has considered the proposed NHS reforms – both in general terms and specifically around public health – on a number of occasions. This has included proposals to establish GP consortia, Health and Wellbeing Boards and the transfer of Public Health responsibilities to local councils.

3.3 Members of the Board will undoubtedly be aware of the listening exercise around the proposed reforms, recently announced by Government. In a recent letter from the Chief Executive of the NHS in England, this exercise is likely to affect the timing of some of the proposals. A copy of this letter is attached at Appendix 2 for information.

3.4 As part of the Board's consideration of the local impact of proposed changes, some members of the Scrutiny Board met with representatives of Leeds Local Medical Committee on 25 March 2011. A copy of the draft notes from this meeting are attached at Appendix 3 for information.

Children's Congenital Cardiac Services – national review

3.5 As previously reported, the proposals / recommendations issued for consultation will be considered by a regional Joint Health Overview and Scrutiny Committee (HOSC). This will be made up of representatives from other Health Overview and Scrutiny Committees across the Yorkshire and the Humber region.

3.6 A specific update on the work of the Joint HOSC is included elsewhere on the agenda.

Inquiry into Teenage Conceptions

3.7 Following the Scrutiny Board's decision to undertake some joint scrutiny with Scrutiny Board (Children's Services), an initial working group meeting to help scope this work is scheduled for 20 April 2011. A verbal update from this working group will be provided at the meeting.

Health Service Developments Working Group

3.8 As previously reported, the Health Service Developments Working Group meeting scheduled for 15 February 2011 was postponed. A further meeting of the working group has not yet been arranged.

Dermatology Services

3.9 A specific item on dermatology services in Leeds is included elsewhere on the agenda.

Garforth Squash and Leisure Centre – working group

3.10 At its previous meeting on 22 March 2011, the Board agreed to establish a working group to consider the health and wellbeing needs in and around Garforth and how these will influence the development of the proposed Community Asset Transfer.

3.11 Since that meeting, the Council's Executive Board (at its meeting on 30 March 2011) considered a report seeking its support for granting a long-term lease (at a nominal peppercorn rent) to the School Partnership Trust (SPT) in Garforth. In considering this report, the Executive Board passed the following resolutions:

(a) That the proposed method of disposal via direct negotiation with the Schools Partnership Trust, together with the aims of the proposed transfer and the risks and mitigations identified within the submitted report, be noted.

(b) That the principle of a community asset transfer of Garforth Squash and Leisure Centre to the School Partnership Trust at less than best consideration be approved.

(c) That the Acting Director of City Development, in consultation with the Executive Member for Leisure, be authorised to finalise a lease agreement in keeping with the principles and terms outlined within the submitted report and subject to receipt of a suitable and robust business plan to conclude a lease with the School Partnership Trust.

3.12 Subsequently, these decisions have been 'called-in' and are due to be considered by Scrutiny Board (City Development) at a meeting on 20 April 2011. As the outcome of the call-in cannot be pre-determined, it is difficult to predict the impact this development may have. As such, at the current time and until such time that the position is clarified, it would be inappropriate for the Scrutiny Board (Health) to proceed with arrangements for the working group detailed above.

3.13 The outcome of the Scrutiny Board (City Development) Call-in meeting will be provided at the meeting.

Leeds Girls High School – statement of common ground

3.14 Since the previous meeting, a member of Scrutiny Board (Health), Cllr. Illingworth, has requested that the Board give consideration to the above matter on the grounds that it:

'…effectively claims that the proposed development on inner-city playing fields in one of the most deprived areas of Leeds has no implications for Public Health.'

3.15 The Chair of the Scrutiny Board (Health) has agreed for this matter to be raised at this meeting. However, in considering this matter, members of the Board are reminded that this matter seemingly relates to a specific/ individual planning application and decision, which is also likely to form part of a Public Inquiry later in the year. As such, members of the Board are further reminded that Paragraph 11.1 of the Scrutiny Board Procedure Rules (as detailed in the Council's Constitution 2010/11) states that no Scrutiny Board may undertake a review into:

- any decision of a Plans Panel or the Licensing Committee or a Licensing sub-committee.
- any decision taken by an officer under delegated authority which falls within the terms of reference of a Plans Panel or the Licensing Committee or a Licensing Sub-Committee

- except in exceptional circumstances, any decision in respect of which there are:
  - ongoing judicial procedures, Ombudsman or audit inquiry or complaint under the Council's formal complaints procedure[1]; or
  - individual personnel issues.

3.16 A copy of the prepared statement, '*Leeds Girls High School – statement of common ground'* is attached at Appendix 4 for information. Nonetheless, Members of the Scrutiny Board (Health) are asked to take into account the matters outlined above (paragraph 3.15) when considering this specific issue.

4.0 Work programme (2009/10)

4.1 Members will be aware that the Scrutiny Board's work programme should be regarded as a 'live' document, which may evolve and change to reflect any in-year change in priorities and/or emerging issues.

4.2 However, as this is the last scheduled meeting during the current municipal year and the work of the Board is nearing its end, members of the Board are asked to consider those matters currently listed as 'unscheduled items' (at Appendix 1) and identify specific matters to be highlighted for consideration by the new Board, following the Annual Council Meeting in May 2011.

5.0 Recommendations

5.1 Members are asked to consider and note the details presented in this report, specifically in relation to;

5.1.1 The recent developments and implications associated with the proposed NHS reforms,

5.1.2 The details presented following the recent meeting with Leeds Local Medical Committee;

5.1.3 The updated position regarding the proposed inquiry around Teenage Conceptions;

5.1.4 The updated position regarding the Board proposed work around Garforth Squash and Leisure Centre;

5.2 Members are also asked to determine what, if any, action to take in relation to the request around Leeds Girls High School – statement of common ground.

5.3 Members are also asked to specifically identify any matters currently listed as 'unscheduled items' in Appendix 1, to be highlighted for consideration by the new Board following the Annual Council Meeting in May 2011.

6.0 Background Documents

- Scrutiny Board (Health) – Work programme (June 2010)
- Scrutiny Board (Health) – Work programme (March 2011)
- Scrutiny Board (City Development) – Call-in: Garforth Squash and Leisure Centre (Agenda papers and report – 20 April 2011)
- Leeds City Council's Constitution 2010/11

[1] It might be appropriate for a Scrutiny Board to conduct an inquiry at the conclusion of any of the proceedings referred to.

APPENDIX 1

Scrutiny Board (Health)
Work Programme 2010 /11

Working Groups			
Working group	**Membership**	**Progress update**	**Dates**
Health Service Developments Working Group	All Board members (subject to availability)	• Working Group established in July 2010 • Working group meeting held on 14 September 2010, and 14 December 2010 • Working group meeting scheduled for 15 February 2011 cancelled. • Future meeting to be arranged	14 Sept. 2010 14 Dec. 2010 15 Feb. 2011 April 2011 (TBC)
Garforth Squash and Leisure Centre	All Board members (subject to availability)	• Future meeting date to be arranged, subject to the outcome of the 'call-in' of the Executive Board decision	TBC

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**
Playing fields in Leeds: Provision and the Public Health Implications	To consider the provision of playing fields in Leeds and the public health implications.	Added to the work programme: March 2011 for consideration in the new municipal year (2011/12).
Healthier Communities	To consider the outcome of the recent peer review and the associated actions/ improvement plan.	Process for publication to be confirmed. Member of the peer review team to be invited to present the report (TBC).
Children's Neurosurgery Services	To contribute to the national review and consider any local implications.	**Carried over from 2009/10.** First bulletin published (September 2009) National stakeholder event held 30 November 2009. Newsletter issued in April 2010. Local involvement likely to be towards the end of 2010.

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**
Foundation Trust Status	To consider LTHT's progress against its aspiration of attaining Foundation Trust status.	**Carried over from 2009/10.** Initial and subsequently revised proposals considered in 2009/10. Details regarding anticipated changes in costs to support proposed new governance arrangements requested in May 2010
Narrowing the Gap	To consider the impact of the 'Narrowing the Gap' initiative, in terms of improving healthy outcomes.	**Added to the work programme: December 2009**, but no formal consideration of issue in 2009/10. Highlighted as an area to consider in July 2010.
Primary Care Service Development and use of the Capital Estate	To consider the NHS Leeds' longer-term strategy for developing/ delivering services through its capital estate.	**Added to the work programme in December 2009**, but no formal consideration of issue in 2009/10. It may be more appropriate to consider this matter across the whole local health economy.

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

Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Health Scrutiny – Department of Health Guidance	To receive and consider revised guidance associated with health scrutiny and any implications for local practice.	**Carried over from 2009/10.** Revised guidance was due to be published in November 2009, but was subsequently delayed until after the general election. No firm publication date is yet available and may be superseded by the details and any subsequent legislation and regulations arising from the White Paper – Equity and Excellence: Liberating the NHS
Specialised commissioning arrangements	To consider the current arrangements for specialised commissioning within the region and the role of scrutiny.	**Carried over from 2009/10.** No formal consideration of issue in 2009/10. Regional work with other local authorities is on-going. The next regional member network meeting is to be confirmed.
Openness in the NHS	To consider how the Department of Health guidance is interpreted and implemented locally.	**Carried over from 2009/10.** No formal consideration of the issue in 2009/10 and may be better linked with any detailed consideration of the White Paper – Equity and Excellence: Liberating the NHS

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**
Hospital Discharges	To consider a follow up report on progress against the recommendations (i.e. 15, 16 and 17) detailed in the Independence, Wellbeing and Choice inspection report	Identified as potential issue for 2009/10 but insufficient capacity to consider the issue. **Highlighted as a potential area for scrutiny by the Executive Board member in June 2010.**
Out of Area Treatments (Mental Health)	To consider the report prepared by Leeds Hospital Alert and the response from LPFT.	Leeds Hospital Alert report received 1 July 2009. Responses received from LPFT in July 2009. No formal consideration of issue in 2009/10. **Carried over from 2009/10.**
Use of 0844 Numbers at GP Surgeries	To consider the impact of the recent Government guidance on local GP practices and any implications for patients.	**Carried over from 2009/10.** Various correspondence exchanged and clarification sought. The Board to maintain a watching brief and kept up-to-date with any developments. No formal consideration of issue in 2009/10.

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

This page is intentionally left blank

From the Office of Sir David Nicholson KCB CBE
Chief Executive of the NHS in England

TO: All Chief Executives in NHS Trusts in England All Chief Executives in NHS Foundation Trusts in England All Chief Executives in Primary Care Trusts in England All Chief Executives in Strategic Health Authorities in England **CC:** All Chairs of NHS organisations in England All Chief Executives of Arm's Length Bodies in England All Chief Executives of Local Authorities in England Chief Executives of independent sector partners Leads for pathfinder consortia	*Richmond House* *79 Whitehall* *London* *SW1A 2NS* *Tel: 020 7210 5142* *Fax: 020 7210 5409* *david.nicholson@dh.gsi.gov.uk* **Gateway reference: 15966** 13 April 2011

Dear Colleague,

***EQUITY AND EXCELLENCE: LIBERATING THE NHS* - MANAGING THE TRANSITION**

1) Introduction

The end of one financial year and the start of the next is a good time to take stock of what we have achieved together and our shared task ahead. I thought, therefore, that it would be timely to write to you with the latest in my series of transition letters, which covers:

- Delivery in 2010/11;
- Delivery in 2011/12 and beyond;
- Progress on transition, and
- Engagement over the coming weeks and months.

It will not have escaped your attention that the NHS has been the subject of considerable debate in Parliament and the media. My message to you is simple: whilst we cannot help but be interested in these debates, especially when they potentially affect our own futures, we must not allow ourselves to be diverted from our core purpose and responsibilities in the year ahead.

In taking forward decisions this year, you need to ask yourself two questions:

- Will it improve care for my patients?
- Will it improve value for taxpayers?

If the answer to both is 'yes', then it's the right thing to do. If anyone is in doubt as to the core responsibilities for which they will be held to account this year, then they need look no further than the *NHS Operating Framework for 2011/12*.

2) Delivery in 2010/11

On 24 March, David Flory's latest quarterly report on NHS performance published data for the third quarter of the year. That report, and the provisional data for the end of the year, shows that the NHS had another very strong year last year, making further improvements for our patients:

- Referral to treatment waiting times remain low and at levels promised under the NHS Constitution;

- Patients with symptoms of cancer continue to see a specialist quickly;

- MRSA and *C.difficile* are at the lowest level since records began, and

- At an aggregate level, financial management remains strong. In line with the plans, we are forecasting a surplus in PCTs, SHAs and NHS Trusts of £1.4bn.

The NHS and all its staff should be proud of these excellent achievements for patients. This progress was made in spite of an exceptionally cold winter putting considerable pressure on the service and our staff.

Nevertheless, I have no doubt we can do more together for our patients. The quarter three results also showed slight deterioration in some areas, notably access in A&E departments, ambulance response times and referral to treatment waits. These were affected by the severe winter weather to some extent, but we must strive to improve them next year.

In addition, the NHS Staff Survey results, published on 16 March 2011, showed that the commitment to staff experience and engagement is holding up well. Continuing to support staff over this coming year will be critical to delivering the changes to make services more responsive to patients.

3) Delivery in 2011/12 and beyond

Financial context

The overall financial environment ahead is difficult but manageable. We have a financial settlement that ranks with the best in the public sector, but is still very tight by historical standards. Last year, we had already begun to adjust to much slower growth in recurrent funding.

Our ability to maintain and improve patient care whilst living within our means is critically dependent on meeting the quality and productivity challenge. As leaders of the NHS, we must not be diverted from meeting the all important challenge to release up to £20bn of recurring quality and productivity savings by 2015.

We must also recognise the financial pressure on our partners in local government. This is why the Government has made an additional £1bn p.a. of grant funding available for social care by 2014/15, which will be allocated through the local government Formula Grant. In addition, the NHS Operating Framework sets out two funding streams that PCTs have been allocated to support adult social care services. This joint investment is designed to support the integration of services around patients and service users and we will need to be able to account for the expenditure and the results it achieves.

Planning for the years ahead

Even with the more challenging financial climate ahead, the integrated plans for investment and quality improvement across the NHS are well advanced and contracts between providers and commissioners are mostly signed. This is a testament to effective partnership working across local health systems. In the small number of places where agreements are yet to be reached locally, I am expecting all chief executives and boards to work together positively so that contracts can be signed quickly.

Together with the NHS leadership team at the Department of Health, I am currently visiting each region of the NHS as part of a programme of assurance visits to probe each region's plans and progress with transition. We have been deeply impressed by the commitment to improving services and the positive way in which people are approaching the transition in each region we have visited so far.

One of the most striking themes that has emerged is that planning tends to focus on the year ahead and, in many cases, planning horizons need to be extended to the three years beyond.

We need shared ownership of the four-year QIPP agenda from all key players in the system, current and future. By this I mean SHAs, PCTs, the emerging PCT clusters and GP-led commissioning consortia, their local government partners, and the full range of provider organisations. In each locality, those organisations will only succeed in meeting the quality and productivity challenge together, not apart. The combination of clinical engagement in commissioning and democratic accountability is now an essential part of how we will achieve both efficiency and improving outcomes.

I am also expecting chief executives and boards to pay particular attention to the deliverability of their planning assumptions. It is not credible to close gaps with unrealistic balancing figures for cost improvement programmes or demand

management schemes. These plans must be robust to avoid the risks of financial deterioration or passing legacy debts to successor organisations.

As the costs of drugs, new technologies and treating more patients rise in the years ahead, we know there will be increased pressure on the paybill. We are responding to this with a range of interventions, such as the national pay freeze for staff paid over £21,000; more productive ways of working; reducing sickness absence by focusing on staff health and well being; and reducing agency and management consultancy. Where significant staffing changes occur, we expect plans to be agreed with medical and nursing directors, as well as workforce and finance directors, to assure the resilience of quality and safety.

Quality and performance challenges

Good performance is being maintained across the three broad domains in the operating framework of improving quality, managing within resources and reforming the NHS. There are six specific areas on which we need particular focus in the year ahead: A&E access and quality; ambulance responsiveness; referral to treatment waits; provision of single sex accommodation; emergency preparedness; and tackling the small number of financial deficits that remain.

On 1 April, a new set of clinical quality indicators for A&E were launched. The aim here has been to broaden the measurement of quality to a range of indicators covering the timeliness and effectiveness of treatment, and the overall patient experience. Systematically measuring quality in order to drive benchmarking and improvement is the essence of the approach to quality improvement set out in *High Quality Care for All*. In the early part of this year, we need to concentrate on improving the data quality across the five clinical quality indicators and subsequently to aim for continuous improvement across all five.

Similarly, we have issued a new range of quality indicators for ambulance services. It is disappointing that ambulance response times slowed marginally in 2010/11 from the previous year, notwithstanding the severe weather conditions. There were tremendous efforts in the latter part of 2010/11 to recover the aggregate position and we must continue that recent trend of improved performance into 2011/12 and widen it to include the new indicators.

On referral to treatment waits, I want to reiterate the message of my last letter on the importance of continuing to meet the waiting times standards as set out in the NHS Constitution and the NHS contract. Timeliness of diagnosis and treatment is what patients expect and remains essential to providing high quality care. The most recent data shows that the NHS continued to meet these standards overall, but by a smaller margin than in the last two years. We cannot allow waiting times to increase, nor can we allow distortion of clinical priorities.

Also from 1 April, there has been the expectation that all providers of NHS funded care should be able to declare that they are compliant with the national definition of single sex accommodation. Where there are breaches, this should be a matter of concern and attention for provider boards, and their commissioners will invoke contractual sanctions on behalf of their patients.

There has been much good work across the NHS, with regional leadership from SHA Emergency Preparedness leads, to ensure that the NHS is resilient to potential emergencies and surges in demand. I want to reinforce that this crucial work must be part of boards' mainstream business. Emergency preparedness plans should be robust, up-to-date and reviewed and refreshed regularly, with clear leadership and accountability at board level. This is particularly important in the run up to the Olympics.

Whilst the overall financial performance of the NHS remains strong, there are still a small number of organisations in deficit. 2011/12 is the critical year to implement sustainable solutions so that successor organisations do not inherit actual debts or underlying financial problems. This will be a crucial test of success by the end of the year.

In summary, all of the expectations for delivery in 2011/12 and beyond are set out in the current Operating Framework. My expectation, based on our track record, is for success. We cannot allow ourselves any excuse, external or otherwise, to fail our patients and communities.

4) Progress on transition

Last week, the Secretary of State set out the intention to use a natural break in the passage of the Health and Social Care Bill to pause, listen, reflect and improve the Government's plans. That is a very important process, of which I will say more below, but I want to stress very firmly that we need to continue to take reasonable steps to prepare for implementation and maintain momentum on the ground. Those who are leading the change at local level, particularly pathfinder consortia, should be at the heart of the engagement process.

This is particularly important because recent progress on the transition has been strong. Many thousands of GPs, nurses, other clinicians and support staff are already actively involved in consortia pathfinders, now covering 88% of the population and proceeding ahead of schedule. 90% of local authorities, together with GP consortia pathfinders and other partners, have signed up to be early implementers of Health and Wellbeing Boards. And all remaining NHS Trusts have now agreed plans with local commissioners for achieving Foundation Trust status. This critical work needs to continue and to inform the engagement exercise, but we must also bear in mind that the outcomes of that exercise may lead to changes to some aspects of the Bill.

We have also made good progress on the changes necessary to sustain capacity during the transition. PCT clusters are now established across the country with senior appointments either completed or being finalised. All clusters will be fully established by 1 June 2011 and we are working with clusters and SHAs to develop a shared operating model for clusters by June. In addition, we recently published guidance to support assignment of staff to emerging consortia, a process which is critical to building capacity.

The National Quality Board has also recently published the first part of its guidance on maintaining quality and safety during the transition and it is important that boards press on with the changes recommended in this report. It also remains essential that NHS boards maintain progress on equality and demonstrate compliance with the Equality Act. The Equality Delivery System, designed by NHS leaders on the Equality and Diversity Council, provides the framework which will enable boards to demonstrate leadership on this issue.

For planning purposes, and subject to the results of the listening exercise and the passage of the Bill, the proposed timeline for completing the key elements of the transition at local level remains unchanged. So, GP consortia would take control of commissioning from April 2013 following authorisation by the NHS Commissioning Board. Health and Wellbeing Boards would also take on their full statutory powers and PCTs would be abolished by April 2013. And we continue to aim for completion of the Foundation Trust pipeline by April 2014.

However, because of the pause in the legislative process and again subject to the results of the listening exercise and the passage of the Bill, all of the statutory changes which were due to take place in April 2012 will take place no earlier than July 2012. That includes:

- The abolition of Strategic Health Authorities;
- The assumption of its full statutory powers by the NHS Commissioning Board;
- The assumption of their full powers by the NHS Trust Development Authority, Health Education England and Public Health England;
- The first phase of taking on its new powers by Monitor, and
- The establishment of HealthWatch England and other changes to Arm's Length Bodies.

The creation of shadow bodies and the appointment of senior staff to these organisations will also be delayed to allow time for the engagement process to take place.

These changes are of course very significant for the organisations concerned and their staff. We are working through the full implications of the changes on a case by case basis and will provide further advice in due course on any further developments. In the meantime, it is important that we continue to support our staff through what will no doubt be a difficult and uncertain period for many.

5) Engagement and the NHS Future Forum

While the overall timing and core pillars of the transition remain broadly in place, the new engagement exercise gives us a real and important opportunity to shape the details of what the new system looks like and how it operates. Co-production and clinical engagement are at the heart of successfully managing change, so it is critical that we take this opportunity to engage with the public, staff and stakeholders at national and local level.

We have chosen to focus the engagement exercise on four areas where there has been particular debate. These are:

- **Choice and competition**, where we need to engage further with patients and the public to understand their priorities for introducing choice, and to understand how competition can best be used as a tool for improving care;

- **Patient involvement and public accountability**, where our priority is to test our plans for the new organisations and structures to ensure that public accountability is sufficiently strong and that patient involvement runs through the new system. This has been a particular concern with respect to GP-led consortia so we need pathfinders to drive engagement on this issue;

- **Clinical advice and leadership**, where we must ensure that clinicians are in the driving seat in our new organisations and that integrated working between primary and secondary care and between commissioners and providers is strengthened not undermined in the new system, and

- **Education and training**, where there is an opportunity for further engagement to test the ideas coming out of the recently completed consultation on 'Developing the Healthcare Workforce' and to stimulate further debate on how we move forward and manage transition.

These are very significant issues and the engagement process may result in changes to how we proceed in implementation, whilst the principles of the modernisation remain

clear. That is why it is important to make the process effective, engaging with as wide a range of people as possible. Our ambition is to hold engagement events in every health economy as part of this process and we will need your help and support in achieving this.

To inform the engagement process, we will be issuing further detail on our emerging plans for discussion and debate. So we plan to publish more information on how the authorisation of consortia might take place, on how the NHS Commissioning Board might be organised, and on how we might measure progress and reward consortia for improving outcomes.

The engagement process will be overseen by a new independent advisory group, the NHS Future Forum. This group brings together a wide range of clinicians and other staff and will be chaired by Professor Steve Field. The group will report back on its initial findings around the end of May in order to inform amendments to the Health and Social Care Bill. You can find out more details about the group and the engagement process at http://healthandcare.dh.gov.uk.

The initial phase of engagement over the next eight weeks will focus particularly on improving the legislation that will underpin the new system. However, the work can and should continue beyond this initial period and look more widely at how policy meets the principles of the White Paper, at plans for implementation, and at the way we go about change itself. So I see this not as a one-off exercise, but as the start of a new phase of implementation where we work even more closely with partners, stakeholders and staff to build understanding and appetite for change and improvement.

As part of this broader engagement work, I have asked Sir Bruce Keogh, the NHS Medical Director, and the national clinical directors to begin longer term work to strengthen our multi-professional clinical networks and to engage with the networks to understand how best to improve outcomes for patients. There is a central role for networks in the new system as the place where clinicians from different sectors come together to improve the quality of care across integrated pathways. So I want to put these networks at the heart of our efforts to renew and strengthen engagement.

6) Conclusions

I know that to some the message to press on with implementation while significantly increasing our levels of engagement on our plans may seem paradoxical. I don't believe that it is. Engagement, learning and adaptation should always be at the heart of effective implementation: good engagement is central to making change happen, it is not an alternative to change. That is why it is particularly important that the current engagement process does not prove to be a one-off exercise, it needs instead to form part of our approach for the duration of the transition.

The scale and breadth of what we need to deliver over the coming period remains as challenging as ever. Maintaining momentum for transition and driving deeper engagement are important goals, but focussing on delivery in order to improve quality for our patients and value for taxpayers must always be our over-riding priority. Clinicians, managers and other staff all have a critical role to play in this. It is the issue on which we will rightly be held to account, and as leaders it is the issue on which we must continue to focus above all in the weeks and months ahead.

Yours sincerely,

Sir David Nicholson KCB CBE
NHS Chief Executive

This page is intentionally left blank

Leeds Local Medical Committee Limited

Registered Office: 2 Farrar Lane, Leeds, West Yorkshire. LS16 7AA
Registered in England and Wales – Registered number 7287736
Tel: (0113) 295 1460 Fax: (0113) 295 1461 email: mail@leedslmc.org website: www.leedslmc.org

Meeting: **LMC meeting with members of Leeds City Council's Scrutiny Board (Health)**

Meeting Date: 25 March 2011

Meeting Venue: LMC Offices, Adel

Present:

Cllr Mark Dobson	Chair of Scrutiny Board (Health) and Healthy Leeds Partnerships
Cllr Peter Harrand	Member of Scrutiny Board (Health)
Steven Courtney	Principal Scrutiny Adviser
Dr Raj Sathiyaseelan	Medical Secretary, Leeds LMC
Dr Richard Vautrey	Assistant Medical Secretary, Leeds LMC
Dr Raj Menon	Vice Chair, Leeds LMC
Kathryn Tate	Executive Officer, Leeds LMC

Apologies: Cllr Kirkham, Dr Robinson, Dr Adams

ITEM	MINUTES	ACTION
1.	**Notes of the meeting 8 October 2010** – Agreed as an accurate record	Info
2.	**The White Paper** The BMA were, in principle, supportive of clinical commissioning, but were campaigning for the Bill to be amended and made 'fit for purpose'. The BMA's main concerns as follows: Roll of Monitor • Monitor would be the health regulator given power to ensure adequate competition in the marketplace. Consortia would be given a duty to ensure competition between providers whether they felt it appropriate or not. • There is a risk of legal challenge from providers who believe they have not been allowed to compete fairly. Potential for external commissioning support • Commissioning support units to be established (out of the cluster PCTs) to provide commissioning support to consortia. These may be social enterprise organisations or private companies and not necessarily NHS bodies. • It was being promoted by DH to ensure economies of scale but also to stimulate a market in commissioning support. • Concerns had been voiced that these organisations may become dominant in the future, GP consortia weakened as a result. National Commissioning Board • Powers over consortia are significant and may lead to it dictating what GP consortia actually do. This could significantly affect the independence of GP consortia and their ability to respond to local need. Consortia	Info

Draft

ITEM	MINUTES	ACTION
	• Will be given individual budgets however these were not known at present and could lead to big winners and losers if not introduced gradually. • Consortia will have some responsibility for performance management of practices and could have power to remove 'failing' GPs/practices from their consortia, therefore leading to potential conflict between practices. Potential conflict of interest • It is suggested that practices could receive a quality premium if the consortium was under budget and hit various quality markers. This could be seen as a conflict of interest by patients and undermine their trust in their GP. Training and education responsibilities • SHAs currently host Deaneries but SHAs will be abolished in 2012. • Deaneries structure currently works well and is not fragmented. • Now proposing a Skills Network made up of local providers of education eg LTHT. It will be hard for the voice of smaller GP training practices to be heard • Conflict of interest between training and service elements of a provider. It was agreed to share the recent BMA approved motions with the Scrutiny Board as these provided a useful summary of current issues and concerns.	KT
3.	**Development of Consortia in Leeds** • A third of practices remain unaligned. • Some practices were in initial discussions with existing consortia and were progressing through the application process. • Still not sure whether 3 or 4 consortia groups. The 4th group represented a small patient number and it was not yet known whether this would remain a viable option. • The average consortia size covered a population size of 200k (approx.) • Implications on what the legal status of consortia would be however PCTs would remain a legal body until 2013. • Consortia should become subcommittees of PCTs until 2013 to mitigate legal and financial risk. • Must have capacity to resist 'any willing provider' as the problem of increased choice may reduce the ability to control costs. • There would be a downsizing of hospitals and an increase in community services and it will be important to manage this process without destabilising overall hospital services. • Structures have not been spelt out and remained to be agreed at consortia level, with the exception that there will be the need for an Accountable Officer and Chief Financial Officer.	Info
4.	**Links to Area Committees/ Development of the Health and Wellbeing Board** • The role for the Health and Wellbeing Board (HWB) needed to be formalised. • It was not yet known how this would connect with local structures. • A steering group to support the development of Leeds' HWB had been established and was currently meeting 6-weekly (approx.). • Area committees have local area budgets. • Having formal links between consortia, HWB and Area Committees was seen as being beneficial. Using the current network of Area Health Champions was seen as a possible mechanism to help formalise such links. SC to progress. LMC happy to support.	SC
5.	**Patient and public involvement**	

Draft

ITEM	MINUTES	ACTION
	Every GP practice had been given an incentive to develop their patient involvement scheme. This is part of the contract and could enable local engagement linked to the commissioning agenda. As such, it is likely that patient and public involvement will become a more central part of decision-making – but there may be issues around implementation to be resolved.	Info
6.	**Financial situation and impact on services in health and social care** • It was noted that the reduction and restrictions on budgets would be felt across the City. No new money was available and additional money must be raised through efficiency savings. • Issues associated with the extension of personal budgets to cover healthcare need clarification and may place more pressure on financial management arrangements. • LTHT were moving towards a centralised services structure. • In the coming years, it would be imperative for LTHT management to see local GPs as an opportunity to work closely with rather than competition. The Trust should be encouraged to release consultant time to work with GPs in the community for mutual gain through integrated pathways.	Info
7.	**Any Other Business** None	Info
8.	**Date of next meeting** It was agreed to meet again in July at the LMC office. Date TBC	KT

Draft

This page is intentionally left blank

STATEMENT OF COMMON GROUND

APPEAL REFERENCES:

APP/N/4710/A/10/2140564/NWF
APP/N/4720/A/10/2140587/NWF
APP/N/4720/A/10/2140578/NWF
APP/N/4720/A/10/2140575/NWF
APP/N/4720/A/10/2140572/NWF

DATE OF INQUIRY:

14th June 2011

SITE ADDRESS AND DESCRIPTION OF THE DEVELOPMENT:

Leeds Girls' High School, Headingley Lane, Leeds, LS6 1BN

APPELLANT:

The Morley House Trust

LPA:

Leeds City Council

This statement addresses the following areas of common ground:

1. Description of the site:

   The appeal site is located within the urban area of Headingley, a suburb of Leeds in the administrative boundary of Leeds City Council. The site is a triangular shaped piece of land located between Headingley Lane and Victoria Road, which converge to the east of the site. The site measures 2.44 hectares. The site was formerly occupied by Leeds Girls' High School and comprises a series of school buildings including Rose Court (Grade II Listed), the Main Senior School Building and the Stables which are all to be retained, except for the extent of demolition shown on drawing 2006-239/601 Revision C. The site entirely falls within the Conservation Area and is bounded on all sides by land which falls within it.

   On the appeal site, there are six tennis courts, some of which have previously been utilised for car parking space. There is also a small car parking area to the east and open lawns and garden areas throughout the site. These areas include a variety of mature trees both within the site and on the southern and western boundaries. The topography of the site slopes down from the north-eastern corner of the site to the south-western corner. The entire site, including the tennis courts and open space, has been in the ownership of the School since the early twentieth century.

There are a mixture of house types which exist within the locality of the proposed development. Traditional back-to-back and terraced houses exist to the south and west of the site, interspersed with more modern housing developments. Directly abutting the western boundary of the site is Headingley Business Park, which is an office development of mid to late C20th appearance. The area to north of the site, across Headingley Lane, is characterised by large villas and terraces set within substantial grounds, including mature trees and vegetation. The buildings in this location have a number of different uses, including commercial uses, but is largely residential. To the east of the site is the local centre of Hyde Park providing a variety of shops, banks, restaurants, takeaways and bars. Beyond this commercial centre is Woodhouse Moor, a major city park providing public open space, allotments and sports facilities.

2. The Proposed Development

If permitted and built, the development of the site would result in a residential scheme comprising 57 townhouses and 59 apartments. This results from the conversion of part of the Senior School Building, Rose Court and the Stable Block to form 48 residential dwellings and the construction of 68 new build properties. Part of the existing main school building will be retained and converted to provide 32 apartments. The later extension to this building, which includes the school library, will be demolished and replaced with four townhouses. Rose Court will be converted to provide 12 apartments. The Stables to the north of the Main School Building are to be retained.

0.5 hectares of Public Open Space would be provided on the site. The open space provided on the site would be of value to existing and future residents and be open to other people who live in the surrounding area.

The proposals for the site are separated into five individual applications.

Outline planning permission for 53 townhouses (including two in the lodge to the north west of the site) and 15 apartments;

This application is for outline planning permission for 53 townhouses and 15 apartments, the matters to be approved as part of this outline application include access, layout and scale. The matters not up for determination with this application are landscaping and external appearance. The design of this scheme has had a number of minor alterations throughout the application process. The final amended plan can be seen in drawing reference 2006-239/050/R.

This application includes three blocks of townhouses opposite Rose Court which front onto an area of open space, a series of townhouses developed around the retained Senior School Building in the north western quadrant of the site and a series of townhouses to the southwest of the site overlooking an area of public open space with a four/five storey block of apartments in the south western corner.

The two landscaped areas of POS provide a link across the centre of the site and would provide onsite amenity spaces for future residents and the existing residents who reside in the surrounding area.

Vehicular and pedestrian access to the site is taken from two separate points on Victoria Road and allows for the closure of the existing Headingley Lane access to members of

the public (but that access remains for emergency vehicular access). The main access into the site is taken centrally from the south, providing access to new build development to the southeast and north of the site, to the converted Senior School Building and to part of the car parking provided for Rose Court. The access in the south western corner of the site provides access to all properties along the western edge of the site including the new build development in the south west corner which comprises townhouses and an apartment block, the new build development in the north west of the site and the conversions of the lodge in the north west corner and stable block to the rear of the Senior School Building.

The new build town houses are 2/3 storeys in height, except the townhouses adjacent to the Senior School Building which are 3/4 storeys high. The apartment block in the south west corner is 4/5 storeys high with undercroft car parking.

The drawings numbers relevant to this application are listed below:

9006-050/003 Rev D – Pre Development Tree Survey to Main School Site
9006-050/006 Rev F – Indicative Landscape Proposal to Main School Site
9006-050/014 Rev B – Main School Building Landscape Plan
2006-239/023 Rev G – Senior School and Extension Ground Floor Plan (Level 1)
2006-239/036 Rev D – Main School Site Indicative Sections A-A, B-B, C-C
2006-239/037 Rev D – Main School Site Indicative Sections D-D, E-E, F-F
2006-239/038 Rev E – Main School Building Cross Sections
2006-239/049 Rev C – Main School Building Elevations as Proposed
2006-239/050 Rev R – Main School Site Indicative Masterplan
2006-239/051 Rev C – Main School Building Proposed Site Plan
2006-239/057 Rev A – Main School Site Parking Strategy Diagram
2006-239/058 Rev A – Main School Site Adoptable Extent Plan
2006-239/061 Rev - – Preliminary SW Apartment Block GA Plans
2006-239/101 Rev B – Location Plan Main School Site
2006-239/105 Rev C – Main School Site Arboricultural Constraints
2006-239/601 Rev B – Main School Site Demolition Plan
2006-239/602 Rev A – Senior School Demolition Floor Plans
2006-239/603 Rev A – Senior School Elevations – Proposed Demolitions
2006-239/604 Rev A – Senior School Elevations Proposed Demolitions
2006-239/606 Rev B – Demolition Plan - Existing Two Storey Building
2006-239/804 Rev A – Main School Site Survey
2006-239/805 Rev B – Senior School Ground Floor as existing
2006-239/806 Rev B – Senior School Upper Ground Floor as existing
2006-239/807 Rev A – Senior School First Floor as existing
2006-239/808 Rev A – Senior School Second Floor as existing
2006-239/809 Rev A – Senior School Third Floor as existing
2006-239/810 Rev A – Senior School Elevations as existing (1 of 2)
2006-239/811 Rev A – Senior School Elevations as existing (2 of 2)
2006-239/814 Rev A – The Lodge Floor Plans and Elevations as existing
2006-239/815 Rev A – Senior School Composite Elevations as Existing
2006-239/818 Rev A – Senior School – Gym Building Plan and Elevations as existing
2006-239/820 Rev E – Main School Site Indicative Levels
SW Apartments Block Elevations 02nd November 2010
SW Apartment Block Document

The conversion of the Senior School Building to 32 apartments and the stable block to four town houses;

This application proposes the conversion of the original Senior School Building into 32 apartments with the stable block to the rear being converted into four townhouses.

The application retains the front part of the original Senior School Building. Access to the Senior School Building is provided from the centrally located access road with parking located to the rear within undercroft parking facilities.

The drawings numbers relevant to this application are listed below:

9006-050/003 Rev D – Pre Development Tree Survey to Main School Site
9006-050/006 Rev F – Indicative Landscape Proposal to Main School Site
9006-050/014 Rev B – Main School Building Landscape Plan
2006-239/023 Rev G – Senior School and Extension Ground Floor Plan (Level 1)
2006-239/024 Rev F – Senior School and Extension First Floor Plan
2006-239/025 Rev F – Senior School and Extension Second Floor Plan
2006-239/026 Rev E – Senior School and Extension Third Floor Plan
2006-239/027 Rev D – Main School and Extension Longitudinal Section
2006-239/038 Rev E – Main School Building Cross Sections
2006-239/039 Rev C – Stable Block Floor Plans as Proposed
2006-239/048 Rev B – Proposed Senior School – Stable Block Elevations
2006-239/049 Rev C – Main School Building Elevations as Proposed
2006-239/050 Rev R - Main School Site Indicative Masterplan
2006-239/051 Rev C – Main School Building Proposed Site Plan
2006-239/055 Rev - – Senior School and Extension Mezzanine Floor Plan
2006-239/056 Rev - – Senior School and Extension Roof Plan
2006-239/057 Rev A – Main School Site Parking Strategy Diagram
2006-239/058 Rev A – Main School Site Adoptable Extent Plan
2006-239/059 Rev - – Main School Site 3no Access Points
2006-239/104 Rev A – Location Plan Main School Building
2006-239/105 Rev C – Main School Site Arboricultural Constraints
2006-239/601 Rev B – Main School Site Demolition Plan
2006-239/602 Rev A – Senior School Demolition Floor Plans
2006-239/603 Rev A – Senior School Elevations – Proposed Demolitions
2006-239/604 Rev A – Senior School Elevations Proposed Demolitions
2006-239/804 Rev A – Main School Site Survey
2006-239/805 Rev B – Senior School Ground Floor as existing
2006-239/806 Rev B – Senior School Upper Ground Floor as existing
2006-239/807 Rev A – Senior School First Floor as existing
2006-239/808 Rev A – Senior School Second Floor as existing
2006-239/809 Rev A – Senior School Third Floor as existing
2006-239/810 Rev A – Senior School Elevations as existing (1 of 2)
2006-239/811 Rev A – Senior School Elevations as existing (2 of 2)
2006-239/815 Rev A – Senior School Composite Elevations as Existing
2006-239/818 Rev A – Senior School – Gym Building Plan and Elevations as existing
2006-239/820 Rev E – Main School Site Indicative Levels

Conservation Area Consent for the demolition of the Senior School Building extension and other buildings on the site;

This application proposed the demolition of the modern extension to the Senior School Building and a large proportion of the school buildings to the northern part of the site.

The drawings numbers relevant to this application are listed below:

9006-050/003 Rev D – Pre Development Tree Survey to Main School Site
9006-050/006 Rev F – Indicative Landscape Proposal to Main School Site
9006-050/014 Rev B – Main School Building Landscape Plan
2006-239/023 Rev G – Senior School and Extension Ground Floor Plan (Level 1)
2006-239/036 Rev D – Main School Site Indicative Sections A-A, B-B, C-C
2006-239/037 Rev D – Main School Site Indicative Sections D-D, E-E, F-F
2006-239/038 Rev E – Main School Building Cross Sections
2006-239/049 Rev C – Main School Building Elevations as Proposed
2006-239/050 Rev R - Main School Site Indicative Masterplan
2006-239/051 Rev C – Main School Building Proposed Site Plan
2006-239/057 Rev A – Main School Site Parking Strategy Diagram
2006-239/058 Rev A – Main School Site Adoptable Extent Plan
2006-239/061 Rev - – Preliminary SW Apartment Block GA Plans
2006-239/101 Rev B – Location Plan Main School Site
2006-239/105 Rev C – Main School Site Arboricultural Constraints
2006-239/601 Rev B – Main School Site Demolition Plan
2006-239/602 Rev A – Senior School Demolition Floor Plans
2006-239/603 Rev A – Senior School Elevations – Proposed Demolitions
2006-239/604 Rev A – Senior School Elevations Proposed Demolitions
2006-239/606 Rev B – Demolition Plan - Existing Two Storey Building
2006-239/804 Rev A – Main School Site Survey
2006-239/805 Rev B – Senior School Ground Floor as existing
2006-239/806 Rev B – Senior School Upper Ground Floor as existing
2006-239/807 Rev A – Senior School First Floor as existing
2006-239/808 Rev A – Senior School Second Floor as existing
2006-239/809 Rev A – Senior School Third Floor as existing
2006-239/810 Rev A – Senior School Elevations as existing (1 of 2)
2006-239/811 Rev A – Senior School Elevations as existing (2 of 2)
2006-239/814 Rev A – The Lodge Floor Plans and Elevations as existing
2006-239/815 Rev A – Senior School Composite Elevations as Existing
2006-239/818 Rev A – Senior School – Gym Building Plan and Elevations as existing
2006-239/820 Rev E – Main School Site Indicative Levels

The conversion of Rose Court to 12 apartments;

This application proposes the conversion of Rose Court to form 12 apartments. This conversion is respectful of the buildings current character and appearance, making few alterations to the external appearance of the property and retaining all internal features worthy of retention.

The conversion of this property has been recommended for approval following consultation with the Council's Conservation Officer, English Heritage and the Victorian

Society. The Council has supported this application and has recommended its approval subject to conditions.

The drawings numbers relevant to this application are listed below:

9006-050/003 Rev D – Pre Development Tree Survey to Main School Site
9006-050/006 Rev F – Indicative Landscape Proposal to Main School Site
9006-050/013 Rev C – Detailed Landscape Proposals to Rose Court
2006-239/030 Rev E – Rose Court Basement/Lower Ground Floor
2006-239/031 Rev E – Rose Court Ground Floor Plan
2006-239/032 Rev E – Rose Court First Floor Plan
2006-239/033 Rev D – Rose Court Second/Attic Floor Plan
2006-239/034 Rev C – Rose Court Roof Plan
2006-239/035 Rev D – Rose Court Indicative Sections
2006-239/044 Rev D – Rose Court Elevations as Proposed
2006-239/045 Rev D – Rose Court Site Plan
2006-239/050 Rev R - Main School Site Indicative Masterplan
2006-239/052 Rev B – Rose Court New Windows and Door Details
2006-239/057 Rev A – Main School Site Parking Strategy Diagram
2006-239/058 Rev A – Main School Site Adoptable Extent Plan
2006-239/059 Rev - – Main School Site 3no Access Points
2006-239/060 Rev - – Rose Court Refuse and Cycle Store Elevation, Section and Plan
2006-239/103 Rev B – Location Plan Rose Court Site
2006-239/105 Rev C – Main School Site Arboricultural Constraints
2006-239/605 Rev C – Rose Court Floor Plans as Existing – Proposed Demolition
2006-239/607 Rev C – Demolition Proposed Works Rose Court Elevation
2006-239/804 Rev A – Main School Site Survey
2006-239/812 Rev B – Rose Court Floors Plans as Existing
2006-239/813 Rev B – Rose Court Elevations as Existing
2006-239/820 Rev E – Main School Site Indicative Levels

Listed building consent for the works carried out to Rose Court;

A parallel application was submitted for listed building consent for the works to Rose Court.

The drawings numbers relevant to this application are the same as the drawings listed for the full planning application for the conversion of Rose Court.

3. Relevant Local and National Planning Policy and Guidance:

SA1: Securing the highest environmental quality
SP3: New development should be concentrated within or adjoining the main urban areas and should be well served by public transport
GP5: General planning considerations
GP7: Guides the use of planning obligations
GP9: Promotes community involvement during the pre application stages
BD5: Consideration to be given to amenity in design of new buildings
H1: Provision for completion of the annual average housing requirement identified in the Regional Spatial Strategy
H3: Delivery of housing land release

H4: Residential development on non-allocated sites
H11, H12 and H13: Affordable Housing
H15: Area of Housing Mix
LD1: Criteria for landscape design
N2 and N4: Provision of green space in relation to new residential developments
N3: Priority given to improving green space within the priority residential areas identified
N6: Protected Playing Pitches
N12: Development proposals to respect fundamental priorities for urban design
N13: Building design to be of high quality and have regard to the character and appearance of their surroundings
N14 to N22: Listed Buildings and Conservation Areas
N19: Conservation Area assessment
N23: Incidental open space around new built development
N38B and N39A: Set out the requirement for a Flood Risk Assessment
T2: Seeks to ensure that developments will not create or materially add to problems of safety, environment or efficiency on the highway network
T24: Requires parking provision to reflect detailed guidelines

Neighbourhoods for Living
Affordable Housing Policy
Greenspace relating to new housing
Headingley Neighbourhood Design Statement
Residential Design Aid 4 – Space about dwellings
Headingley Hill, Hyde Park and Woodhouse Moor Conservation Area Appraisal and Management Plan (Draft)

PPS1: Delivering Sustainable Development
PPS3: Housing
PPG13: Transport
PPS5: Planning for the Historic Environment
PPG17: Planning for Open Space, Sport and Recreation
PPS25: Development and Flood Risk

4. Principle of Development

Notwithstanding other objections, the site is located within a sustainable location in close proximity to Leeds City Centre and a local shopping centre, public transport links and leisure facilities, including Woodhouse Moor. The site is located in a predominantly residential area and redevelopment of the site for residential use is considered acceptable in principle.

5. The development of protected playing fields.

The southern part of the site is allocated under Policy N6 of the LUDP as protected playing pitches. Policy N6 has two separate criteria, however in order for development to be acceptable it must only comply with one of the criteria not both.

The Local Planning Authority does not rely on Policy N6 as a reason for refusing the applications.

The site includes six tennis courts, which in the latter period of use as a school were

partially used as car parking rather than for tennis purposes. Further to this the tennis courts have never been publicly available either during the use as a school or since the closure.

The area of land utilised for tennis courts measures 0.34 hectares, split into two distinct areas measuring approximately 0.12 and 0.22 hectares in size respectively. Due to small scale of the courts and the lack of space surrounding the facilities, the site is insufficient in size for the formal use for sports such as football, rugby, cricket or hockey.

The definitions of playing fields and playing pitches are provided within Schedule 5 of The Town and Country Planning (Development Management Procedure) (England) Order 2010 as follows:

(i) *"playing field" means the whole of a site which encompasses at least one playing pitch;*

(ii) *"playing pitch" means a delineated area which, together with any run-off area, is of 0.2 hectares or more, and which is used for association football, American football, rugby, cricket, hockey, lacrosse, rounders, baseball, softball, Australian football, Gaelic football, shinty, hurling, polo or cycle polo;*

Policy N6 of the LUDP is an either/or policy that only requires compliance with one of the two criteria rather than with both.

Insofar as it applies, the proposed development complies with UDP Policy N6(i) which allows for the development of playing pitches where there is a demonstrable net gain to overall pitch quality within the same locality of the city consistent with the site's functions. Leeds Girls' High School has merged with Leeds Grammar School to form The Grammar School at Leeds at Alwoodley Gate. It is accepted that facilities at Alwoodley Gate are sufficient to comply with Policy N6(i).

Sport England raise no objections to the development of the site and Sport England's exception policy E4 is met.

6. Layout and scale considerations

The 10 townhouses proposed in the north-western corner of the site, including the conversion of the existing 2 storey villa, have an acceptable impact upon:

- The Residential Amenity of existing and future residents in terms of privacy
- The character and context of the Rose Court Listed Building

The 9 townhouses to the north of the Senior School Building and to the west of Rose Court have an acceptable impact upon:

- The Residential Amenity of existing and future residents in terms of privacy

The 10 townhouses to the southeast of the site have an acceptable impact upon:

- The Residential Amenity of existing and future residents in terms of privacy

The 16 townhouses to the southwest of the site have an acceptable impact upon:

- The Residential Amenity of existing and future residents in terms of privacy

The 4/5 storey apartment block to the southwest of the site has an acceptable impact upon:

- The Residential Amenity of existing and future residents in terms of privacy

7. Public Open Space

The amount of Public Open Space provided on the site combined with the commuted sum payable towards a LAP is sufficient to comply with the provisions of Policies N2 and N4 of the Leeds UDP.

8. The conversion of Rose Court and the senior school building

The conversion of Rose Court is considered acceptable and would have no adverse impact on the setting or fabric of the listed building.

No objections are raised to the principle of the conversion of the original Senior School Building and the Stable Block to 32 apartments and 4 townhouses.

9. Extent of demolition

The area of building hatched red on the plan attached to the Statement of Common Ground reference 2006-239/601 Revision C, shows the extent of demolition that the Council raise objection to. All of the demolition in the remaining hatched area is considered acceptable.

10. Highways Safety

The development proposed will not have a detrimental impact on highways safety.

11. Health and Equality Issues

The tennis courts at the LGHS site have never been available for public use and development of the site cannot be directly attributed to any health problems in the area.

Signed on behalf of Appellant

.....**Date**.15.03.11.

Position.....Director.....

Signed on behalf of LPA

.....**Date**.....15/3/2011

Position.....Area Planning Manager

This page is intentionally left blank