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Leeds CITY COUNCIL

N.B. Please note 2.00 p.m. start with pre-meeting at 1.30 p.m.

SCRUTINY BOARD (HEALTH)

Meeting to be held in Civic Hall, Leeds on Tuesday, 18th November, 2008 at 2.00 pm

(A pre-meeting will be held for ALL Members of the Board at 1.30 p.m.)

MEMBERSHIP

Councillors

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

- **Co-opted Members**

E Mack	-	Leeds Voice
S Saqfelhait	-	Touchstone

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Steven Courtney
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Produced on Recycled Paper

A G E N D A

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

Item No	Ward/Equal Opportunities	Item Not Open		Page No
3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATIONS OF INTEREST** To declare any personal / prejudicial interests for the purpose of Section 81 (3) of the Local Government Act 2000 and paragraphs 8 to 12 of the Members Code of Conduct.	
5			**APOLOGIES FOR ABSENCE** To receive any apologies for absence.	
6			**MINUTES OF THE PREVIOUS MEETING** To receive and approve the minutes of the previous meeting held on 21 October 2008	1 - 6
7			**LEEDS HOSPITALS NHS TRUST - THE PAYMENT OF CLINICAL NEGLIGENCE CLAIMS** To receive and consider the attached report of the Head of Scrutiny and Member Development.	7 - 8
8			**GP-LED HEALTH CENTRE - SCRUTINY INQUIRY UPDATE** To receive and consider the attached report of the Head of Scrutiny and Member Development.	9 - 24
9			**MENTAL CAPACITY ACT** To receive and consider the attached report of the Director of Adult Services	25 - 30

Item No	Ward/Equal Opportunities	Item Not Open		Page No
10			**JOINT STRATEGIC NEEDS ASSESSMENT** To receive and consider the attached report of the Director of Adult Social Services, Director of Children's Services and Director of Public Health	31 - 60
11			**WORK PROGRAMME** To receive and consider the attached report of the Head of Scrutiny and Member Development.	61 - 72
12			**DATE AND TIME OF NEXT MEETING** Friday, 12 December at 10.00 a.m. (Pre-meeting for all Members at 09.30 a.m.)	

SCRUTINY BOARD (HEALTH)

TUESDAY, 21ST OCTOBER, 2008

PRESENT: Councillor P Grahame in the Chair

Councillors D Atkinson, A Blackburn, M Iqbal, G Kirkland, A Lamb, G Latty, A McKenna and L Rhodes-Clayton

27 Apologies for Absence

Apologies for absence were submitted on behalf of Councillors Chapman, Illingworth and Langdale and Co-opted Member – Somoud Saqfelhait.

28 Minutes of the Previous Meeting

RESOLVED – That the minutes of the meeting held on 16 September 2008, be confirmed as a correct record.

29 Implementation of the Mental Health Act 2007

The report submitted on behalf of the Leeds Mental Health Act Steering Group informed the Board of the requirements of the Mental Health Act 2007 and current progress on implementing its requirements.

The Chair welcomed the following to the meeting:

- John England – Deputy Director, Adult Social Care
- Kwai Mo – Service Delivery Manager (Mental Health), Adult Social Care
- Peter Hayden – Project Lead (Mental Health Act), Adult Social Care
- Jeff Barlow – Mental Health Legislation Implementation Project Manager, Leeds Partnership Foundation Trust
- Dr David Newby, Leeds Partnership Foundation Trust

The Board was informed that some parts of the Act were already active, while a number of other elements were due to come into force on 3 November 2008.

It was reported that the steering group was a multi-agency group that involved partners from the Council, Leeds PCT, Leeds Partnership Foundation Trust and voluntary organisations. The group had considered issues across Leeds and how to implement the amendments of the Act. The main implications of the Act were detailed in the report and the Board was informed of issues surrounding the detainment of patients to prevent them and others from harm and procedures to provide Supervised Community Treatment Orders.

In response to Members comments and questions, the following issues were discussed:

- Current arrangements for the detainment of patients and the most appropriate methods of treatment.
- Concern was expressed regarding the possibility of patients not taking medication and other associated problems when left to look after themselves. It was reported that the basis of the Supervised Community Treatment Orders would involve robust care plans and monitoring processes that would ensure patients complied with any necessary treatment regime. The care plans would be drawn up and supervised with the involvement of clinical physicians, mental health practitioners, social workers and other appropriate professionals.
- Training – the Board was advised that all staff involved had been trained to current required levels and training would be ongoing where necessary to maintain the requirements of the Act.
- There was an opportunity to reduce hospital stays and numbers detained under the Mental Health Act.
- The provision of age appropriate services was a requirement of the Act, and this aspect formed one of 6 specific workstream areas established by the streering group.
- 24 hour crisis teams were available along with on-call psychologists.
- Not all aspects of the Act would be implemented immediately and impacts of the Act on patients would be strongly monitored.
- Any concerns following the implementation of the Act could be addressed by one of the 6 multi agency workstreams established by the steering group.
- Patients and carers would be informed of any changes as part of the communication strategy.
- Patients carers and responsible family members would be involved at patient discharge meetings.
- The use of Electro-convulsive therapy (ECT) and new safeguards for patients.

RESOLVED – That the report be noted and further updates be provided to future meetings of the Board.

(Councillor Atkinson left the meeting at 10.50 a.m. during the discussion on this item).

30 Accountability Arrangements for 2008/09 and Quarter 1 Performance Report

The report of the Assistant Chief Executive (Planning, Policy and Improvement) outlined the approach to performance reporting and accountability which had resulted from the introduction of the Leeds Strategic Plan and Council Plan. Appended to the report was a list of performance indicators relevant to the remit of the Scrutiny Board (Health) and Quarter 1 performance information for 2008/09.

The Chair welcomed Marilyn Summers, Senior Performance Manager, Planning, Policy and Improvement to the meeting.

The following issues were highlighted:

- The Leeds Strategic Plan set out customer focussed targets and the Business Plan would be used in the delivery of these targets.
- The Audit Commission had significantly reduced the number of national performance indicators to 198. These would be closely monitored in respect of the Comprehensive Area Assessment which would replace the Comprehensive Performance Assessment.
- There were 89 performance indicators within the Leeds Strategic Plan, of which 67 had been drawn from the national indicator set. The Council's Business Plan included 4 indicators drawn from the national indicator set.
- The importance of monitoring the 198 national indicators for accountability was stressed. It was not possible to report on all of these at this stage as some indicators were only supported by annual information.
- Comparative data from other authorities was not available at this stage.
- The timeliness and frequency of information, along with supporting evidence where performance was only collated/ reported on an annula basis.
- The Council worked closely with other organisations, including Leeds PCT, where indicators were the responsibility of more than one organisation.

RESOLVED – That the report be noted.

31 Performance Report (NHS Leeds)

The report of the Head of Scrutiny and Member Development reminded the Board of the priorities and targets for NHS Leeds, Leeds Teaching Hospitals NHS Trust (LTHT) and the Leeds Partnership Foundation Trust (LPFT). The Board had previously agreed to consider the performance report presented to the NHS Leeds Board on a bi-monthly basis and the most recent performance report was submitted with the agenda papers.

The Chair welcomed Beverly Bryant, Director of Performance, Leeds NHS to the meeting.

In brief summary, the following issues were discussed:

- The Light Community Walk In Centre and plans to increase opening hours at walk in and minor illness and injury centres across Leeds.
- Childhood obesity, the collection of information and use of 'soft data' for the purpose of performance reporting. The Board requested a more detailed briefing note on this aspect of the discussion.

- Ambulance response times – it was reported that NHS Leeds had taken a proactive role with the Yorkshire Ambulance Service Board. It was reported that the 75% response time target had been met in September 2008, but this did not represent a sustainable performance level. It was stated that the introduction of a new technological approach within the service would aim to improve performance.
- 18 week referral standards and how many patients are sent for treatment outside Leeds. It was confirmed that a number of independent organisations were used to treat patients – one of the main drivers for this was to create capacity within LTHT for more specialised treatment.

RESOLVED – That the report be noted.

(Councillor Latty left the meeting at 11.45 a.m. at the conclusion of this item).

32 Renal Services - Transport Update

The report of the Head of Scrutiny and Member Development updated the Board on issues surrounding transport for renal services patients. Appended to the report were submissions from Leeds Teaching Hospital Trust and the Yorkshire Ambulance Service which addressed points raised by the Board at its September meeting.

The Chair welcomed Diane Williams, Nicola Greaves and Sarah Fatchett of the Yorkshire Ambulance Service to the meeting.

It was reported that a letter had been sent to all renal services transport users with contact details for the Yorkshire Ambulance Service (YAS) and reference was made to a meeting held with YAS, the Kidney Patients Associations and Leeds Teaching Hospitals Trust to continue addressing outstanding issues for patients. The report of the Yorkshire Ambulance Service detailed statistical information in relation to transport provision and also included benchmarking information against the Cheshire and Merseyside Action Learning Set.

The Chair introduced Judith Lund, Dr Chas Newstead and Amanda Dean of the Leeds Teaching Hospital Trust to the meeting.

The Board was informed of 3 main areas highlighted at the recent meeting between the Yorkshire Ambulance Service, Leeds Teaching Hospital Trust and Kidney Patients Association which focussed on planning concerns, communication issues and how to reduce complaints. Reasons for missed appointments were also highlighted.

Lilian Black of the Kidney Patients Association addressed the meeting. She informed the Board of outstanding concerns which included future provision of services at Leeds General Infirmary, response to complaints and the times involved in transporting patients.

RESOLVED – That the report be noted and the Board be kept updated on the position regarding Renal Services transport.

33 Work Programme

The Head of Scrutiny and Member Development submitted a report which detailed the Board's Work programme and an update on the role of the Board's Working Groups.

Issues discussed included a further report on the Mental Health Act 2007 and the membership of the Health Proposals Working Group. There was also some discussion around the implications/ impact of the requirements of the Mental Health Act 2007 on young carers.

RESOLVED –

(1) That the updated work programme be agreed and amended as appropriate.
(2) That the information provided in relation to each of the working groups be noted and that Councillor Rhodes-Clayton be added to the membership of the Health Proposals Working Group.
(3) That the implications/ impact of the requirements of the Mental Health Act 2007 on young carers be referred to the Children's Services Scrutiny Board for consideration.

34 Date and Time of Next Meeting

Tuesday 18 November 2008 at 2.00 p.m. (Pre-meeting for all Members at 1.30 pm.)

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Agenda Item 7

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 18 November 2008

Subject: Leeds Hospitals NHS Trusts – The payment of clinical negligence claims

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

1.0 Introduction

1.1 On 15 September 2008, it was reported in the local media that between June 2005 and June 2008 Leeds Teaching Hospital NHS Trust (LTHT) made clinical negligence payments in the region of £13M.

1.2 As a result, the Chair of the Scrutiny Board (Health) requested that further and more detailed information regarding the level of payments be presented to the Board. The attached report (to follow) from LTHT provides such information for the Board's consideration.

2.0 Recommendations

2.1 The Board is requested to consider the information provided in the attached report and determine any matters that require any further scrutiny.

3.0 Background Papers

None

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Originator: Steven Courtney

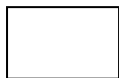
Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 18 November 2008

Subject: GP-led Health Centre – scrutiny inquiry update

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

1.0 Introduction

1.1 At its meeting on 22 July 2008, the Scrutiny Board (Health) agreed the terms of reference for undertaking a scrutiny inquiry to consider the proposals for and implications of developing GP-led Health Centres (Polyclinics) in Leeds. The scope of the inquiry is to make an assessment of and, where appropriate, make recommendations on the following areas:

- The likely impact of Lord Darzi's interim report (NHS Next Stage Review) on healthcare in Leeds in the short, medium and longer term.
- The impact which the proposed GP-led health centre will have on healthcare provision and Council Services (particularly Adult Social Care and Children's Services) in Leeds.
- How the PCT can best manage the establishment of the new health centre in order to maximise the benefits for the population of Leeds and minimise any negative impact.
- How the Council ought to approach the issue, and its overall role in managing public expectation.

1.2 At the July 2008 meeting, the Board also agreed the membership of a working group to undertake some aspects of the inquiry.

2.0 Progress update

2.1 An update on the work undertaken by the working group was provided at the previous Board meeting held on 21 October 2008. At this meeting it was reported that the

working group had met on three occasions, and engaged with NHS Leeds regarding the proposals to establish a GP-led Health Centre in the Burmantofts area of Leeds. Meeting notes from 19 August 2008 and 21 August 2008 are attached at Appendix 1 and 2 respectively.

2.2 Since the last Scrutiny Board, a further meeting between members of the work group and NHS Leeds was held on 29 October 2008. The purpose of this meeting was to clarify some specific aspects of the proposals. A summary of the notes from that meeting are provided at Appendix 3.

Consultation

2.3 The draft public consultation analysis report was presented to the Scrutiny Board at its meeting on 16 September 2008. At that meeting some points of clarification regarding the both the consultation itself and the content of the draft report were raised. Further information seeking to address the points raised by the Board was provided by NHS Leeds and is presented at Appendix 4.

2.4 The Scrutiny Board should note that the final analysis report has now been completed, published and is available from NHS Leeds' website.

Additional considerations

2.5 The Board will note that part of the terms of reference for this inquiry includes making an assessment of *'the likely impact of Lord Darzi's interim report (NHS Next Stage Review) on healthcare in Leeds in the short, medium and longer term'.* Members should note it is proposed for the Board to consider matters associated with this aspect at its meeting in December 2008.

3.0 Recommendations

3.1 The Board is requested to consider the information provided in the this report and associated appendices and determine any matters that require further scrutiny.

4.0 Background Papers

Terms of reference – Inquiry into GP-Led Health Centres/Polyclinics (agreed 22 July 2008)
Proposals for a new GP-led Health Centre in Leeds – NHS Leeds consultation analysis report (October 2008)

Scrutiny Board (Health)

Scrutiny Board Inquiry: GP-led Health Centres

Working Group Meeting: 19 August 2008

Present: **Members**
Councillor Grahame (Chair)
Councillor Kirkland

Officers
John Lennon (Adult Social Care)
Christine Farrar (Healthy Leeds Partnership)
Sue Whitworth (Leeds Partnership Foundation Trust (LPFT))
Steven Courtney (Principal Scrutiny Adviser)
Laura Nield (Scrutiny Adviser)

Apologies Leeds Teaching Hospitals NHS Trust (LTHT)
Leeds Primary Care Trust (PCT)

Background

At its meeting on 17 June 2008, the Scrutiny Board (Health) agreed to undertake a scrutiny inquiry to consider the proposals for and implications of developing GP led Health Centres (Polyclinics) in Leeds. The terms of reference for this inquiry was agreed at the Scrutiny Board meeting held on 22 July 2008.

These notes provide a summary of the main discussion points and the agreed outcome/ action points arising from the working group meeting held on 19 August 2008.

Background information

To assist members of the working group undertaking this inquiry, the following background papers were provided at the meeting:

- Terms of reference;
- Summary of information regarding the proposed GP outlet in Burmantofts;
- A copy of the PCT's consultation document (available from the PCT website);
- A summary of relevant extracts from Leeds Local Medical Committee (LMC) newsletter (LMC viewpoint);
- High Quality Care for All - NHS Next Stage Review Final Report (Summary, June 2008);
- High Quality Care for All - Kingsfund briefing;
- BMA position statement;
- Our NHS, our future - NHS Next Stage Review Interim Report (Summary, October 2007).

Summary of discussion

Members were reminded that the issue of developing a GP-led Health Centre had, in part, been identified as the subject of a scrutiny inquiry as a result of the recent media coverage about the development of ‘Polyclinics’ – which had arisen as an early proposal within elements of Lord Darzi’s NHS Next Stage Review.

There was a general discussion around the proposals being put forward by Leeds PCT and specific reference was made to the PCT summary of information and the consultation document produced by the PCT.

The main discussion points centred around 3 themes – namely, consultation, procurement and the proposed location of the GP-led Health Centre.

- Consultation – members were keen to know the results of the consultation and how these will be used in the development of the proposals.
- Procurement – members wanted to understand the procurement timetable, and be provided with details such as the tender brief/ specification provided to prospective bidders, the tender evaluation process and the tender evaluation team.
- Proposed location – members made some comments on the proposed location and queried whether the established Health Centre at Burmantofts would be fit for purpose. Members were keen to establish details of any immediate refurbishment, maintenance, or improvement works planned for the existing Health Centre. It was suggested that the working group might wish to visit the existing Health Centre.

Agreed Outcomes

It was agreed that representatives from Leeds PCT be invited to attend a further meeting on 21 August 2008 to discuss the general proposals for establishing a GP-led Health Centre in the Burmantofts area of the City and to specifically comment on the areas identified at the meeting.

Steven Courtney
Principal Scrutiny Adviser

Scrutiny Board (Health)

Scrutiny Inquiry: GP-led Health Centres

Working Group Meeting: 21 August 2008

Present: **Members**
Councillor Grahame (Chair)
Councillor Kirkland

Officers
Emma Wilson (Leeds Primary Care Trust (PCT))
Carolyn Walker (Leeds PCT)
Christine Farrar (Healthy Leeds Partnership)
Steven Courtney (Principal Scrutiny Adviser)
Laura Nield (Scrutiny Adviser)

Background

At its meeting on 17 June 2008, the Scrutiny Board (Health) agreed to undertake a scrutiny inquiry to consider the proposals for and implications of developing GP led Health Centres (Polyclinics) in Leeds. The terms of reference for this inquiry was agreed at the Scrutiny Board meeting held on 22 July 2008.

An initial working group meeting was held on 19 August 2008, where it was agreed that Leeds PCT be invited to attend a further meeting to discuss the proposals for establishing a GP-led Health Centre in the Burmantofts area of the City.

These notes provide a summary of the main discussion points and the agreed outcome/ action points arising from the working group meeting held on 21 August 2008.

Summary of discussion

Further to the summary information previously provided and by way of introduction, the following points were highlighted by Leeds PCT:

- The PCT was not developing a polyclinic. It was proposed to establish a GP-led Health Centre on the current Burmantofts Health Centre site.
- The development would address the national mandate to develop a GP-led Health Centre within the City and provided some scope for providing additional facilities. The PCT was responsible for ensuring value for money.
- In the short-term, the planned refurbishment would be completed by 1 December 2008 and the development would make use of the accommodation vacated by the Dr. Potts surgery.
- It was recognised that the current Health Centre had a number of limitations and as such may only offer a temporary solution. In the longer-term, the PCT was looking at other opportunities.
- Costs associated with the refurbishment part of the PCT capital programme.
- Start-up cost associated with the new service to be met by the PCT and funding had been allocated in order to provide a GP-led service from January 2009.

In response to a range of questions, the following additional points/ information was provided and discussed:

Procurement

- It was hoped to award a 3-year contract by 1 December 2008 and this represented an opportunity to provide/ procure some additional capacity in the City.
- It was felt that the PCT's previous procurement experience would prove to be beneficial.
- A significant difference in the proposed service would be patients (registered with another GP) accessing the service would be placed onto the correct care pathway rather than being referred back to their own GP.
- The procurement process was such that the detail of which/ how services would be delivered would form the basis of proposals submitted by potential providers. This would include:
    - Details of any new/ additional services.
    - The number of GPs/ other professionals.
    - Working with other agencies.

  All bids would then be assessed as part of the tender evaluation process to establish a reputable, quality 8:00am-8:00pm, 7 days per week all year round service.
- It was acknowledged that a number of projects had promised improved patient access through extended opening hours and more flexible arrangements. However, such proposals had not always proved sustainable and had been reduced over time. The working group sought some assurances that the proposed service would continue to be an 8:00am-8:00pm, 7 days per week all year round service.

Consultation

- Initial analysis of the consultation around the proposals indicated the following issues as being important to patients:
    - Patient choice
    - The ability to see a GP quickly (longer opening hour and greater flexibility)
    - Accessing services through a multi-purpose facility
- Some concerns over the proposals had been voiced in terms of the potential impact on other local GP surgeries.
- It was suggested that some of the concerns raised by GPs may have resulted from 'fear about their own businesses'.
- There was a role for the PCT to ensure current GP surgeries are not affected by the proposals and are fit-for-purpose.
- The development of the new centre may raise standards and/or improve accessibility of services across other GP surgeries.

Patient numbers

- The current Lincoln Green GP practice (operating at the Burmantofts Health Centre) operated with 2 GPs and a senior nurse practitioner with a patient list of 3200 (approx.)
- It was suggested that the new centre would register up to 2000 patients in the first year.
- It was not thought that Leeds has a large population of unregistered patients and proposals for registering new patients would be determined by the successful bidder.

- It was envisaged that the centre would cater for registered, walk-in and unregistered patients – with the aim of patients being assessed within 20 minutes and seen within 2 hours.

Agreed Outcomes

a) Confirmation of the following points regarding the current Burmantofts Health Centre was requested:
   - Reasons for the closure / withdrawal of Dr Potts GP surgery/ service and when services ceased?
   - Details of the works planned refurbishment works to be undertaken and the level of expenditure?

b) It was also agreed that a site visit to the current Health Centre be arranged as soon as possible.

c) Detailed analysis of the consultation be provided as soon as practicable, ideally to be reported to the Health scrutiny Board meeting scheduled for 16 September 2008.

Steven Courtney
Principal Scrutiny Adviser

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GP-led Health Centres meeting – 29th October

Attendees:
Cllr Pauleen Grahame
Cllr Graham Kirkland
Emma Wilson
Laura Nield

- Members wished to clarify what the new GP-led service will offer, and also how it will be funded.
- There will be three elements to the service offered by the new facility:
    - The option to register as a patient in the normal way
    - The option to walk in and request an appointment if not registered
    - The option to walk in and wait to see a doctor if not registered.
- The opening hours will also be extended – 8am-8pm, 7 days a week.
- The service will only be a GP service. However, the difference to an existing walk-in centre will be that the GPs will be able to refer patients to other services directly, rather than sending them back to their own GP for a referral. So a walk-in patient can be referred directly to hospital or another service.
- The provider of the GP service may well choose to offer other things on site, such as minor surgery or a smoking cessation service. However, details of this will not be available until the provider has been appointed.
- The only thing which the service is *required* to offer is the three ways of seeing a GP listed above.
- The procurement of the service will be funded with DoH money through Primary Care. The contract is expected to be awarded in December.
- Additional funding has also been provided by DoH for the physical provision of the building. This has been combined with existing capital planning money to fund the refurbishment of Burmantofts Health Centre (as some of this work would have gone ahead without the GP led service).
- Members asked why the Burmantofts site had been chosen, given the obvious constraints of space at the site. It was explained that the site had been chosen partly due to the time constraints – there is not enough time to build a completely new facility. However, the surrounding area is also a 'hotspot' for additional health needs with many residents using A&E as their first port of call. Therefore it makes sense to locate the service in this part of the city.
- The issue of transport was also raised, with members concerned in particular about the lack of parking at the site. It was explained that capital planning restrictions would limit the amount of parking available at any facility. It is recognised that parking may be an issue, but it is hoped that many patients will live locally.
- There is a requirement from the DoH to get the service up and running by early 2009, but it is recognised that there may be a need to rethink how and where it is delivered in future.
- Members questioned whether the walk-in aspect of the service will function with only two GPs. This is something which will be tackled as part of the procurement process. All bidders are aware of the facilities at Burmantofts, and of what they would be expected to deliver. It is up to them to find innovative ways of doing this.

- Members asked whether the current provider of the Lincoln Green surgery (in the same building) will bid for the contract. It is not possible to reveal this at present, but clearly such an arrangement would generate economies of scale.
- Any other services provided alongside the GP service, such as Chiropody, will not be subject to the same opening hours and 'walk-in' requirements. However, the GPs will be able to refer patients directly to these services.
- In terms of completing the building work, the builders are aware that the work will need to be completed for when the provider starts. The provider is expected to be appointed in December, and there is an anticipated 6 week lead-in time until the service will start to operate.

Submission from NHS Leeds (Leeds PCT)

Additional Information following GP-led Health Centre Consultation

Number of comments forms sent out

We printed 5,500 copies which were distributed to GP practices, dental practices, pharmacies, opticians, parish councils, One Stop Centres, libraries children's centres and local businesses. The analysis document will be distributed to all stakeholders along with any person who requested further information on their comments form.

We also distributed individual copies of the document to the PCT's Patient, Carer and Public Involvement network which has approximately 200 members of the public who are actively involved in health services.

E-mail

We regularly distribute information via e-mail to partners and stakeholders who then cascade it to their colleagues and partner organisations. This makes it possible for us to reach a wider audience but very difficult to measure exactly how far and wide the documents and comments forms do go.

On 19th May 2008 we distributed the consultation document, comments form and explanatory e-mail to a number of different contacts. Among these were:

- Leeds VOICE – who sent it onwards to all their members, close to 300 members
- Leeds MPs
- Leeds City Councillors, some of whom sent on to Area Management Teams
- Leeds Teaching Hospitals NHS Trust
- Leeds Partnerships Foundation Trust

Press releases

We issued press releases to Yorkshire Evening Post and to relevant local press on 19th May, 13th June, 18th June, 22nd July promoting the GP-led health centre drop-in events. Each one included telephone number for Patient Advice and Liaison Service (PALS), website and freepost address.

Drop-in events

We held 13 drop-in events which were publicised in the local areas. We received five e-mails from ward councillors with regard to these drop-in events. In response to Cllr Harrand, we arranged an event at Wetherby Health Centre. This was publicised in the local area and press.

We communicated along with the consultation documents dates of the drop in events to ensure a wide cross section of people were aware of the opportunity to have their say. This included as above our voluntary, community and faith sector colleagues through Leeds VOICE's networks and our PCT Patient, Carer and Public Involvement network which has approximately 200 members of the public.

Comments by ward

For the purposes of the report, it was agreed that responses from inner city areas (where most responses were received) would be detailed separately and areas on the outskirts of Leeds (where fewer responses were received) would be reported together, ensuring all wards were mentioned and postcodes highlighted. After receiving comments from the OSC, regarding wards on the outskirts of Leeds being reported

together, we have revised this information and also detailed wards where no responses were received. (See below).

We thank Scrutiny committee for their comments and will incorporate their suggestions into the final analysis document.

This will be distributed individually to everyone who supplied their contact details, e-mailed to the stakeholders mentioned above, posted on our website and available through GP practices, pharmacies etc

Revised comments by ward

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

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

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

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

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

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

Calverley and Farsley					**LS19**
Total replies	3	Would use the centre	1	Would not	2
Accessing the service All would access the service either by drop-in **or** scheduled appointment.					
Summary of comments:	a) Convenient access from work (3 responses) b) Convenient access out of hours (1 response)				

Otley and Yeadon					**LS21**
Total replies	6	Would use the centre	0	Would not	6
Accessing the service One person would access the service either by drop-in **or** scheduled appointment and one person would access by appointment.					
Summary of comments:	a) Convenient access out of hours (1 response) b) Too far to travel (6 responses)				

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

No comments forms received from the following wards: Adel and Wharfedale, Middleton Park, Temple Newsam, Kippax and Methley, Hyde Park and Woodhouse, Roundhay, Moortown, Wortley and Harewood.

NHS Leeds
22 September 2008

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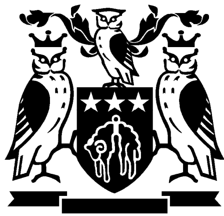

Originator: Dennis Holmes

Tel: 2474959

Report of the Director of Adult Social Services

Scrutiny Board - Health

Date: 18th November 2008

Subject: The Mental Capacity Act 2005

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

EXECUTIVE SUMMARY

The Mental Capacity Act is a wide ranging piece of legislation potentially affecting the lives of many thousands of citizens in Leeds. It's main provisions, covered in greater detail in this report, are aimed at protecting the interests of the most vulnerable people in our community, people who, for a great variety of reasons, are judged to lack the mental capacity to make significant decisions in relation to their own life and circumstances.

Although the provisions of the Act were laid out in 2005, such were the technical challenges associated with it's implementation that the timetable for its introduction (published In December 2006) spanned 3 phases: April and then October 2007 with the final phase, dealing with the 'Deprivation of Liberty' requirements, commencing in November 2008. All the provisions of the Act will be applicable from April 2009.

The Act and it's associated guidance placed responsibilities on Local Authorities to lead the process, supported by a comprehensive 'Code of Practice' published in April 2007. The lead Government Department for Implementation was Department of Constitutional Affairs (now Ministry of Justice) supported by Department of Health.

In December 2006 The Local Authority were required to undertake two principal tasks, firstly to procure an Independent Advocacy service by April 2007 utilising ring-fenced monies and secondly to immediately establish a Local Implementation Network (LIN) comprising all the principal organisations most likely to be affected by the provisions of the Act (NHS Leeds {formerly Leeds PCT}; Acute Trust; Partnership Foundation Trust; Advocacy provider; LCC Legal Services and the Police) . The role of the LIN Board has been to co-ordinate the implementation of the Act, to oversee the expenditure of the grant monies which have been provided to support its implementation, to ensure the procurement and availability of Advocates for those people lacking capacity, to ensure awareness of the provisions of the Act are raised amongst the wider public and staff and to secure the availability of general and specialist training for those responsible for the day to day requirements associated with the Act's provisions. This report also deals with the work undertaken by the Leeds LIN.

A report covering the main provisions of the Act was considered by the Executive Board of the Council on the 5th November this year.

1.0 Purpose of Report

1.1 The purpose of this report is to inform members of Scrutiny Board with regard to the implications associated with the implementation in Leeds of the Mental Capacity Act 2005. This report also outlines the requirements of the Deprivation of Liberty Safeguards (DoLS) which are incorporated into the Mental Capacity Act but which also feature prominently in the implementation of the Mental Health Act 2007 (the requirements of which are the subject of a companion report).

1.2 This report summarises the principal requirements of the Act, highlighting how it will potentially affect people in a variety of circumstances. The report deals with the implications for staff within the main statutory organisations, including Adult Social Care, and describes the co-ordination arrangements that have been established to oversee the implementation of each element and fulfil the statutory reporting and monitoring associated with that.

2.0 Background

2.1 The Mental Capacity Act is a wide ranging piece of legislation potentially affecting the lives of many thousands of citizens in Leeds. It's main provisions are aimed at protecting the interests of the most vulnerable people in our community, people who, for a great variety of reasons, are judged to lack the mental capacity to make significant decisions in relation to their own life and circumstances. The Act has potential implications for many adults and some children, it is estimated that, at any one time, up to 2 million people in England and Wales lack mental capacity to make decisions for themselves by virtue of, for example, dementia; learning disabilities; mental health problems; stroke and brain injuries. The Act therefore applies to all those aged 18+, and has provisions relating to Young People aged 16+ in specific circumstances.

2.2 The Mental Capacity Act therefore provides a welcome, statutory framework to empower, support and protect people aged 16+ who may not be able to make all their own decisions all the time. It provides a legal framework for good practice and current common law principles. It deals with the assessment of a person's capacity and any acts of care by those looking after or working with those who lack capacity. The Act also provides additional rights in relation to making advance plans concerning medical treatment and control over an individuals financial affairs.

2.3 The Act sets duties on Local Authorities to ensure the provision of Independent Advocates for people determined to lack capacity, to ensure the appropriate training of staff to undertake specialist roles associated with the determination of capacity and to ensure that staff are available to protect the interests of those deemed to lack capacity.

2.4 As part of the provisions of the Mental Capacity Act (and incorporated into the provisions of the Mental Health Act 2007) Deprivation of Liberty Safeguards are introduced. The Safeguards are designed to prevent arbitrary decisions that deprive vulnerable people of their liberty by providing processes of application, assessment, authorisation and review when it is necessary to deprive a person of their liberty, and providing them with representation and rights of review.

2.4 In Leeds the co-ordination of the implementation of the Act, it's associated requirements and statutory reporting of progress towards full implementation has been ongoing since December 2006 with the establishment of a Local Implementation Network Board chaired by the Chief Officer – Social Care Commissioning and containing representatives of each of the main statutory organisations in the City. The specific work of the LIN Board is highlighted later in this report.

2.5 The LIN Board has also overseen the expenditure of grant monies provided to support those elements of the Act set out at paragraph 1.3, a short summary of the overall grant provided 2006 – 2010 is set out in section 5 of this report.

3.0 Main Issues

3.1 The Act is based on 5 key principles which are:

- ◊ A presumption of capacity.
- ◊ Right of individuals to make their own decisions.
- ◊ Right not to be treated as lacking capacity merely because of unwise or eccentric decisions.
- ◊ Need to ascertain what is in the best interests of the individual.
- ◊ Least restrictive intervention.

3.2 The main provisions of the Act introduced since 2007 are set out below.

- ◊ **Independent Mental Capacity Advocacy** (IMCA) Service to be operational. – this is a legally defined role in the Act to support a person who lacks capacity, has no-one to support them and there is a major health or residential care decision to make – but also can be appointed if either the perpetrator or victim in a Safeguarding investigation lacks capacity. Additional powers to instruct IMCA's in Adult Protection cases and reviews of accommodation. The first annual report of the Leeds IMCA service is attached as Appendix 1.
- ◊ Two new **Criminal Offences** are introduced of ill treatment or wilful neglect of a person without capacity carrying up to five years imprisonment if found guilty.
- ◊ **Capacity Defined**, the Act sets out the criteria for assessment, and codifies existing Common Law it also sets out a clear decision specific test. Under the new regulations no one can be labelled as 'incapable' just because s/he has a particular condition, nor can lack of capacity be established just though reference to age, appearance, or any condition or behaviour which may lead to others making unjustified assumptions.
- ◊ **Best Interest Checklist**. The Act provides a checklist that decision makers must work through in deciding what is in the person's best interests and how to decide this
- ◊ **Acts in Connection with Care/Treatment** ('Section 5 acts') For the first time there is law to protect carers, healthcare and social care staff from liability when acting in connection with care or treatment for those who lack capacity under Section 5 – but only if they follow the guiding principles of the Act, believe that the person lacks capacity to give permission for the action and act in the person's Best Interests.

◊ **Lasting Powers of Attorney** (L.P.A's) appointed in advance by someone if s/he should lose capacity - able to make health and welfare decisions as well as property and affairs if authorised.
◊ **A new Court of Protection**. the new Court will have jurisdiction relating to the whole Act so its remit includes social care and health decisions when appropriate. this structure replaces current receivership and deputies are able to make welfare, financial and most health decisions as authorised by the Court.
◊ **A new Public Guardian**. - who will supervise Court of Protection deputies and powers of attorney, and work with all agencies in relation to any concerns with these roles.
◊ **Court Appointed Deputies** (replace receivership's this structure replaces current receivership and deputies are able to make welfare, financial and most health decisions as authorised by the Court.
◊ **Advance Decisions** (formerly know as Advance Directives or Living Wills) there will be statutory rules with safeguards and strict formalities, so that people can make an advance decision about refusing medical treatment.
◊ **Research Issues**. very clear guidelines that protect the person who lacks capacity.

3.3 In relation to the **Deprivation of Liberty Safeguards**, the safeguards create two new legal entities, **Managing Authority** (Care Homes/Hospitals) who provide care and must request authorisation to deprive the liberty of an individual who may be deemed to lack capacity. **Supervising Bodies** who must organise assessments and issue authorisations if assessments require them to do so. Leeds Adult Social Services will undertake both functions which will require appropriate processes, governance, management and operational arrangements to be put into place to assure the independence of decision making.

3.4 Supervising Bodies (SB) must arrange for assessments to be carried out, one of these assessments (a Mental Health assessment) must be carried out by a registered medical practitioner, the others by a 'Best Interest Assessor' (BIA). In discharging their responsibilities as a SB Local Authorities (who will chiefly be the source of Best Interest Assessors) and Primary Care Trusts (the source of registered medical practioners) must ensure sufficient assessors are available, ensure the assessors have the skills, qualifications and training to provide the role; appoint the assessors, ensure the assessors have the relevant skills and experience required for that assessment (for example in relation to the needs of people with Learning Disability/Older People/ People with Mental Health needs) and ensure there is no conflict of role.

4.0 Implementation in Leeds

4.1 Leeds successfully procured the IMCA service in advance of the required commencement date in April 2007, the first annual report of the successful provider is available to Members, this sets out the significant amount and quality of work that that has been undertaken since the commencement of this service. In contrast to many other Authorities, the method of procurement and specification used for the IMCA service in Leeds has lead to a relatively small group of advocates developing highly developed skills in this very specialist area. This has proved to be a very sustainable and cost effective model to date, in other Authorities in contrast, have experienced significant waste and quality issues associated with this service.

4.2 On behalf of the LIN, the Local Authority hosts a training officer with specific responsibility for implementing the training and awareness raising plan around the wider partnership. In addition to this two sub groups have been established reflecting the importance of planning and delivering training and communication, they are co-ordinating the significant task of raising awareness and communicating to the wider workforce, some of whom have specific specialist roles to play in relation to Public Guardianship and Receivership.

4.3 Finally, a wider stakeholder event was held in February to raise awareness of MCA among existing and potential service recipients and their carers. However, it is important to note that the extensive activity undertaken thus far has reached only a small proportion of wider public (and potential beneficiaries) of the MCA. The LIN recognises the importance of continuing to take all opportunities to raise awareness of the Act among all the communities of Leeds, to improve access to information and advice.

4.4 The further requirements associated with Deprivation of Liberty Safeguards to provide advanced training for specialist professional staff are now the chief focus of the work of the board and it's sub-groups, negotiations are underway with the main academic institutions in the City to ensure that the necessary courses of professional study and qualification are available for Leeds professionals and for those in the wider region.

4.5 All indications from the Department of Health (which has monitored the implementation of the Act) following the provision of update reports from this Authority, are that the arrangements that have been put into place in Leeds are robust and effective and that our planning in relation to the implementation of the Act and use of resources to support it has been to a high standard.

5.0 Financial Implications

5.1 Specific Grant funding has been made available to both the Local Authority and Health community in Leeds since 2006 to support the introduction of the new legislation and all its statutory requirements, the grant has three specific elements, the first element is for Authorities to use in relation to the procurement of the IMCA service, the second in relation to ensuring the training needs of staff are addressed and the third recognises the overall management costs of introducing this scale of legislation. Although originally 'ring –fenced' to support the implementation of the requirements associated with the legislation, the sums set out below now form part of the 'area based grant' to the Local Authority.

5.2 The grant amounts are:

2006/07	£94,000
2007/08	£212,000
2008/09	£344,000
2009/10	£433,000
2010/11	£416,000

5.3 In addition, within the annual budget of the Leeds PCT, £103,000 has been made available over the two years 2007 – 2009 to support the specific implications for the wider health community.

5.4 The expenditure of the two funding streams has been co-ordinated by the LIN Board to ensure that the maximum benefit is derived and that the potential for duplication is eliminated. To date funding has been expended in supporting the availability of Independent Advocates, for training provided to professional staff, the generation of publicity materials to raise awareness more generally and to provide dedicated officer support time to ensure that all the different requirements associated with the Act are implemented.

5.5 It is envisaged that as all the requirements associated with the Act are brought into effect from April next year, the totality of funding will be taken up with additional expenditure incurred in providing the training and ensuring the availability of professional staff able to fulfill deprivation of liberty assessment requirements (provision of Best Interest Assessors and availability of appropriate medical practitioners).

6.0 Legal Implications

6.1 The legal implications are set out in Section 3 of this report.

7.0 Conclusions

7.1 The provisions of the Mental Capacity Act should be regarded as establishing a welcome set of safeguards and balances designed to protect the rights and interests of a range of vulnerable people who may be deemed to lack capacity and who may have no other appropriate person to act on their behalf. The Act applies to those most essential elements of everyday life, health, accommodation, personal finance and liberty. By reaching into all those elements of the lives, the Act requires that awareness of its provisions should be raised, not only among statutory organisations and professional groups but across the general public and into all the communities of our City.

7.2 Although all the statutory provisions of the Act will be fully effective in April next year and arrangements are already in place within the statutory partners, including Adult Social Care for the effective management of those arrangements, it is likely to be some time before all the provisions contained in the Act attain widespread public understanding.

7.3 Finally, although there is an association between the provisions of the Mental Capacity Act and those of the Mental Health Act 2007, the two are distinct pieces of legislation, the latter having a much narrower focus on the needs of people with mental health needs, the former having potential applicability to any citizen.

8.0 Recommendation

8.1 Members are invited to consider the content of this report, to note the key features of the Act highlighted in it, to note the progress made to date in it's full implementation and the plans which are being progressed to raise greater awareness among the public of it's provisions and implications.

Background Documents
Mental Capacity Act 2005
Mental Health Act 2007

Originator: John England

Tel: 0113 24 78647

Report of the Director of Adult Social Services, Director of Children's Services, Director of Public Health

Scrutiny Board: **Adult Social Care Scrutiny Board**
Children's Scrutiny Board
Health Scrutiny Board

Date: **12 November 2008 (Adult Social Care)**
13 November 2008 (Children's)
18 November 2008 (Health)

Subject: **Leeds Joint Strategic Needs Assessment (JSNA)**

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

Executive Summary:

1. Leeds City Council and Leeds PCT have a new statutory duty under Section 116 of the Local Government and Public Involvement in Health Act (2007) to produce a Joint Strategic Needs Assessment for health and well being. The legislation states that there is a joint accountability between the Director of Adult Social Services, the Director of Children's Services and the Director of Public Health for the JSNA. Guidance published by the Department of Health clarifies the minimum requirements for the JSNA, but also states that the scope of the JSNA is for local determination. The legislation and accompanying guidance seeks to strengthen the role that data, analysis, and the voice of patients, service users and the public plays in shaping the priorities for the commissioning of services that improve health and well being in the medium to long term; up to ten years.

2. The work programme in Leeds has been agreed by the two key agencies and has been led by an independent Programme Manager seconded for this purpose from the Department of Health, Quarry House. Three partnership project teams were established, each given responsibility to meet agreed objectives, including establishing that current priorities are confirmed by further analysis of the evidence and identifying priorities for future commissioning intentions. The Programme Management phase of the work is now reaching a conclusion, and prior to

publication of a public report, key stakeholders are being invited to comment on the draft findings and recommendations.

1. Purpose of Report

This report invites Members of the Board to consider the progress made in producing Leeds' first Joint Strategic Needs Assessment (JSNA) and to provide comments to guide its further development.

2. Background

2.1 The requirement to produce a Joint Strategic Needs Assessment (JSNA) is contained within section 116 of the Local Government and Public Involvement in Health Act (2007). The legislation intends that the JSNA will inform the targets and priorities set for the Local Area Agreement in meeting the future health and well being needs of the community as well as informing future commissioning priorities that will lead to improved outcomes for people and reduced health inequalities.

2.2 Guidance produced by the Department of Health clearly indicates that each JSNA will be a unique document, shaped at a local level through the Local Strategic Partnership and a detailed understanding of local communities needs. Whilst the guidance makes clear that there are a number of key steps in the process which will be common to all, the uniqueness of each JSNA and the intention that it becomes a live and dynamic process rather than a time limited technical document, places an emphasis on local arrangements for producing the JSNA and for setting the expected outcomes for the population at a city wide and local neighbourhood level..

2.3 Guidance clearly states that the JSNA should inform the Local Area Agreement (LAA) and the forthcoming Sustainable Community Strategy. Whilst work on the LAA for Leeds led to the agreement and signing of the first LAA in March 2008, the JSNA has confirmed the rationale for the priorities set both in the Leeds Strategic Plan and the Leeds PCT Strategic Plan. In time the process for the JSNA will be synchronised with that of the city's strategic planning framework and the target setting for the 198 national indicators for local delivery.

2.4 The legislation places the accountability for producing the JSNA with three key Directors;

- the Director of Adult Social Services,
- the Director of Public Health and
- the Director of Children's Services.

2.5 Draft guidance produced by the Department for Communities and Local Government, "Creating Strong, Safe and Prosperous Communities" states that the JSNA is primarily concerned with the those areas where the responsibilities of the PCT and local authority overlap, or where one organisation in carrying out its functions has the potential to make a significant impact for the other organisation's functions.

2.6 To understand the scope of the JSNA it is helpful to base this on an understanding of the scope of well being. In 2006 a Government working group developed a statement of common understanding of well being for policy makers.

"Wellbeing is a positive physical, social and mental state; it is not just the absence of pain, discomfort and incapacity. It arises not only from the action of individuals, but from a host of collective goods and relationships with other people. It requires that basic needs are met, that individuals have a sense of purpose, and that they feel able to achieve important personal goals and participate in society. It is enhanced by conditions that include supportive personal relationships, involvement in empowered communities, good health, financial security, rewarding employment, and a healthy and attractive environment.

2.7 Whilst this statement of common understanding captures the scope of the work undertaken on the Leeds JSNA, it has not been formally adopted. To do justice to the statement more work would be required in both data capture and analysis to explore in more detail the interaction between good health and for example involvement in empowered communities, financial security and rewarding employment. At this stage in the JSNA process further views are being sought on the scope of the JSNA to understand the extent of the influence strategic needs assessment should have across Council and other agencies services.

2.8 To undertake the initial work programme for the JSNA, three project teams have been formed across the City Council and Leeds PCT. They are:

- Data collection and analysis; and
- Public and stakeholder engagement and consultation.
- Planning and alignment; (looking at how across the Council and with Leeds PCT activity to support strategic commissioning can be undertaken with closer alignment and greater efficiency).

3. Key outputs from the JSNA work programme

3.1 The JSNA Data Pack

This substantial pack of data and analysis presents a comprehensive picture of the health and well being of the city. It currently runs to 280 pages and more data and analysis will be added as it becomes available. The contents of the data pack, in terms of the minimum requirements, have been set out in the national guidelines. The Leeds data pack builds on analysis already undertaken to inform the needs assessment in other statutory plans. Most notable are the Children and Young Persons Plan, the Joint Strategic Assessment – Safer Leeds, the Leeds PCT, Director Of Public Health Annual Report 2007/8 and Measuring the Gap, Tackling Health Inequalities, (Leeds Initiative) which all contain extensive assessments of need.

3.2 Public and Stakeholder Engagement

This project team has undertaken an overview of all the related consultation and engagement activity-taking place across the city. Annex A to this report is an extract from the data pack and summarises headlines from public, patient and service user and carer feedback.

For the future, opportunities to build a citywide database of the results from consultation and engagement have been explored. The City Council has a system called Talking Point Leeds, which is accessed through the City Council's website. This database already contains information on 72 surveys and consultations completed as well as those currently underway. The PCT has agreed to consider

whether to include information about similar activities they are undertaking so that Talking Point becomes a citywide resource.

3.3 **Planning and Alignment**

This project team focused on how the JSNA process can be sustained and developed across all appropriate partnerships within the city. The group also considered and made recommendations on how strategic needs assessment would influence the setting of priorities and decisions about the commissioning of services in the future. Whilst there is a significant amount of work required to turn the objectives into a reality, the key recommendations from the team are contained within the JSNA report and are under discussion with key partners through both internal and partnership groups. A summary of the recommendations from this group can be found at Annex B

3.4 **The Public Report – Implementing the Leeds Strategic Needs Assessment Framework.**

This report, now in draft form brings together the key findings and analysis from the three project teams. It will confirm that the evidence previously available to support priorities identified in the Leeds Strategic Plan and the Leeds PCT Strategic Plan remains valid, however important health and well being issues are identified for prioritisation over the medium term (3 – 5 years).

The report also makes recommendations regarding future arrangements for Joint Strategic Needs Assessment across the city. These recommendations along with the indicative actions are still being consulted on and there is an opportunity for Scrutiny Board members to comments on all the proposals, which seek to strengthen both partnership work and the 'One Council' approach.

4. <u>What have we learnt from the JSNA so far</u>?

4.1 It is difficult to do justice to the considerable work undertaken so far by providing a brief overview. Consequently a more detailed summary is provided at Annexe C, which is a synthesis of the data pack (which currently runs to 280 pages). Members may wish to refer to this summary, as it contains specific sections on health, adult social care and children's services.

4.2 The work so far has confirmed that the priorities identified in the Leeds Strategic Plan are the key priorities to be tackled at the present time. They include:

- Narrowing the gap in all age all cause mortality, between the average for the city and the average for people living in the 10% most deprived SOA's
- Circulatory diseases and stroke
- Tackling obesity and raising activity
- Improving sexual health and reducing teenage conception
- Improving mental health and emotional well being
- Improving the quality and responsiveness of services that provide care and support for people

- Improving safeguarding for children and adults.

However, from the analysis that has been undertaken of the data gathered so far, new priorities and areas for further work have emerged. They include:

4.3 **Responding effectively to demographic change:**

4.3.1 **An ageing population:**

It is reasonable to anticipate that people will have increased expectations that the quality and availability of services will increase in line with demand. However, we already have experience of difficulties in recruiting people into personal care roles. Increased investment in preventative services should reduce the time during which people need additional care and support, however existing evidence of health inequalities in the most deprived areas of the city does indicate that there will be an increase in life-limiting conditions, such as stroke, diabetes and dementia as the population ages and people live longer. There is a pressing need to undertake more work to understand the impact of demographic change for services in Leeds and to have a better understanding of the expectations of future users of these services.

4.3.2 **Children and Young People**

Unhealthy children of today will become the unhealthy adults of tomorrow. We need to ensure tomorrows children and young people are healthier through ensuring the effectiveness of current programmes to tackle childhood obesity, emotional well being, teenage conception and sexual health. The projected increase in the proportion of children from new or minority ethnic communities over the next 10 years, does indicate more targeted action all outcomes for children, particularly for those groups who are currently not achieving good outcomes, for health, well being and achievement. An emerging priority is a focus on infant mortality, where again the evidence shows that in some communities in Leeds infant mortality rates are within the bottom quartile nationally, in contrast with the overall picture for Leeds, which compares favourably with the national picture.

4.3.3 **Counteracting widening inequalities between neighbourhoods.**

The likelihood is that the number of Leeds SOAs in the most deprived 10% nationally will decrease in the future, to follow the trend of 2000 and 2009. However, whilst there will be some improvements in mortality rates in many of the most deprived areas, current evidence suggests that the onset of life limiting illness and disability will continue at current levels or greater, without a continued focus on tackling health inequalities in these areas. Even more significant (using the information around community cohesion in the data pack) will be an acceleration of the different needs of neighbourhoods within those 10% SOAs.

The association between good health and well being and the factors which can determine these outcomes for people, such as employment, education, good parenting, clean and attractive environments, will have significant implications for commissioning decisions in the future, if current priorities on tackling health inequalities are to be realised. In other words, Leeds City Council and NHS Leeds could be jointly commissioning services which contribute to more employment opportunities, better education outcomes, reduced crime and the perception of crime, social inclusion and financial inclusion.

4.4 Responding effectively to specific health and well being challenges

Whilst the data pack contains considerable evidence on a range of health related data there are a number of key issues which emerge as priorities for action in the future.

4.4.1 Obesity

In 2005, 22.1% of men and 24.3% of women were obese and almost two-thirds of all adults overweight. From a regional perspective the report on 'Yorkshire Futures' supported by Yorkshire Forward identified obesity in the region as the main threat to public health in the future. Programmes to address people who are either obese or over-weight require both the City Council and the PCT to work together through focused commissioning of services.

4.4.2 Alcohol

Within the Yorkshire and Humber Region adults' drinking above safe levels is estimated at 155,000, of which 25,000 may be dependent. Alcohol related deaths in the region rose by over 46% in 2004 -the biggest rise in the country. Alcohol related death rates are 45% higher in high deprivation areas. Analysis of the national TellUs survey of young people shows that 20% of young people in Leeds have been drunk at least once in the past four weeks, a rate that is broadly in line with the national average. However, the recently published health profile for the city shows that alcohol related admissions to hospital are higher in Leeds than for the average England average, with a rate per 100,000 population of 301 compared to 260 nationally. In the same report Leeds is shown as significantly worse in relational to data estimates on binge drinking.

The estimated annual cost of alcohol misuse in Leeds is £275 million, of which £23 million is health related.. The city has adopted an Alcohol Strategy and the action plan is showing some results. A focus on high impact preventative actions is required, and Newcastle for example has placed an emphasis on increased use of regulatory and control powers.

4.4.3 Drugs

The data pack doesn't give a clear message on trends although it does show changing patterns of use e.g. heroin and cocaine. Approximately one in seven young people (15%) reported having used drugs at least once in the national TellUs Survey. The rate in Leeds is the same as the national average. The Leeds Health Profile published by the Department of Health, indicates that the overall rate of drug misuse for all people aged 15 -64 is higher than the national average at 13.4 per 1000 population. However, the social impacts are so significant, that while drugs may suddenly go out of fashion the Director of Public Health is supporting a call for the Council and NHS Leeds as commissioners to take an increased and a more holistic role than the priorities defined by the National Treatment Agency, which sets national targets and monitors performance in this area.

4.4.4 Tobacco

The pattern of deprivation and smoking is clearly seen across Leeds. It is clear that the distribution of smokers varies across the city, the highest rates being seen in inner east, inner south and inner west Leeds and the lowest in the north east. This corresponds with published synthetic estimates where even greater variations can be seen at ward level with the lowest estimated smoking level of 18% being seen in Wetherby and the highest of 46% being seen in Seacroft. The take –up of smoking amongst young people, particularly women appears to remain resilient based on national data, which points to the need to continue with current smoking cessation programmes with more funding from mainstream sources.

5 Targeted work to improve health and well being outcomes for specific groups

5.1 Whilst there are important health and well being issues for all population groups the JSNA work programme, particularly through stakeholder events, has highlighted the need to develop a better understanding of the health and well being needs of the following groups.

- People with a learning disability
- Gypsy and travellers,
- People with dementia
- Asylum seekers and newly arrived communities
- Looked After Children and Young People.

Future work would include ensuring that there is improved data and analysis available for these population groups and that work directly with service commissioners will focus on how outcomes for these population groups can be improved.

6 Sustaining the JSNA Process

6.1 A key objective of the work programme over the last nine months has been to develop proposals, which ensure that strategic needs assessment is integral to strategic planning and commissioning processes in the future. Partners are agreed that more needs to be done to develop data management and analytical skills within the workforce, and have systems in place that can ensure that population needs assessment for example is undertaken as a corporate task, rather than on a service-by-service basis, which tends to be the current practice.

6.2 The project teams established for the JSNA brought together people with common roles and responsibilities, into a ‘virtual team’ which was able to exchange information and experience and explore new ways of working. From each of the project teams there have emerged proposals for building and sustaining this approach, including for example Leeds PCT and Leeds City Council sharing a single system for recording consultation and engagement activity and developing a single data warehouse to hold the data which forms the basis of the strategic needs assessment.

6.3 The project has also explored how data and information can feed into and inform the commissioning of services across health and well being. To this end a survey of commissioners was conducted to explore these issues and access to the data pack has been made available during the course of the work programme, with the result that current commissioning activity including service review has incorporated information from the JSNA.

6.4 The Public report contains a series of proposals for sustaining the JSNA process, which form the basis for a work programme during the next phase of the process. Annexe 4 to this report contains the action plan proposals from the draft public report.

7 **Questions for Scrutiny Board Members**

I. Are the themes set out in section 4 the ones that should be given greatest priority for future action?

II. Is the scope of the JSNA too broad or just about right? See section 2.6 for a proposed definition of well being.

III. Are there other themes, which from your local experience or information you have identified?

IV. In addition to the proposals set out in section 4, are there any other suggestions that will improve partnership working in increase efficiency and effectiveness in strategic needs assessment?

V. How can the JSNA assist Scrutiny Board and Area Committees in identifying priorities at a city wide and area level?

8. **Recommendation**

8.1 That Scrutiny Board Members consider the progress made, consider the questions at point 7 above and provide comments for further development of the Joint Strategic Needs Assessment.

Background Documents referred to in this report

Local Government and Public Involvement in Health Act (2007)
Leeds Strategic Plan
Leeds PCT Strategic Plan
Guidance produced by the Department for Communities and Local Government, “Creating Strong, Safe and Prosperous Communities”
Children and Young Persons Plan
Joint Strategic Assessment – Safer Leeds
Leeds PCT, Director Of Public Health Annual Report 2007/8
Measuring the Gap, Tackling Health Inequalities, (Leeds Initiative)

Annex A: Public, patient, service user and carer feedback

The JSNA Stakeholder Engagement and Consultation Project group have collated a wide variety of qualitative material from across Leeds, including information collected from health organisations, the local authority, the voluntary, community and faith sector and Patient and Public Involvement Forums (PPIFs).

The initial emerging themes are outlined below. This has been grouped into the key areas where it is suggested the information is held:

- Health (including Leeds PCT, Leeds Teaching Hospitals Trust and Leeds Partnerships Foundation Trust)
- Local Involvement Network (LINk) Preparatory Group (incorporating the work of the previous PPIFs)
- Voluntary, community and faith sector (mainly focusing on the members of the Leeds Voice health forum)
- Leeds Strategic Plan (which highlights a number of cross cutting themes from across the local authority).

Based on the information received, a subjective approach needed to be taken to make an initial analysis. Further work will need to be developed for future years to identify a more robust and methodical approach to analysing this feedback.

Health

Health themes have predominantly come from patient surveys and public perception surveys. These are:

- commissioning of primary care services (in particular more NHS dentistry and GP out of hours)
- the top conditions that people say are important – heart-related diseases, arthritis, asthma and depression.
- the need to recruit more clinical staff (GPs and nurses)
- the most important services for people – heart failure clinics and child health services.

On skimming the results from this years patient survey, the PCT scored quite low on the question ‘In the last 12 months, have you been asked by someone at your GP practice/health centre about how much alcohol you drink?’

Local Involvement Network (LINk) Preparatory group

Themes identified through LINk were existing priorities developed by the previous PPIFs. Further work in future years will be necessary to secure LINk's contribution in informing the themes for the JSNA process.

PPIF priorities were:

- access to out of hours and urgent healthcare
- patient medication reviews for older people
- oral health
- access to primary care services for deaf and hard of hearing people.

After meeting with LINk to discuss key priorities, the points above were confirmed as still relevant along with others that have already been raised from other areas. Four other themes were identified as current issues:

- quality of maternity services, particularly following the Healthcare Commission survey for 2007–08
- discharge from hospital, especially lack of care packages and poor communication between organisations
- accessible information for people with literacy problems
- access to services and information for vulnerable groups and BME communities.

Voluntary, community and faith sector (VCFS)

Some emerging themes coming from the VCFS have been developed by a sub-group of the Leeds Voice Health Forum.

This section has been based on the current collated research done across Leeds highlighting a few key areas. This will be developed to give a more comprehensive picture.

- Accessible information on health came out strongly as important to a number of groups – including ensuring that information is available in formats that are easy to read, in appropriate languages and readily available.
- Mental health and support for people and communities suffering from emotional distress was highlighted in a number of areas.
- The quality and attitude of health service staff was highlighted, including the need for services to be culturally 'competent'.
- Transport to and from health services was seen as a big issue.

Leeds Strategic Plan

Finally, the themes developed from consultation on the Leeds Strategic Plan focusing on health and wellbeing were taken into account. These were broad-ranging and covered all areas of the city and communities of interest.

The top priorities following the outcome of the consultation were:

- Priority 27 – Reduce obesity and raise physical activity for all
- Priority 29 – Promote emotional wellbeing for all
- Priority 32 – Increase the proportion of vulnerable adults helped to live at home.

It was identified that further work needs to be done to support a couple of key areas which were not highlighted in the plan's priorities:

- the need for more priorities that promote healthy lifestyles
- the need for more recognition and support for people with mental health issues.

Children and young people

Following the Joint Area Review a number of themes have been identified through engagement processes which impact on the health and wellbeing of children and young people. The main themes are:

- access to services for adolescent mental health and emotional wellbeing
- child poverty
- impact of domestic violence
- substance misuse.

Some of this is reinforced by young people themselves, in particular through the national Tellus2 survey and the local Every Child Matters (ECM) survey which identified that one in four children and young people want more information, particularly on drugs, sex and emotional health. The surveys also highlighted that exams, friendships and family were the most commonly cited worries and so impact on the emotional wellbeing of children and young people.

Annexe B High Level Plan to improve joint planning and commissioning through JSNA

	Short Term [In readiness for JSNA 2009]	Medium Term [2-3 Years]	Longer Term [3 Years +]
General Governance	• Put in place effective structures and governance arrangements to maintain oversight of the JSNA process		
Joint Planning and Commissioning	• Feed themes and key issues for action into forward work programmes of Healthy Leeds JSCB sub-groups and Children Leeds • Undertake the bespoke piece of work mapping world class commissioning competencies with the one council approach to commissioning framework and locality commissioning. • Maintain regular meetings of officers from the LCC and PCT to refresh priority/target discussions and identify further opportunities for planning alignment. • Develop longer term projections/trajectory information for a wider range of communities of interest, localities and city wide targets • Develop a parallel focus alongside the needs of communities on the available human resources to meet those needs • Develop a partnership with higher education to address identified needs in relation to further research and predictive modelling and analytical techniques	• Determine key areas to undertake analysis of cost-effectiveness / VFM – spend against performance • Make disaggregated data available for all localities in Leeds • Launch the real-time on-line data base with associated training to create self-sufficient partner users. • Develop review, evaluation and learning methodologies	→

	• Explore how the JSNA can be extended to support all strategic outcomes in the eight themes of the Leeds Strategic Plan 2008-11		
Data Gathering and Analysis	• Develop and implement the shared data repository approach • Complete data pack • Identify areas where we have not included data from the core data set and actions/reasons • Agree way forward to collect ethnicity data in primary care • Joint data group to meet quarterly-agree Terms of Reference (linked to JSCG) • Place data pack on intranet • Strengthen evidence base across all equalities strands e.g. address ethnicity and disability data gaps across all public services	• Produce 'Vitality index' for localities • Complete detailed programme needs assessments for: mental health; older people and alcohol • Start forecasting work	• Develop comprehensive system for forecasting and future modelling • Joint working with YPHO to ensure updates of JSNA and measuring the gap are timely for commissioners
Stakeholder Engagement	• Consolidate learning developed through JSNA process • Set up Joint involvement and consultation working group with terms of reference, work plan and reporting arrangements etc. • Formalise process for future partnership working and collation of qualitative information • Feed into the shared information database	• Explore potential for shared surveys and joint use of methods such as citizens panel • Communicate best practice and learning across organisations. • Consider new ways of joint working	-

Summary of the JSNA Data Pack Annexe C

Evidence of need

The JSNA data pack provides a detailed picture of the diverse health and well being needs of the people of Leeds. The quantitative data was collected in line with the original draft data set from the Department of Health. Some additional information was collected based on local need. For example a detailed revision of the data set collected in 2007 on children and young people has been revised and updated for the pack; student health has been added as Leeds has a large student population, and also a section on vulnerable groups. Not all of the final data set was able to be collected mainly as the data is not yet available.

Qualitative data was collected from a wide range of consultations that have taken place both within the PCT (for example the patient survey and the consultations on the PCT strategy) and also from the council via a stakeholder and engagement groups who pulled it all together.

It is envisaged that the data pack will be available on a web based site so that this information can be used by everyone who requires it for planning, commissioning future services in Leeds and by the communities whose needs it describes.

The data pack provides detailed information on key conditions; services; client groups and communities that can be used by the range of health and well being commissioners within the city for their specific programme areas. In order to identify some emerging themes a scoring exercise was also carried out by a number of people within the PCT and LCC . Key questions asked were:

- Is this an issue which affects a significant proportion of the population (directly or indirectly)?
- Is the problem likely to increase if there is no intervention?
- This an issue which significantly affects vulnerable groups?
- Is this issue a significant contributor to the health inequality gap?
- Is there evidence of unmet need
- How great are the costs (direct and indirect) of not intervening?
- Does this issue have the possibility of investing to save?

Key emerging themes from this fall into three categories:

Influences on health and well being - poverty/low income; housing; education and unemployment- also the economic wellbeing of children

Conditions of ill health – circulatory disease; cancer; obesity

Lifestyle issues – healthy life; alcohol;

The data pack was produced by a joint information group between the PCT and the LCC Who produced it. This also had a sub group of people working around children's issues to update the relevant data

In future it is envisaged that this gathering of data will become an integral part of the role of the Joint Strategic Commissioning structure within the city

Data Pack.
Detailed below is a summary of the information within the data pack

1. Demography
The Leeds Metropolitan District covers 552 square kilometres (217 square miles) and is the second largest Metropolitan District in England. It is recognised as one of Britain's most successful cities having transformed itself from a mainly industrial city into a broadly-based commercial centre regarded as the most important financial, legal and business service centre in the country outside London.
The city includes a vibrant city centre and the built up areas that surround it together with more rural outer suburbs and several small towns, all with their own very different identities. Two-thirds of the district is designated green-belt.

Despite the success of the city as a whole there are wide gaps between those areas that are wealthy and thriving and those that suffer high levels of multiple deprivation.

At the time of the 2001 Census Leeds had a population of 715,400 living in approximately 301,000 households. In 2005 the population of Leeds was estimated at 723,100. Following recent revisions by the Office for National Statistics to the way in which population estimates are calculated the population of Leeds is now estimated to be 750,200, an increase of 4.9% from the 2001 figure.
Leeds has a significantly higher proportion of 15 – 29 year olds when compared to both the country and the region, whilst the proportion of older people is slightly below the national and regional averages.

At the time of the 2001 Census there were almost 78,000 people from BME communities living in Leeds (10.8% of the total resident population). Geographic analysis of the Census data has shown how BME communities are concentrated in particular geographic areas of the city

Leeds is clearly becoming a more diverse place and is now home to over 130 different nationalities. This diversity is valuable and has helped fuel the prosperity of the city.

The data pack details the needs of different communities/groups living in Leeds– gypsies and travellers, migrants communities, asylum seekers, refugees, faith communities

Changing Populations
The Office for National Statistics produces population projections which indicate that the population in Leeds will increase from 750,200 in 2006 to 974,300 by 2031
There will be significant changes in the size and profile of black and ethnic minority communities in the coming years. Work done by the University of Leeds (School of Geography) for the Yorkshire Futures Group suggests that by 2030 the BME population in Leeds will increase by 55% (N.B. this work was undertaken prior to the ONS revisions to the 2006 Mid Year population estimates outlined above), the age structure of black and ethnic minority communities will also contain higher proportions of people in older age groups.

2 Key influences on Health and Well being

2.1 Social and economic context.
Although Leeds as a whole is ranked as 85th most deprived (on the average of Super Output Areas (SOAs) scores), 95 out of the 476 SOAs in Leeds are ranked in the most deprived 10% in England on the Index of Multiple Deprivation. The majority of these are located in the inner city and just under 150,000 people (20% of the resident population) live in these areas. A quarter of all children in the city live in these most deprived areas together with 18% of the city's older people. The data pack shows that people in these areas:

- Live significantly shorter lives
- Are more likely to be the victims of crime
- Have lower qualification levels, and
- Live in the poorest housing and environments

Comparison with the 2004 Index of Multiple Deprivation **(IMD)** the 2007 IMD shows an improving position for Leeds with fewer SOAs ranked amongst the most deprived in the country. Of the 476 SOAs in Leeds 415 have seen an improvement in their IMD ranking and 61 have seen their ranking fall

One approach to analysis of inequalities that is used in the data pack is to compare the most deprived parts of Leeds with the rest of Leeds. This analysis looks at those parts of "deprived Leeds" which fall within the worst 10% deprivation band in England according to the Index of Multiple Deprivation, and analysed at the level of small areas termed lower layer Super Output Areas (mean population 1500 people). Leeds has approximately twice the expected number of LSOAs graded as being 'the worst 10% most deprived nationally' i.e. 20% of Leeds LSOAs fall into the worst 10% nationally.

2.2Employment Rate

Leeds has seen sustained job growth over the last 20 years and latest figures show the overall employment rate in the city to be 75.3%, which is above the current England average of 74.3%.

In 2007 gross average hourly earnings for full-time workers in Leeds was £10.84, this was below the England average of £11.58 but above the Yorkshire and The Humber regional average of £10.53

Almost 65,000 people of working age are not in employment and are claiming some kind of benefit. At 28.7% the claimant rate in the "Deprived Area" is more than double the rate for the city

2.3 Unemployment in Leeds

The estimated real level of unemployment in Leeds in 2007 according to CRESR was 29,500, a rate of 6.4%. This compared with 13,995 claimants (a rate of 3%) and 17,000 ILO unemployed (a rate of 5.3%). Thus, just over twice as many people were unemployed by CRESR's calculations than the claimant count and approximately 42% less people were counted as unemployed according to the ILO count

2.4 Benefits

Incapacity Benefit data shows that: across the city 6.5% of the working age population are claiming Incapacity Benefit while in the "Deprived Area" it rises to 12.4%, nearly twice the city average. 44% of claimants are claiming due to "Mental Disorders", in the "Deprived Area" this rises to 48% of claimants ,16% of claimants are claiming due to "Musculoskeletal Diseases.

Almost 71,000 households in the city (23%) are in receipt of local authority administered benefits, almost 12,500 of which are lone parent households. while in the "deprived area" the benefit take-up rate is 44% almost double the average for the city

2.5 Housing

Data within the pack covers key issues within housing such as availability of central heating, ownership; decency and overcrowding.

In the last ten years there have been substantial changes in housing market conditions in Leeds and in the patterns of housing choice and use made by households and individuals. With Leeds growing economically and becoming a thriving regional centre, a 'two-speed' housing market has emerged, showing a clear gap between parts of the city where there is considerable affluence and buoyant (and often overheating) housing markets, and parts

where housing is in poor condition, housing markets are frail, and where there exists significant social and economic deprivation. At the same time, throughout the city and within neighbourhoods, there have been changes in housing tenure patterns with a continuing home ownership and a substantial increase in the number of households renting privately. The share of the market taken up by social rented housing (and by Council housing in particular) has declined substantially through Right to Buy activity and demolition and disposal of stock. It is estimated that there are 51,400 private sector dwellings in Leeds that are occupied by "vulnerable households". Of these an estimated 37% are classified non-decent. In order to raise the proportion of private sector dwellings occupied by vulnerable people above the 70% threshold for decency, 3,880 dwellings will need to be made decent by 2010.
Homeless/supporting people etc
The Census data shows that almost 62,500 households within Leeds (20.7% of all households in the city) did not have central heating, affecting almost 135,900 *people* (19.3%). The Leeds 2007 Fuel Poverty Survey showed that within the private sector 30% of all households are experiencing fuel poverty, with a figure of 22% for vulnerable households.

2.6 Transport
As more people live in and travel to work in Leeds greater strain will be imposed on the transport system. Road traffic grew by 4.9% between 1996 and 2006 and further growth is predicted. In 2001 around 108,000 people commuted into Leeds daily for work and that number is estimated to have grown significantly in recent years; in 2006 the total number of trips into the city averaged about 122,500 a day.
Data from the 2001 Census of Population over 1/3rd of all households in the city (34.5%) do not own a car or van, a considerably higher proportion than for England and Wales (26.8%), rising to 58.34% over half the population) within 'deprived Leeds'

2.7 Crime
In 2007, Safer Leeds (Crime and Disorder Reduction Partnership) identified the major crime, disorder and substance misuse issues that require partnership attention. The priority issues were informed by the findings of the joint strategic assessment and public-partnership consultation (ref). The data shows that between 2005/06 and 2007/08 considerable progress was made in tackling crime across the city. In 2007, there were 85,737 recorded crimes, almost 12,300 fewer offences than in 2005/06; this is a 12.5% reduction in crime
The third biggest category of crime is violence against the person, this can include the most serious offences like murder and rape to assaults where the victims suffers relatively minor injuries. Some violence does not include physical harm for example, harassment although the psychological effects of such offences must not be under estimated.
There are parts of the city where disproportionately high levels of crime persist over time. In the twelve months from October 2006, 60% of crime happened in 30% of the 476 Lower Super-Output Areas in Leeds.
One key issues within the Safer Leeds JSNA is drug use.
National estimates of prevalence of problematic drug users have been produced by the Home Office through a study by the University of Glasgow that estimates the prevalence of problematic drug users at a local and national level. The estimated number of problem drug (opiate and/or crack cocaine) users in Leeds according to this study is approximately 6,565. In Leeds heroin is the most heavily misused drug, by 84% of drug users – a higher proportion than nationally.
In 2007/08, there were 3,554 drug users in treatment. The number of new presentations increased by 5.2% from the previous year (1145 in 06/07 and 1204 in 07/08). The largest group of known drug users is in 20-24 age range, the majority nationally are 35 and over, of known drug users the injection status of 68% is unknown. There are an estimated 515 problematic drug users unknown to services

3. Access to Services

Within the data pack there is only limited information about access to services. IN terms of prioritisation this would be an important area to consider
For the City over 80% of all Lower Level SOAs have a population weighted average road distance (PWARD) to a Food Store, a GP Surgery and a Post Office of less that half a kilometre. In addition 87% of LSOAs are within one kilometre of a primary school. Whilst almost 10% of LSOAs have a PWARD to a GP Surgery of more than two kilometres the population of only four LSOAs (less than 1%) have to travel this distance or farther to a Primary School.

4. Health and Ill Health

4.1 Life Expectancy

Life Expectancy is increasing for males and females. However there remains a marked gap between the life expectancy of males and females. 2004 – 2006 averages show a gap of 4 years. Comparing ward data for all people the difference is more extreme with a life expectancy gap of 10 years between the ward with the highest life expectancy (Adel and Wharfdale) and the lowest (City and Hunslet); this Ward differential is correlated to deprivation.

4.2 All Age All Cause Mortality

The all age, all cause mortality rate in Leeds fluctuated around the national average between 1993 and 2000 at a level below the regional average. From that point, although the rate continued to fall, it was consistently higher than the national average but remained below the regional average. In 2003-2005, compared to the core cities in England, Leeds had the lowest all age, all cause mortality rate but was significantly higher than the national average. The deprived areas of Leeds had rates that were significantly higher than the Leeds, Y&H Spearheads and national averages between 2001 and 2005.Between these years the gap between Leeds deprived and Leeds overall fluctuated

4.3 Circulatory Disease Mortality

Within Leeds the mortality rate under 75 years from circulatory diseases ranged from 50 per 100,000 in Adel and Wharfedale 224 per 100,000 in City and Hunslet electoral wards.
The deprived areas of Leeds had mortality rates under 75 years from circulatory diseases that were consistently significantly higher than the Leeds, Yorkshire and Humber Spearhead and national averages between 2001 and 2005.

4.4 Cancer Mortality

The deprived areas of Leeds had mortality rates under 75 years from cancer that were consistently significantly higher than the Leeds, Yorkshire and Humber Spearhead and national averages Although there was a reduction in the gap between Leeds deprived and Leeds and the gap between Leeds deprived and England between 2001 and 2003, the gaps have now widened . Inner West Leeds particularly has risen over 2005-7, with all the other inner areas also showing rises.

4.5 Chronic Obstructive Pulmonary Disease Mortality and Prevalence

The mortality rates for COPD demonstrate wide variation across areas in Leeds with the inner south area continuing to have significantly higher rates since 2003, and continuing to rise.

4.6 Stroke Mortality
Mortality form stroke is continuing to fall in the majority of areas since 2003. Highest rates are in inner North East, but there are also high rates within the outer East . followed by Inner South and Inner East.

4.7 Limiting Long Term Illness
At the time of the 2001 Census there were over 128,000 people living in Leeds who considered themselves to have a limiting long-term illness (18% of the total resident population). Of these people 57,732 were of working age. Geographic analysis of the Census data has shown how people with a LLtI are concentrated in particular geographic areas of the city

4.8 Top Ten Causes of Death and Admission Rates
CHD is the most common cause of death in men and is also one of the main causes of hospital admissions for males.
CHD was the most common cause of death in women in 2006, followed by cerebrovascular disease. This is not reflected in the figures for hospital admissions.

5. Healthy Lifestyles

5.1 Smoking
The pattern of deprivation and smoking is clearly seen across Leeds. It is clear that the distribution of smokers varies across the city, the highest rates being seen in inner east, inner south and inner west Leeds and the lowest in the north east. This corresponds with published synthetic estimates where even greater variations can be seen at ward level with the lowest estimated smoking level of 18% being seen in Wetherby and the highest of 46% being seen in Seacroft.

5.2 Alcohol Admissions
Within the Yorkshire and Humber Region Adults' drinking above safe levels is estimated at 155,000, of which 25,000 may be dependent. Alcohol related deaths in the region rose by over 46% in 2004 -the biggest rise in the country. Alcohol related death rates are 45% higher in high deprivation areas/
The estimated annual cost of alcohol misuse in Leeds is £275 million, of which £23 million is health related.

5.3 Obesity
In 2005, 22.1% of men and 24.3% of women were obese and almost two-thirds of all adults overweight. In 2003, nearly a quarter of males in Yorkshire and Humber (24.6%) were estimated to be obese, the highest prevalence of any region in England. The region also has the highest obesity prevalence among young adult males (aged 16-24) of any region in England (based on 2002 data).

5.4 Physical activity
In the Citizens Panel Sports Provision Survey 2000 illustrated that 50% of people in Leeds felt that participation in sport and active recreation was important to them; by 2005 this had increased to 65%. It is encouraging that there have been significant increases in the number of adults who regard taking part in sport as important, and who perceive the facilities in Leeds to be good or excellent.
A major national participation survey was commissioned by Sport England in October 2005. It shows that only 20.5% of the adult population in Leeds are participating for 30 minutes, three times a week in moderate intensity sport and active recreation, very slightly above the Yorkshire average of 20.1% but below the England average of 21%.

6. Indicator Comparison

When compared to the national average, (based on the latest data July 2007) Leeds has significantly worse values for 24 of the key indicators including all age all cause mortality, male life expectancy, smoking prevalence in long term condition patients, alcohol related admission rates, prevalence and mortality from circulatory and respiratory diseases, incidence and mortality from cancer and emergency admissions for chronic illnesses such as COPD and asthma.
Compared to the national average, of the 47 indicators compared people living in the deprived areas of Leeds experience significantly worse values for 34 of them. This pattern does not change dramatically when making comparisons between the deprived areas of Leeds and Yorkshire and the Humber region, the spearhead areas within Yorkshire and the Humber or the Leeds average.

Overall Leeds reflects the fact that Yorkshire and Humberside is an area of comparatively poor health in England and Leeds is not atypical of the region. However health in the more disadvantaged areas of Leeds, containing around 150,000 population, is significantly worse than in those areas which the government has designated as priority areas for health improvement, meaning that the challenge of narrowing the gap is significantly greater.

7. Children

Towards the end of 2007 Children's Services undertook a Needs Analysis as part of the Joint Area Review. The information in the data pack is drawn from this earlier work (updated where possible). The Needs Analysis was structured around the 5 outcomes for Every Child Matters.(ECM)

- Stay Safe
- Be Healthy
- Enjoy and Achieve
- Make a positive contribution
- Achieve economic well-being

7.1 Staying Safe

Within this section is detailed information on Looked After Children. The numbers of looked after children in Leeds are significantly higher than statistical neighbours and are increasing. At September 2007 Leeds has 1395 looked after children. If it were to reflect the same proportions of the total population of children as the average of its statistical neighbours then it would have 912. There are more boys than girls in every age group in the looked after children cohort. In total boys comprise 58% of the looked after population. This proportion has risen by 6% since 2004.Most Looked after children in Leeds have been in care for over 3 years. BME children are over-represented in the looked after population and continue to rise.
Given the current trajectory the numbers of looked after children is forecast to grow to around 1800 by 2010. This will create additional foster care costs rising to around £5.7 million per year in 2010-11 based on the 06/07 unit costs.
Other areas that are covered within this section are bullying and harassment (In the Leeds ECM survey, 46% of primary respondents and 42% of secondary respondents reported that they had been bullied at some point in school in the last 12 months, of these 5% of both primary and secondary pupils said they were bullied most days.); how Safe young people feel (the ECM survey showed around 405 children and young people (both primary and secondary) do not feel safe in the area they live after dark, although over 90% feel safe in the area they live in daylight) and Child Protection (the proportions of children who are the subjects of a child protection plan or on the child protection register is growing and is currently in line with that of national averages.)

7.2 Be Healthy

The Indicators of Child Health assessed were perinatal mortality; low birthweight and infant mortality.
- The recognised association between deprivation and higher perinatal mortality is demonstrated in the pack although the differences at small area level are not on the whole statistically significant, so differences in the rates should be interpreted with caution.
- The low birth weight rate for Leeds in 2006 was 8.0% which was similar to the national rate, and slightly lower than the regional rate (although not significantly). Over the last two decades there has been an upward trend in low birth weight rates in Leeds, rising from a rate of 7.3% in 1985, and reaching 9.0% in the late 1990s. There was a similar but less marked national trend over the same period, during which time the rates in Leeds were slightly but consistently higher than national rates. However, rates have fallen again somewhat in Leeds. Analysis of low birth weight rates (aggregated for 3 and 5 years) at local level demonstrates the recognised association between deprivation and higher rates of low birth weight.
- The 3 year aggregate infant mortality rate for Leeds (2004-6) was 6 per 1000 live births. This rate was higher than the England rate at 5 per 1000 live births, and slightly higher than the Yorkshire and Humber rate at 5.8 per 1000 live births.
3 year rolling rates show a rising infant mortality rate for Leeds, which has levelled off in the most recent year. This is in contrast to the national downward trend.
Detailed local analysis shows the association between higher rates of infant mortality and wards with high levels of deprivation

Oral Health
The most recent national survey data (2005/06) of nearly 240,000 5 and 6 year olds across the United Kingdom suggested that the mean number of decayed, missing or filled teeth (dmft) in England was around 1.47 teeth per five year old. For Yorkshire and Humber, the mean dmft was 1.82, with the Leeds experience being similar to the region at 1.83. The survey showed that dental health was poorer in the North of England than areas in the South and Midlands.
Results from the 2005/06 survey for Leeds, compared with the region and England. Despite some marked improvements in Leeds since the 2003/04 survey, the dental health of young children in Leeds remains slightly worse than the national experience. Nearly 43% of 5 and 6 years old Leeds have evidence of some tooth decay, with more than 4 teeth being affected on average.
The ECM survey showed that only two thirds of Year 5 children are achieving the recommended frequency of teeth brushing, though this appears to increase somewhat among the older age groups.

Teenage Conceptions
The Leeds national target is to reduce the rate by 55% from 1998 baseline. The Leeds rate figure (2006) is 50.7 which is 0.4% above the 1998 baseline. This is considerably higher than the national rate, is not a reduction and is a fair way from the 2010 target rate of 22.7 per 1000 females aged 15-17
Following the Local Area Agreement negotiation, a target for the next two years was devised. The focus is on reduction in the six highest wards (Harehills, Middleton, City & Holbeck, Seacroft, Hunslet and Richmond Hill) within Leeds and the impact this will have on the whole Leeds rate

Obesity
Across all categories Leeds is very slightly below the regional and national averages at reception.1 in 5 children in Reception in Leeds have a weight which is above what is considered healthy. This equates to around 1389 children. By Year 6 almost 1 in 3 children in Leeds are either overweight or obese. This equates to around 2505 children. Levels of

obese children have almost doubled from Reception to Year 6. This is more or less in line with the picture at a national and regional level.
Levels of overweight children are slightly higher than in Reception. Levels of obesity are higher in Reception in deprived areas of the city. Though this difference is small it is statistically significant. By Year 6 rates are higher across all measurements for children living in deprived areas of the city. Again the difference is small but statistically significant.

Physical Activity

Locally Leeds has already exceeded the National Indicator target to increase the percentage of school children who spend a minimum of two hours a week on high-quality PE and school sport within and beyond the curriculum to 85 per cent by 2008. Leeds achieved 86% in 2007and is likely to achieve 90% by end of 2008
In England only half of children regularly travel to school on foot, even though many children live within 1 mile of primary school and 2 miles of secondary school. In 2007, 28% of pupils who live in Leeds travelled to school by car compared to 56% nationally. Leeds has a lower than average cycling modal split percentage 0.41% compared to a 4% national average although we are in-line with the core cities average.. When pupils were asked to give a preference as to their preferred journey mode, nearly a quarter of pupils (23%) stated a desire to cycle to school
The ECM survey also covered nutrition, smoking, alcohol, drug use, and sexual health
- *Nutrition*. The results suggest that only a third of younger children (32%) are eating the recommended 5 portions of fruit and vegetables a day, and that the trend in older age groups is for this proportion to diminish (12% in Year 11). Conversely, the trend towards eating large quantities of high calorie, high sugar snack appears to increase in the older age groups, with nearly 40% of Year 11 students consuming 3 or more portions of snacks each day.
-Smoking. 12 % of Year 9 pupils and 22% of Year 11 pupils report regular smoking (note - It is difficult to draw a direct comparison with national data, since the wording of questions and methods of data collection vary.) A recent national survey carried out for the NHS Information Centre “Drug Use, Smoking and Drinking Among Young People in England in 2007” reported that the proportion of regular smokers was 15% among 15 year olds, hence suggesting that levels may potentially be somewhat higher in Leeds
- *Alcohol.* National data from “Drug Use, Smoking and Drinking Among Young People in England 2007” (NHS Information Centre) reports that 46% of 11 to 15 year olds have never drunk alcohol (an improvement from 39% in 2003). The results of the Leeds ECM Survey suggests that 50% of Year 5 pupils have never drunk alcohol, but that this proportion falls to 6% in Year 11. Although the results are not directly comparable, this could imply that the levels of drinking are somewhat higher in Leeds than the national findings. The ECM results indicate that over a third (36%) of Year 11 pupils are drinking regularly (at least once a week). A small but worrying percentage of children and young people report drinking on a daily basis from a very young age (1% in Year 5).
- Drug Use. The Leeds ECM Survey enquired whether young people had ever used illegal drugs or glues, gases and solvents as drugs. The self-reported levels of drug use in the survey suggest that the proportion rises from 11% in Year 9 to over a quarter of young people (28%) in Year 11. The National Survey “Drug Use, Smoking and Drinking Among Young People in England 2007” found that 25% of young people aged 11-15 years said they had tried drugs at least once. Recognising that the survey cover slightly different age groups, it seems likely that the level in Leeds may be similar to the national level.
- Sexual Health. The Survey enquired whether young people had ever had sexual intercourse. The responses indicated that proportion who replied positively increased from 20% in Year 9 to 47% in Year 11. In Year 9, slightly more girls than boys (52.7% girls: 47.3% boys) had had sexual intercourse, but by Year 11 this was approximately equal. Pupils were asked what forms of protection they had used on the last occasion when they had sexual intercourse. The table shows three quarters of Year 9 pupils, but only half of Year 11 pupils,

used a condom. A worrying 15% of Year 9 pupils and 20% of Year 11 pupils did not use any form of protection at all.

Other areas covered within Be Healthy include:
-Immunisation
The data shows that overall uptake rates for DTP have fluctuated, but in recent years have remained below the target level of 95% required to achieve 'herd immunity' (the level of immunity in a population which would prevent the spread of an epidemic), dropping to around 92% coverage in 2007. However, uptake levels for MMR are considerably lower, reaching around 80% in 2006 and 2007, which reflects some improvement over the previous years.

- Vulnerable children – including looked after children, gypsy and traveller children and asylum seeker children
-Local statistics suggest that Leeds had 1281 looked after children and young people in 2007/8, as well as 83 unaccompanied asylum seeking children. 251 of these looked after children (excluding asylum seekers) were from black and minority ethnic groups. This is a proportion of nearly 20%, which is an over-representation compared to the ethnicity of the child population of Leeds (14%).Leeds appears to be achieving lower levels of coverage of health needs assessments and dental check-ups than the region or England as a whole, and considerably poorer levels of immunisation coverage. It also suggests a slightly higher level of substance misuse problems in the looked after population, although this may reflect better recognition and response to problems, since Leeds also reports that 96% of these young people received an intervention for their substance misuse problem during the year, which is amongst the best practice in the country, and better than the performance for England as a whole (62%).
-The Gypsy and Traveller population has a higher proportion of children and young people than the Leeds population in general (44% of the Gypsy and Traveller population is under 17 years, compared to 20% for Leeds as a whole). The proportion of people aged over 60 in the Gypsy and Traveller population is dramatically lower than for Leeds in general, reflecting the lower life expectancy of this population group. The census report highlights that average life expectancy for Leeds in general is 78 years, but for Gypsies and Travellers is 50 years.
- Statistics for children in the Asylum system have to be obtained from various sources including the City Council & CART. In July 2008, of 2146 individuals who were seeking asylum, 493 were under 18 years old and a dependant of an adult claimant

7.3 Enjoy and achieve

This section details education achievement and attendance, play, exclusions and preventing offending. Overall this is a positive picture of how Leeds is improving
Primary - The expected level of achievement at KS2 is level 4. Outcomes have risen by 1% across all subjects in Leeds. This rise has been mirrored nationally and Leeds remains in line with national attainment except in science where Leeds remains 1 percentage point below the national figure. Leeds is in line with outcomes in comparative authorities for English, but 1 percentage point below for maths and 2 percentage points below for science.
After a drop in attendance in primary schools in 2005/06, attendance rose in 2006/07.
Attendance in Leeds primary schools is now at it's highest level and remains higher than national levels of attendance.
Secondary -Results for achievement at Key Stage 4 show that GCSE results in Leeds are at an all time high, with the percentage of pupils achieving 5 or more A*-C grades at 55.9%.
This is 3.5 percentage points higher than the 2006 figure. Although Leeds' performance is still below the levels reached nationally and by comparative authorities, there is a clear indication of above average improvement. The gap between the Leeds and national figure has closed from 5 percentage points in 2005 to 4 percentage points in 2007.

Unlike in primary schools, attendance in Leeds secondary schools is below national and comparative authorities.

Over 70% of both primary and secondary pupils who responded to the Every Child Matters survey had visited a local play area or park in the last four weeks. Participation in the majority of activities is higher for primary than secondary age pupils, particularly swimming, sports clubs and after school or breakfast clubs.

Preventing offending **-L**eeds YOS has successfully reduced the number of new first time entrants into the criminal justice system by 11.8% from 2005/06 to 2006/07.
Exclusions From School -65 pupils were permanently excluded from maintained Leeds schools in 2006/07. The number of permanent exclusions in Leeds schools has fallen significantly in recent years. There has been a 61% reduction since 2003/04. This pattern of reducing exclusions is not matched nationally, where the percentage of pupils permanently excluded has not reduced significantly.

7.4 Achieving Economic wellbeing

Children and poverty -The data shows that 1/5th of all children in the city live in families where no-one is in work. In the "deprived area" over 40% of children live in workless households – double the city average
Information on young people Not in Education Employment or Training after Year 11(NEET) in 2006, was 8.2%, the same as in 2005..NEET for year 11 leavers is higher for young people resident in deprived areas, with the percentage NEET almost double the Leeds average for pupils eligible for free school meals. Pupils with Special Education Needs and Looked After Children also have higher levels of NEET after leaving school. Overall, pupils BME heritage had lower levels of NEET than the Leeds average in 2006. However, some ethnic groups have higher levels of NEET, particularly Traveller groups and Black Caribbean heritage.
For young people Aged 16-18 NEET the percentage fell from 10.4% in 2005/06 to 9.1% in 2006/07, this is lower than in statistical neighbours, but higher than national levels of NEET for this age group. In July 2006/07, 17% of 16-19 year old pupils with LDD were NEET in Leeds, compared to 19% in West Yorkshire

7.5. Consultation

Following the Joint Area Review a number of themes have been identified through engagement processes which impact on the health and wellbeing of children and young people. The main themes are: access to services for adolescent mental health and emotional wellbeing; child poverty; impact of domestic violence; substance misuse

8. Older people

The latest information from the Office for National Statistics shows that there are currently 110,700 people in Leeds who are aged 65+. This number is predicted to rise by almost 40% to 153,600 in 2031
Pension Credit provides financial help for people aged 60 and over whose income is below a certain level. The data shows that there are just over 34,500 pension credit claimants in the city (27.2% of the post-working age population) Even though the outer areas have higher proportions of older residents the Pension Credit claim rates in all five outer areas are lower than their inner area counterparts
At the time of the 2001 Census there were over 70,000 pensioner households (defined as females aged 60+ and males aged 65+) in Leeds of which just over 43,000 were older people living alone. The Census data shows that almost 24,000 people in Leeds aged 65

and over were living in households without central heating ;that there were just over 41,300 pensioner households without transport (59% of all pensioner households). Of the 43,312 pensioner households that were living alone just over three-quarters (32,956 households) were living alone without transport. At the time of the 2001 Census there were over 70,000 pensioner households (defined as females aged 60+ and males aged 65+) in Leeds of which just over 43,000 were older people living alone. The POPPI system has produced projections for the numbers of older people living alone by applying percentages from the 2004 General Household Survey to local population these are detailed in the pack

9. Adult social care

During 2007/08 there were 9101 people aged 18 or over who received a completed assessment. Of these, 7366 were elderly (aged 65 and over) and 1735 were adults aged 18-64. In around 70% of cases it was determined that the person was eligible to receive services either directly provided or else commissioned by the department through another agency.
There was significant variation in the number of people assessed based on which ward they were living in, with numbers varying between 89 in Headingley and 374 in Middleton Park
There was some variation between the various areas in reaching the target completion time. In most areas of Leeds around 78% of assessments were completed within 28 days. However, in the south this figure rose to 86%.

9.1 Service Provision.

At 31/3/08 there were 15,756 people aged 18 or over who were in receipt of services provided through the adult social care process. Of these 10,983 were elderly people aged 65 and over and the remainder (4,773) were adults aged 18-64.
Looking separately at elderly care users and those aged 18-64 there is a significant difference between where they are located. Of elderly community based service users around 23% are living in on of the 10% most deprived areas (which it should be remembered, comprise around 20% of the areas in Leeds). For people aged 18-64 the proportion is far higher, with around 30% of service users located in one of the 10% most deprived areas. This suggests a clear correlation between deprivation and need for those aged 18-64.

9.2 Speed of Service Provision

One of the key measurements by which adult social care departments are judged is the speed with which services, having been agreed upon, are subsequently provided. National Indicator NI 133 measures the percentage of new elderly (age 65+) service users receiving services within 28 days of the decision being made to provide such services. During 2007/08 85.3% of new elderly service users received their services within the required 28 days. This is deemed to be 'good' by the Commission for Social Care Inspection, to whom this information is reported. At ward level there were significant differences in the overall number of elderly people receiving services following assessment, varying from a low of 43 in Headingley up to 238 in Middleton Park. Insofar as the timeliness of service provision was concerned variation between wards was significantly greater than at an area level. In Gipton and Harehills 96.5% of people received their services within the designated 28 days compared to 77.0% in Rothwell. As with the direct payment figures these variations suggest that in order to improve performance the authority should be targeting particular areas.
Looking at service provision times by deprivation of the areas in which the person was living the best performance was in the 20% most deprived areas. This perhaps reflects that people living in such areas are often deemed to have the greatest level of need and are therefore responded to more quickly.

9.3 Carers
During the year 2007/08 2,984 carers of people aged 18 or over were offered some form of assessment or review. Of these, 2,300 went on to be offered a service to support them in their caring activities. In 1,005 instances this service took the form of providing a respite placement for the person being cared for, in order to give the carer a break from looking after them.
If one examines the numbers of carers offered a service as a percentage of the number of people living in an area who were in receipt of community based services then this varies from 21% & 19% in the south and west respectively, down to 16% in the north east and north west, suggesting that perhaps carers services should in future be slightly more targeted towards these areas.
Looking at carers receiving services split by deprivation it can be seen that of those carers who were offered a service 401 (17%) were caring for people living in areas deemed to be in the 10% most deprived areas of the country. This compares to the fact that among service users around 25% were living in such areas, suggesting that the authority ought perhaps to concentrate future efforts on encouraging carers for people living in such areas.
This section also details information on direct payments and people supported to live at home

10. Patient and Public Views

As part of the JSNA qualitative data was also analysed .Themes from Health have predominantly come from patient surveys and public perception surveys.
Key issues included: Commissioning of primary care services (in particular more NHS Dentistry and GP out of hours);the top conditions that people say are important are – Heart related diseases, Arthritis, Asthma and depression; people highlight the need for recruitment of more clinical staff (GPs and Nurses);the most important services for people are – Heart failure clinics and Child health services;the results from this years patient survey the PCT scored quite low on (In the last 12 months, have you been asked by someone at your GP practice/health centre about how much alcohol you drink).
Themes identified through the new Local Involvement Network Preparatory Group were existing priorities developed by the previous Patient and Public Involvement Forums.
Further work in future years will be necessary to secure the LINk’s contribution in information the themes for the JSNA process.
The Previous PCT PPI Forum priorities were: access to out of hours and urgent healthcare. Patient Medication Reviews for Elderly Patients ;Oral Health; access to primary care services for deaf and hard of hearing people.
Four other themes have now been identified as current issues.

- Quality in maternity services particularly following the healthcare commission survey for 2007/08
- Discharge from hospital is an ongoing issue for many people, in particular, lack of care packages being in place and lack of communication between organisations
- Accessible information for people with literacy problems
- Access to services and information for vulnerable groups and BME communities

10.1 Voluntary, Community and Faith Sector

Some emerging themes coming from the VCFS have been developed by a sub group of the Leeds Voice Health Forum.
This has been based on the current collated research done across Leeds highlighting a few key areas. This will be developed to give a more comprehensive picture.

- Accessible information on health came out strongly as important to a number of groups including ensuring information is in formats that are easy to read, in appropriate languages and readily available.
- Mental health and support for people and communities suffering from emotional distress was highlighted in a number of areas.
- The quality and attitude of health service staff was highlighted including the need for services to be culturally 'competent'.
- Transport to and from health services was seen as a big issue.

10.2 Leeds Strategic Plan

Finally the themes developed from consultation on the Leeds Strategic Plan focussing on health and wellbeing were taken into account. These were broad ranging and covered all areas of the city and communities of interest.
The top priorities following the outcome of the consultation were:

- Priority 27 – Reduce obesity and raise physical activity for all
- Priority 29 – Promote emotional well-being for all
- Priority 32 – Increase the proportion of vulnerable adults helped to live at home.

It was identified that further work needs to be identified to support a couple of key areas which were not highlighted in the plan's priorities.

- The need for more priorities that promote healthy lifestyles
- The need for more recognition and support for people with mental health issues

11. Emerging questions and themes/analysis

The data pack paints a picture of Leeds as one of two cities with part of the city moving up in terms of economic; social ; and health outcomes whilst a core part (the size of a small town|) experiencing the opposite outcomes. This area (known in the pack as 'deprived Leeds) experiencing outcomes as bad if not worse than those areas identified by the Department of Health as most 'deprived' within England.
Many of the issues addressed in the pack are problems of lifestyle, behaviour, education economic and social circumstances. The emerging themes coming from the scoring exercise demonstrated this.
Influences on health and well being - poverty/low income; housing; education and unemployment- also the economic wellbeing of children
Conditions of ill health – circulatory disease; cancer;
Lifestyle issues - healthy life; alcohol, obesity
One of the key issues is the impact of the changing population which is described in the pack, and also the intra Leeds issues of deprivation, vulnerable groups and broader community well being.

12. Commissioning impact and improved outcomes

The data pack details the underlying scale of the problem but would need to be considered in line with effective interventions, and cost effectiveness intelligence.
The data could lead to two approaches for joint commissioning across the city. Both of which would form part of the new joint commissioning structures.
The first would be within the realm of the priority groups, children and older peoples commissioning groups where joint priorities of those most in need can be agreed and the effective interventions can be identified.
The second is based on a neighbourhood approach to intelligent commissioning. The PCT and LCC have already agreed a focus on the 10% worst SOAs within Leeds. This provides the ideal opportunity to agree neighbourhood plans for meeting the identified needs. A range of the data can be compiled at a neighbourhood level (as per the example with the data

pack). From this data a joint approach to key deliverables and outcomes within each of these neighbourhoods can be agreed.

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Agenda Item 11

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 18 November 2008

Subject: Scrutiny Board (Health) – Work Programme

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

1.0 INTRODUCTION

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

2.0 WORKING GROUPS

2.1 At its meeting in July 2008, the Board established a number of working groups. A summary of activity for each working group is also detailed in Appendix 1.

3.0 RECOMMENDATIONS

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

4.0 BACKGROUND DOCUMENTS

None

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Scrutiny Board (Health)
Work Programme 2008/09

Item	Description	Notes	Type of item
Meeting date – 18 November 2008			
Mental Capacity Act (2005)	To consider the implications and proposed arising from the Mental Capacity Act (2005)	Following on from the Board's October meeting where it considered the impact, implications and proposed response to legislative changes regarding the Mental Health Act (2007).	B
Joint Strategic Needs Assessment (JSNA) - update	To consider an update in the development of a joint assessment that identifies the future needs of the populous of Leeds and any identified service changes/ reconfigurations	Also likely to be reported to the Adult Social Care Scrutiny Board and Children's Services Scrutiny Board.	B
GP-led Health Centre – scrutiny inquiry	To consider an update report from the working group.		
Compensation payments	To consider a report from Leeds Teaching Hospital NHS Trust (LTHT) on the level of compensation payments.	YEP related article: 15 September 2008	

Key:

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

Scrutiny Board (Health)
Work Programme 2008/09

Item	Description	Notes	Type of item
Meeting date – 12 December 2008			
Implications of Lord Darzi's NHS Next Stage Review report 'High Quality Care for All' and current implementation	To consider the implications of the report for the Health Trusts in Leeds and the people they serve.	Input from each of the NHS Trust is required.	
Mental Health Act	To consider an update on the implementation of the Act, including examples of changing clinical pathways		
Improving Sexual Health Among Young People Scrutiny Inquiry	To consider a report on teenage conception and sexual health as part of the Board's inquiry.		
Meeting date – 20 January 2009			
Renal Services	To consider an update on the transport arrangements for renal patients	Invite Dennis Crane – National Kidney Federation	
Performance Management	Quarter 2 information for 2008/09 (July-Sept)	All Scrutiny Boards receive performance information on a quarterly basis	PM

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

Scrutiny Board (Health)
Work Programme 2008/09

Item	Description	Notes	Type of item
Performance Report	To consider the latest performance report considered by the Primary Care Trust Board alongside the outcome of that consideration.	Performance Report presented to the Primary Care Trust Board on 20 November 2008.	PM
Health Proposals Working Group	To consider an update from the working group		
Recommendation Tracking	This item track progress with previous Scrutiny recommendations on a quarterly basis		MSR
Meeting date – 17 February 2009			
Health and Wellbeing Plan	To consider and comment on the draft plan, prior to it being considered by the Executive Board.	Added to the Budget and Policy Framework on 22/5/08(CG&A on 14/5/08) Scheduled to be considered by the Executive Board on 1st April 2009 and Council on 22nd April 2009	DP
Mental Health Act	To consider an update on the implementation of the Act.	Focus on specific work streams (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

Item	Description	Notes	Type of item
Health Proposals Working Group	To consider an update from the working group		
Recommendation Tracking	This item track progress with previous Scrutiny recommendations on a quarterly basis.		MSR
Meeting date – 24 March 2009			
Annual Health Check	To receive and consider the local NHS Trusts self assessment against the 24 “core standards” set by Government under the domains: • Safety; • Clinical and Cost Effectiveness; • Governance; • Patient Focus; • Accessible and Responsive Care; • Care Environment and Amenities; and, • Public Health	Precise timing to be confirmed	PM
Neonatal Services	To consider an update report on the level of service provided and related performance.	The timing of the report may be affected by the outcome / publication of the review being undertaken by the joint NHS Task Group established to look at Neonatal Services across the country.	

Key:

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

Scrutiny Board (Health)
Work Programme 2008/09

Item	Description	Notes	Type of item
Performance Report	To consider the latest performance report considered by the Primary Care Trust Board alongside the outcome of that consideration.	Performance Report presented to the Primary Care Trust Board (to be confirmed).	PM
Meeting date – 28 April 2009			
Renal Services	To consider an update on the transport arrangements for renal patients		
Mental Health Act	To consider an update on the implementation of the Act.	Focus on specific work streams (TBC)	
Performance Report	To consider the latest performance report considered by the Primary Care Trust Board alongside the outcome of that consideration.	Performance Report presented to the Primary Care Trust Board (to be confirmed).	PM
Performance Management	Quarter 3 information for 2008/09 (Oct-Dec)	All Scrutiny Boards receive performance information on a quarterly basis	PM
Health Proposals Working Group	To consider an update from the working group		

Key:

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

Scrutiny Board (Health)
Work Programme 2008/09

Item	Description	Notes	Type of item
Annual Report	To agree the Board's contribution to the annual scrutiny report		

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

Scrutiny Board (Health)
Work Programme 2008/09

Working Groups			
Working group	**Membership**	**Progress update**	**Dates**
Health Proposals	Cllr Grahame Cllr Lamb Cllr McKenna Cllr Rhodes-Cayton Eddie Mack	➢ Initial terms of reference agreed on 22 July 2008 ➢ Revised terms of reference agreed on 16 September 2008 ➢ 8 September 2008 - notes attached for SB meeting held on 21 October 20 ➢ 6 October 2008 - issues discussed included: ▪ Project updates on: o Changes to GP services; o Urgent care services ▪ New Proposals around Older Peoples Mental Health service	*8 Sept. 2008* *6 Oct. 2008* *15 Dec. 2008* *3 Feb. 2009* *30 March 2009*
Improving Young Peoples Sexual Health	Cllr Grahame Cllr Monaghan Cllr Kirkland Cllr McKenna Somoud Saqfelhait	➢ Initially proposed to consider the issue of teenage pregnancy, the Board agreed to expand the scope of this inquiry to cover sexual health among young people in general. ➢ Terms of reference agreed 16 September 2008 ➢ Initial meeting held on 9 September 2008 – notes presented to the SB meeting held on 21 October 2008 ➢ Report scheduled for SB meeting in December ➢ Further working group meeting dates to be confirmed	*9 Sept. 2008*

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

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Working Groups			
GP-led Health Centres	Cllr Grahame Cllr Kirkland Cllr Illingworth Eddie Mack	➢ Initial terms of reference agreed on 22 July 2008 ➢ Initial meetings / discussions held on 19 August 2008 and 21 August 2008. ➢ Summary of information provided by the Director of Primary Care presented to the SB meeting on 16 September 2008. ➢ Consultation analysis report presented to the SB on 16 September 2008 and referred to the working group further consideration. ➢ Site visit and discussion on refurbishment proposals held on 7 October 2008 ➢ ➢ Further working group meeting dates to be confirmed	*19 Aug. 2008* *21 Aug. 2008* *7 Oct. 2008* *(site visit)* *29 Oct. 2008*

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
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Unscheduled / Potential Items		
Item	**Description**	**Notes**
Review of National Blood Service Strategy	At its meeting in July 2008, the Board considered proposed changes to the structure of NHS Blood and Transplant and the specific implications of closing the blood testing and processing centre within Leeds and transferring its operation to other centres in the North of England	The Board is likely to need to re-consider the information provided to date and receive any additional information in order to agree its position on the proposals.
Children's Hospital Services and Clinical Services Reconfiguration	To consider an update on the full business case for the proposed service reconfiguration.	Originally scheduled for November 2008. Likely to be reported in Spring 2009, but the precise timing is to be confirmed
Specialised commissioning arrangements	To consider the current arrangements for specialised commissioning within the region and the role of scrutiny.	

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

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