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Leeds CITY COUNCIL

SCRUTINY BOARD (HEALTH)

Meeting to be held in Civic Hall, Leeds on
Tuesday, 16th February, 2010 at 10.00 am

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

MEMBERSHIP

Councillors

S Bentley	-	Weetwood;
J Chapman	-	Weetwood;
D Congreve	-	Beeston and Holbeck;
M Dobson (Chair)	-	Garforth and Swillington;
D Hollingsworth	-	Burmantofts and Richmond Hill;
J Illingworth	-	Kirkstall;
M Iqbal	-	City and Hunslet;
G Kirkland	-	Otley and Yeadon;
A Lamb	-	Wetherby;
P Wadsworth	-	Roundhay;
L Yeadon	-	Kirkstall;

Co-opted Members

Arthur Giles - Leeds LINk
Vacancy - Leeds Voice

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

Agenda compiled by:
Janet Pritchard
Governance Services
Civic Hall
LEEDS LS1 1UR
Telephone No: 247 4327

Principal Scrutiny Advisor:
Steven Courtney
Tel: 247 4707

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:- **No exempt items or information have been identified on this agenda.**	

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 26th January 2010.	1 - 8
7			**SCRUTINY INQUIRY: THE ROLE OF THE COUNCIL AND ITS PARTNERS IN PROMOTING GOOD PUBLIC HEALTH (SESSION 3)** To consider the attached report of the Head of Scrutiny and Member Development introducing the third session of the Scrutiny Board's inquiry aimed at considering the role of the Council and its partners in promoting good public health, with particular focus this session on issues associated with promoting responsible alcohol consumption and reducing alcohol related harm.	9 - 66
8			**UPDATED WORK PROGRAMME 2009/10** To consider the attached report of the Head of Scrutiny and Member Development presenting an update on current activity and the Board's revised outline work programme for the remainder of the current municipal year, for the Board to consider, amend and agree as appropriate.	67 - 76

Item No	Ward/Equal Opportunities	Item Not Open		Page No
9			**DATE AND TIME OF NEXT MEETING** To note that the next meeting of the Board will be held on 16th March 2010 at 10.00am with a pre-meeting for Board Members at 9.30am.	

SCRUTINY BOARD (HEALTH)

TUESDAY, 26TH JANUARY, 2010

PRESENT: Councillor M Dobson in the Chair

Councillors S Bentley, J Chapman, D Congreve, D Hollingsworth, J Illingworth, M Iqbal, G Kirkland, A Lamb, P Wadsworth and L Yeadon

59 Chair's Welcome

The Chair welcomed everyone to the meeting, and in particular the guests from Calderdale Council: Councillor Ruth Goldthorpe (Chair of Calderdale's Adults, Health and Social Care Scrutiny Panel) and two scrutiny officers, Mike Lodge and Paul Preston, who were attending to observe the work of the Board and to learn how LCC operated health scrutiny in terms of developing scrutiny in Calderdale.

60 Late Items

In accordance with his powers under Section 100B(4)(b) of the Local Government Act 1972, the Chair admitted to the agenda additional information published by NICE entitled 'Promoting physical activity for children and young people' which was relevant to Agenda Item 7 'Scrutiny Inquiry: The role of the Council and its partners in promoting good Public Health (Session 2 – continued)'. (Minute No. 63 refers).

61 Declarations of Interest

In respect of Agenda Item 6 'Minutes of the Previous Meeting and Matters Arising' (Minute No. 62 refers), Councillor Chapman declared a personal interest as a member of her family worked in one of the adult renal wards.

In respect of Agenda Item 7 'Scrutiny Inquiry: The role of the Council and its partners in promoting good public health (Session 2 – continued)' (Minute No. 63 refers), Councillor Illingworth declared a personal interest as a Lecturer at the University of Leeds.

In respect of Agenda Item 9 'Leeds Teaching Hospitals NHS Trust – Foundation Trust Consultation: Scrutiny Board Submission' (Minute No. 65 refers), Councillor Dobson declared a personal interest as a member of Leeds Teaching Hospitals NHS Trust.

62 Minutes of the Previous Meeting

With regard to Minute No. 55 'Renal Services: Statement', the Principal Scrutiny Adviser confirmed that the deadline for a response from the

Secretary of State was imminent. Members of the Board agreed that this matter should be followed up.

With regard to Resolution (c) of Minute No. 54 'Scrutiny Inquiry: The role of the Council and its partners in promoting good public health (Session 2)', the Principal Scrutiny Adviser agreed to follow up the swimming data requested from the Head of Service (Health Initiatives and Wellbeing Team), Education Leeds.

RESOLVED – That the minutes of the meeting held on 15th December 2009 be confirmed as a correct record.

63 Scrutiny Inquiry: The Role of the Council and its Partners in Promoting Good Public Health (Session 2 - continued)

The Head of Scrutiny and Member Development submitted a report introducing the continuation of the second session of the Scrutiny Board's inquiry aimed at considering the role of the Council and its partners in promoting good public health.

The second session of the inquiry was to consider issues associated with reversing the rise in levels of obesity and promoting an increase in the levels of physical activity.

Attached to the report was the following information:

- Action Plan for the Improvement Priorities in the Health and Wellbeing Partnership Plan (2009-2012) of the Leeds Strategic Plan (2008-2011) – Appendix 1
- NICE Public Health Guidance 8 Promoting and creating built or natural environments that encourage and support physical activity – Appendix 2
- Can't Wait – Leeds Childhood Obesity Strategy – Appendix 3
- Adult Obesity – Appendix 4
- House of Commons Select Committee Report on Obesity (published 2004) – Appendix 5

A paper produced by NICE on 'Promoting physical activity for children and young people' was also accepted as an additional paper.

The Chair advised that, due to the length of the debate at the previous meeting, officers from NHS Leeds had been invited back to this January meeting of the Board for Members to hear their contribution.

The following officers from NHS Leeds, Directorate of Public Health, were welcomed to the meeting:

- Janice Burberry, Children and Young Peoples Lead
- Emma Croft, Lead for Obesity, Food and Physical Activity

(NB Brenda Fullard, Head of Healthy Living and Inequalities, arrived later in the meeting.)

The Children and Young Peoples Lead gave the Board a brief update on progress being made in relation to the 'Can't Wait, Leeds Childhood Obesity Strategy', referring to Appendix 3 of the report. She referred to:

- Levels of childhood obesity in Leeds – quoting 1 in 5 reception children being obese, as an example.
- The information provided in the strategy on prevalence, causes and local action needed to help Leeds families be a healthy weight.
- The HENRY (Health Exercise and Nutrition in the Really Young) initiative – which represented a good example of partnership working with Early Years staff.
- Treatment Services, particularly Carnegie Weight Management – Members were advised that, despite recent inaccurate reporting in the local Press regarding insufficient investment from NHS Leeds in this service, 50 places onto the scheme and two family support workers had been commissioned by NHS Leeds. However, the following issues were highlighted:
    - The low number of families coming forward to take up places;
    - Access to fresh food across the City - particularly in deprived areas;
    - Access to physical exercise.
- The Joint Obesity Board which was being set up to co-ordinate and oversee the work of the NHS and partners in this regard.

The Lead for Obesity, Food and Physical Activity gave the Board a brief update on progress being made in relation to combating adult obesity in Leeds and referred to Appendix 4 of the report. Reference was made to:

- NHS Leeds' commitment to delivering Healthy Ambitions Staying Healthy in Yorkshire and Humber Pathway and the five recommendations directly related to obesity.
- Actions in the city wide food strategy 'Leeds Food Matters' and 'Active Leeds a Healthy City'.
- Joint work with adults and children through the healthy weight programme.
- Action to increase cooking skills in the community and the work of Ministry of Food in Kirkgate market, in this regard.
- Action needed to make Leeds a more health orientated city and promoting healthier lifestyles.
- Access to healthy foods and the influence of take-aways in the community.

The Head of Healthy Living and Inequalities advised Members of the:

- Importance of partnership working between NHS Leeds, the City Council and others.
- Massive task to address the determinants around becoming overweight and obese.
- Need to look at the issues with a holistic approach in order to make a positive difference.
- Need to make improvements at a national and international level.
- Key role of City Development in helping to bring about fundamental changes across the City and putting in place new mechanisms to help promote and encourage healthier living.

The Board then discussed the issues around obesity and physical activity with contributions from the NHS officers.

In brief summary, the general issues which were discussed were:

- Whether too much emphasis was put on dealing with the symptoms rather than the root causes.
- The need for a holistic approach to break the poverty cycle and raise people's aspirations.
- The Council's commitment to Narrowing the Gap – inner city areas, lacking in gardens, where most of the unemployed and unskilled workers lived and where there was insufficient public transport to access sports facilities and shops for fruit and vegetables.
- The impact of long working hours on home cooking and access to physical exercise.
- The difficulties of having an impact on some hard to reach groups such as the home educated and people who did not want to participate for religious reasons.
- The need to have the infrastructure in place first (sports centres, playing fields, fruit and vegetable shops etc) in order to then encourage people to use them.

The following issues in brief summary, were also discussed with regard to healthy eating:

- Access to healthy foods rather than unhealthy food, takeaways, cigarettes and alcohol – the Lead for Obesity, Food and Physical Activity advised Members of the mapping work carried out with regard to access to healthy food in certain areas of the city. Shops were available but the range of produce meant it was difficult to eat a healthy balanced diet in some areas. In such circumstances, people would tend to buy the cheapest and most accessible food, including takeaways.
- Healthy eating education – Members perceived this as being good in primary schools but patchy in secondary schools. Officers agreed that raising awareness of healthy eating in secondary schools was important as it was a time when young people were at an impressionable age and starting to make their own choices. This also raised issues of the national perspective of the school curriculum.
- The excessive leafleting by takeaways and the environmental impact that this also had. The belief that there was now saturation of the market for takeaways which had resulted in the extreme amount of leafleting.
- The need to promote breast feeding – officers advised that the NHS had commissioned the National Childbirth Trust for peer support.
- Issues around demand and supply for healthy eating; the role of Planning and Licensing legislation and the limited powers of Councils to restrict certain businesses. Members were advised of the Cumulative Impact Policy in operation in Headingley and the potential opportunities provided by the development of Local Development Plans.
- Larger supermarkets often leading to a smaller number of local shops – with particular reference to some areas of the City, including Holbeck, where local food shops were non-existent.

- Organic food and the amount of space it took to produce, with its price often making it prohibitive to many. The availability of allotments across the city was also discussed.
- Co-operative Supermarkets – officers agreed that stronger partnerships with commercial enterprises could be investigated.
- Intergenerational work - the role of older people passing on skills such as cooking, influencing family custom and supporting mothers with breast feeding.

The following main issues in brief summary, were also discussed with regard to promoting exercise:

- That studies over the past 20 years had recommended increased times for physical activity.
- Reference was made to the additional paper produced by NICE on 'Promoting physical activity for children and young people' and a suggestion was made that this guidance could be incorporated into the Local Development Framework in order to influence planning policy in Leeds.
- The promotion of exercise to hard to reach groups and the need for disability awareness training for tutors.
- Weight Management clinics and the lack of appointments outside of working hours. Members were advised that twilight sessions were being piloted in some parts of the city but appointments were dictated by the opening times of venues and that LCC leisure centres could not be used at peak times.
- The need to consider non-traditional sport and physical activities: Members were advised that, as a result of consultations with young people, officers had learnt that free sports were very popular. It was hoped to obtain more investment for this sport and make better use of the current provision.

In addition, the following examples of healthy eating initiatives were also referred to:

- People with surplus fruit in Chapel Allerton offering it to others.
- Housing Associations teaming up elderly people with gardens with people in flats for instance who wished to garden and where the produce was shared.
- The Holbeck Food Market which was developed as a result of a needs assessment and which was staffed by volunteers and run as a social enterprise.
- The Food Co-op set up by a local champion but which needed more support in order for it to be sustainable in the long-term.

The Chair thanked officers from NHS Leeds for attending the meeting.

With regard to a request by Members for statistical information on healthy outcomes, the Principal Scrutiny Adviser agreed to circulate this information to Members of the Board as soon as practicable and ideally prior to the next meeting.

The Principal Scrutiny Adviser was also able to assure Members that the Board's inquiry report would be produced in time to fit into the development of the Local Development Framework.

RESOLVED –

(a) That the contents of the report and appendices be noted.

(b) That the main issues to come out of this continuation of the second session of the inquiry be included in the Board's final scrutiny inquiry report.

(c) That the Principal Scrutiny Adviser circulate the requested statistical information on healthy outcomes to Members as soon as practicable and ideally prior to the February meeting of the Board.

64 Health Proposals Working Group - Update

The Head of Scrutiny and Member Development submitted a report presenting Members with the draft minutes of the Health Proposals Working Group's first meeting of the municipal year on 3 December 2009 and seeking the Board's endorsement on the proposed actions and recommendations.

The Principal Scrutiny Adviser advised that, due to an earlier request by Members, the Board would be circulated with more detailed information about the work of the Shakespeare Medical Practice and Walk-in Centre and if any issues arose, these would be dealt with at a future meeting of the Board.

RESOLVED –

(a) That the actions and recommendations proposed in the minutes of the Health Proposals Working Group (3rd December 2009) be endorsed by the Scrutiny Board (Health).

(b) That Members of the Board be provided with more detailed information about the work of the Shakespeare Medical Practice and Walk-in Centre.

(Note: Councillor Illingworth left the meeting at 11.55am at the conclusion of this item.)

65 Leeds Teaching Hospitals NHS Trust - Foundation Trust Consultation: Scrutiny Board Submission

The Head of Scrutiny and Member Development submitted a report presenting Members with the Scrutiny Board's submission issued to Leeds Teaching Hospitals NHS Trust, in response to the consultation around the Trust's initial proposals to become an NHS Foundation Trust. Members' approval of the submission was requested.

In brief summary, Members raised the following issues:

- That the consultation was not about whether LTHT NHS Trust would become a Foundation Trust, as this was not optional, but more about what kind of Trust it would become.

- The likely running costs of being a Foundation Trust. (Members noted that this figure had been requested but had not been forthcoming).
- That 'seldom heard' or hard to reach groups were notorious in not taking part in consultations and whether there had been any attempt to consult with small businesses in particular.

The Principal Scrutiny Adviser confirmed that the consultation period had ended but that a request could be made of LTHT NHS Trust to report back to a future meeting of the Board on the process and outcomes of the consultation and on the expected running costs. An additional meeting of the Board could be arranged at the end of this municipal year if this item could not be fitted into the current work programme.

RESOLVED –

(a) That the consultation response as submitted, be formally endorsed by the Scrutiny Board (Health).

(b) That LTHT NHS Trust be invited to a future meeting of the Board to report on the process and outcomes of the consultation and on the expected running costs.

66 Updated Work Programme 2009/10

The Head of Scrutiny and Member Development submitted a report presenting a revised outline work programme for the Board to consider, amend and agree as appropriate.

Attached to the report was the following information:

- Scrutiny Statement - Renal Services in Leeds (December 2009) – Appendix 1
- Letter from the Department of Health – Appendix 2
- Revised outline work programme 2009/10 – Appendix 3
- Minutes of the Executive Board meetings held on 9th December 2009 and 6th January 2010 – Appendices 4 and 5

Steven Courtney, Principal Scrutiny Adviser, drew Members' attention to the information on 'Quality Accounts' contained in the report and sought Members' views on their potential role and the process for submitting these accounts.

It was agreed that the Principal Scrutiny Adviser would hold discussions with health service colleagues with a view to producing a draft submission in March to tie in with performance management reporting.

RESOLVED –

(a) That the contents of the report and appendices be noted.

(b) That the arrangements and revised timetable for completing the scrutiny inquiry around 'The role of the Council and its partners in promoting good public health' be noted.

(c) That the updated information as presented on specific work areas and associated activity be noted.

(d) That the information presented around 'Quality Accounts' be noted and that the Principal Scrutiny Adviser hold discussions with health service colleagues with a view to producing a draft submission to the March meeting of the Board.

(e) That, subject to the above comments and additions, the Work Programme be updated as agreed.

67 Date and Time of Next Meeting

Noted that the next meeting of the Board would be held on Tuesday 16th February 2010 at 10.00am with a pre-meeting for Board Members at 9.30am.

The meeting concluded at 12.10pm.

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 16 February 2010

Subject: Scrutiny Inquiry: The role of the Council and its partners in promoting good public health (Session 3 – promoting sensible alcohol consumption)

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

1.0 Purpose

1.1 The purpose of this report is to introduce the third session of the Scrutiny Board's inquiry aimed at considering the role of the Council and its partners in promoting good public health.

1.2 The third session of the inquiry will focus on promoting responsible alcohol consumption and reducing alcohol related harm.

2.0 Background

2.1 At its meeting on 22 September 2009, the Scrutiny Board (Health) agreed terms of reference for the above inquiry. In this regard, the Board agreed to consider arrangements relating to four specific areas of public health, namely:

- Improving sexual health and reducing the level of teenage pregnancies;
- Reversing the rise in levels of obesity and promoting an increase in the levels of physical activity;
- Promoting responsible alcohol consumption; and,
- Reducing the level of smoking;

2.2 In considering the promotion of good public health, the overall purpose of the inquiry is to make an assessment of the role of the Council and its partners in developing, supporting and delivering targets associated with improving specific aspects of public health.

Health and Wellbeing

2.3 Based on the outcomes and priorities agreed by the Council and its partners, the Health and Wellbeing Partnership Plan (2009 – 2012) is part of the broader Leeds Strategic Plan: It concentrates on the main high level actions necessary to help deliver the agreed strategic outcomes and priorities. These high level actions are detailed in the attached action plan for the improvement priorities (Appendix 1). Actions associated with reducing alcohol related harm are detailed in action plan number 3 in Appendix 1.

2.4 At previous meetings (20 October 2009, 15 December 2009 and 26 January 2010), the Scrutiny Board heard from a range of witnesses relating to other aspects of the Board's inquiry – namely, improving sexual health and reducing the level of teenage pregnancies; and, reversing the rise in levels of obesity and promoting an increase in the levels of physical activity.

House of Commons – Health Committee

2.5 Over recent years, the impact of alcohol consumption on people's health has been the subject of much public debate and formed the basis of a number of reports – including over 20 scrutiny inquiry reports[1]. Most recently, in January 2010 the House of Commons Health Committee (select committee) published a report on Alcohol, which considered a number of aspects including education, marketing and licensing.

2.6 The summary statement and other extracts from that report are attached at Appendix 2.

The National Institute for Health and Clinical Excellence (NICE)

2.7 At its meeting on 15 December 2009, the Scrutiny Board was advised of the work of NICE – as the independent organisation responsible for providing national guidance on promoting good health and the prevention and treatment of ill health.

2.8 The following public health and clinical guidance relating to alcohol has been produced:

- School based interventions on alcohol (PH7) – attached at Appendix 3
- Antenatal Care (CG62).

2.9 It should also be noted that the following guidance is currently under development:

- Personal, social and health education focusing on sex and relationships and alcohol education;
- Alcohol use disorders – preventing harmful drinking;
- Alcohol use disorders – clinical management;
- Alcohol dependency and harmful alcohol use;
- Pregnancy and complex social factors

[1] Reports published and accessible through the library of scrutiny reports detailed on the Centre for Public Scrutiny website:
http://www.cfps.org.uk/scrutiny-exchange/library/search-library/index.php?start=3&search=1&lib_issue=7&lib_title=alcohol&lib_region=&lib_la=&lib_year=&lib_org=&lib_stage=Complete

NHS Yorkshire and the Humber – Health Ambitions

2.10 Healthy Ambitions (published in May 2008) is a five to ten years strategic service framework for the Yorkshire and Humber region. Healthy Ambitions identifies the following pathways, which represent a significant programme to be delivered both regionally and locally:

- Staying Healthy
- Maternity and the Newborn
- Long term conditions
- Children
- Planned Care
- Acute Episode
- Mental Health
- End of Life

2.11 Delivering Healthy Ambitions (published in March 2009) sets out the overall framework for delivery across Yorkshire and Humber region. In particular, this identifies those areas that need to be taken forward regionally and those which need to be taken forward locally.

2.12 The Staying Healthy Clinical Pathway Group identified that the 3 biggest threats to health over the next decade across the Yorkshire and Humber region are:

- Alcohol abuse
- Rising levels of obesity
- Smoking

2.13 A summary of the recommendations associated with the Staying Healthy Pathway is attached at Appendix 4.

3.0 The role of the Council and its partners in promoting good public health: Session 3 – promoting responsible alcohol consumption

3.1 In line with the agreed terms of reference, the aim of this part of the inquiry is to consider issues associated with promoting responsible alcohol consumption, such as:

- The role of the Council in terms of licensing policy and associated enforcement/ control procedures.
- The role of the Council and its NHS health partners in developing and delivering an alcohol strategy that:
    - Raises general public awareness of the health risks associated with alcohol consumption.
    - Identifies and targets those groups most at risk from the affects of alcohol abuse, ensuring they have access to the most appropriate services and treatments.
    - Assesses the quality and effectiveness of services and treatments associated with reducing alcohol related harm.
- The social responsibility role of breweries, retailers and licensees and how this shapes the consumption of alcohol in Leeds.

3.2 A briefing note, providing information regarding the role of the Licensing Authority (Leeds City Council) under the Licensing Act 2003, is provided at Appendix 5.

3.3 A number of representatives from the Council and it partners have been invited to attend this session of the Board's inquiry.

4.0 Recommendations

4.1 Members are asked to consider the details presented in this report and associated appendices, and those matters discussed at the meeting and:

(i) Identify any specific areas/ issues to be included in the Board's scrutiny inquiry report; and,

(ii) Determine any specific matters where additional information may be required and/or where further scrutiny may be needed.

5.0 Background Documents

House of Commons Health Committee - Alcohol – first report of session 2009/10 (January 2010).
NHS Yorkshire and the Humber: Delivering Healthy Ambitions: Update on Acute Pathway and SHA Work Programme for 2009/10 (July 2009)
NHS Yorkshire and the Humber – Delivering Health Ambitions (March 2009)
High Quality Care for All – NHS Next Stage Review final report (June 2008)
NHS Yorkshire and the Humber – Health Ambitions (May 2008)

Improvement Priorities

Improvement priorities

The agreed improvement priorities for health and wellbeing are:

1. Reduce premature mortality in the most deprived areas.
2. Reduce the number of people who smoke.
3. Reduce alcohol related harm.
4. Reduce rate of increase in obesity and raise physical activity for all.
5. Reduce teenage conception and improve sexual health.
6. Improve the assessment and care management of children, families and vulnerable adults.
7. Improve psychological, mental health, and learning disability services for those who need them.
8. Increase the number of vulnerable people helped to live at home.
9. Increase the proportion of people in receipt of community services enjoying choice and control over their daily lives.
10. Improve safeguarding arrangements for vulnerable children and adults through better information, recognition and response to risk.

Notes

For each improvement priority the attached table gives the following information:

- the jointly accountable directors, the key partnerships, strategic leads and the related strategies;
- the national indicators and targets together with the measures of success that are being used;
- an overview of the main areas for action over the next three years. This is not intended to duplicate the detailed individual strategies and action plans which are signposted so that further details can be found.

These action plans will inform the performance management process for the Leeds Strategic Plan. The action plans and outcomes will be reviewed and updated annually. Following a preliminary Equality Impact Assessment in April 2009, further work will be undertaken to define issues and actions for the different equality strands (race, gender, disability, sexual orientation, age, religion or belief.) This process will be informed by continuous self-assessment and developments will be formally included in the annual refresh.

1. Reduce premature mortality in the most deprived areas

Accountable Directors and Key Partnerships	Lead and contributing partners
Ian Cameron / Sandie Keene Healthy Leeds Joint Strategic Commissioning Board – Promoting Health and Wellbeing Subgroup **Rosemary Archer/Sarah Sinclair** Children Leeds Integrated Strategic Commissioning Board	**NHS Leeds** Leeds City Council Leeds Partnership Foundation NHS Trust Leeds Teaching Hospitals NHS Trust VCF sector through Leeds Voice Health Forum Natural England West Yorkshire Fire and Rescue Service
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Brenda Fullard, NHS Leeds John England, Leeds City Council Sharon Yellin, NHS Leeds	**Infant Mortality Action Plan 2009** **Leeds The Leeds Children and Young People's Plan 2009 to 2014** **Leeds Tobacco Control Strategy 2006 to 2010** **Food Matters: a food strategy for Leeds 2006 to 2010** **Active Leeds : a physical activity strategy 2008 to 2012** **Accident Prevention Framework 2008 to 2011** **Older Better 2006 to 2011** **Alcohol Strategy 2007 to 2010** **Self Care Strategy 2009** Leeds Housing Strategy 2009 to 2012 Leeds Affordable Warmth Strategy 2007 to 2016 Leeds Financial Inclusion Project

1. Reduce premature mortality in the most deprived areas

Indicators and targets	Measures of success
NI 120 All Age All Cause Mortality rate per 100,000 Disaggregated to narrow the gap between 10% most deprived SOAs and all of Leeds) **Baseline 2001 -2003** *(for population living in 10% most deprived SOAs)* Men Women 1178 692 **3 year target trajectory for 2010 -2012** *(for population living in 10% most deprived SOAs)* Men Women 918 602 *For Leeds as a whole* Men Women 662 463 Citywide target 472 per 100,000 **NI 121 Mortality rate from circulatory diseases at ages under 75 (per 100,000 population)** Baseline 145 per 100,000 population (1995-7) Target 69.3 per 100,000 population (2010-11)	• Further reduction in the proportion of children living in poverty • 1200 families in fuel poverty will have been referred into a programme for improving warmth in their home • Wider availability of quality, affordable housing • Clear city wide framework for development in place and clear expectations for community provision fulfilled in deprived areas. • Improved learning outcomes and skill levels • More engaged and informed better designed programmes **By 2013 in Leeds as a whole:** • 603 people will have been prevented from having an early death • The infant mortality rate will have been reduced from 8 deaths per 1000 to 7 per 1000 • 75,000 women will have been screened for breast cancer. • All women in Leeds will be receiving cervical screening results in 14 days • We will have reduced the number of people under 75 dying from Cardio Vascular Disease by 269 • 349,000 People aged over 40 will have had a vascular check of whom 70,000 People will receive clinical interventions to reduce their risk of becoming unwell **By 2013 in the most deprived areas of Leeds** • 344 people will have been prevented from having an early death • 147 lives will be saved from people under 75 dying from cancer • 109,000 people aged over 40 will have had a vascular check of whom 22,000 will receive clinical interventions to reduce their risk of becoming unwell • We will have prevented 157 people under the age of 75 from dying prematurely from Cardio Vascular Disease **In the most deprived areas of Leeds** • increased percentage of people who are successful in achieving lifestyle behaviour changes (weight management/healthy eating/ smoking cessation/alcohol harm reduction/increased physical activity) • increased percentage of people who engage with local processes and feel they can influence decisions in their locality • environment created for a thriving third sector

1. Reduce premature mortality in the most deprived areas

High Level Actions 2009 - 2012

Influences on health:

- Develop and expand our programme of work on key influences on health such as housing, low income, skills and employment, transport system and the availability of facilities for people to be active.
- Issue a revised housing strategy aimed at creating opportunities for people to live independently in quality and affordable housing.
- Implement fuel poverty action plan and co-ordinate other winter deaths initiatives.
- Promote financial inclusion adapted to the effects of recession.
- Develop a strategic Child Poverty action plan delivering a range of coordinated services to enable families to move out of poverty.
- Improve access to quality early years resources.
- Improve educational achievement for children and young people in disadvantaged areas and from vulnerable groups.
- Complete Planning Policy Guidance 17 - 'Planning for open space, sport and recreation' assessment, ensuring that gaps in provision are identified and appropriate standards for new facilities are implemented.

Lives people lead:

- Action on key behaviour changes which have a high impact on life expectancy; these to include providing systematic brief interventions; marketing materials and peer / community engagement.
- Develop work around smoking, targeted at the worst 10% deprived neighbourhoods *(see Improvement Priority 2)*.
- A targeted programme of work around alcohol *(see Improvement Priority 3)*
- Programmes addressing obesity, physical activity and healthy eating *(see Improvement Priority 4)*.
- Promote Healthy Ageing with the direct involvement of older people.

Services people use:

- Develop Healthy Living services within neighbourhoods (weight management/smoking cessation/alcohol brief interventions/health trainers) and broader poverty/well being services.
- Implement a comprehensive social marketing approach to Putting Prevention First (vascular check for those between 40-75).
- Interventions to target circulatory diseases including increasing the number of smoking quitters and improved blood pressure and cholesterol control.
- Develop an action plan to ensure equitable access to primary care services for vulnerable groups.
- Work with Practice Based Commissioning to ensure these high impact interventions happen in the 10% most deprived neighbourhoods.
- Implement the Self Care Framework to ensure that individuals are enabled, empowered and supported to self care and that professionals have the relevant knowledge and expertise to promote and deliver self care approaches.
- Develop a programme of initiatives at LTHT in order to utilise that setting to address issues around alcohol, smoking and weight management, and to ensure the equitable provision of CHD, cancer and respiratory care secondary services.
- Develop targeted cancer programmes and increase uptake and awareness in areas of low uptake, high deprivation and within vulnerable groups.
- Implement the Leeds Strategic Maternity Matters and Infant Mortality Action Plans and associated initiatives.

Community development and involvement:

- Develop local infrastructures where partners engage with residents, particularly those 'seldom seen, seldom heard' in services.
- Involve communities, groups and individuals in the preparation and, when appropriate, delivery of health improvement programmes.
- Improve health literacy and provide motivation and support for appropriate health-seeking behaviour.
- Support growth and development of quality local services and community development by the Voluntary, Community & Faith sector.

2. Reduce the number of people who smoke

Accountable Directors and Key Partnerships	Lead and contributing partners
Ian Cameron / Sandie Keene Healthy Leeds Joint Strategic Commissioning Board – Promoting Health and Wellbeing Subgroup	**NHS Leeds** Leeds City Council Leeds Partnership Foundation NHS Trust Leeds Teaching Hospitals NHS Trust VCF sector through Leeds Voice Health Forum
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Brenda Fullard, NHS Leeds John England, Leeds City Council	**Leeds Tobacco Control Strategy 2006 to 2010** **The Leeds Children and Young People's Plan 2009 to 2014** **Infant Mortality Action Plan 2009**

2. Reduce the number of people who smoke

Indicators and targets	Measures of success
NI 123 Stopping smoking (target disaggregated to narrow the gap between 10% most deprived SOAs and the rest of Leeds)	• contribute to the overall reduction in adult and infant mortality rates and to increasing life expectancy by - helping 22,000 people to stop smoking by 2013 - Protecting non-smokers
Baseline (2004) 31% smokers in the Leeds population	• Increase in the rate of smoking cessation in women of child bearing age • Reduce smoking in pregnancy rate by 2 percentage points by 2010 • Increase in the rate of prisoners who quit smoking with NHS Stop Smoking Services in the prison setting
Target (2010-11) 21% smokers in the Leeds population 27% smokers in 10% most deprived SOAs	• By 2013 in practices with 30% or more of their population living in the 10% most deprived SOAs: 7% of registered smokers will be referred to smoking services per year
Vital signs VSB05 4 weeks smoking quitters who attended NHS Stop Smoking Services.	• There will be community based healthy living programmes and activities available in the 50% of the 10% SOAs by 2013
Target 2010/11 4345 people stopping smoking with NHS Stop Smoking Services	

2. Reduce the number of people who smoke

High Level Actions 2009 - 2012

Influences on health:

- Make sure that local capacity for delivery of the tobacco programme and tobacco control is strengthened and sustained.
- Maintain compliance across the city with smoke free legislation.
- Maintain and promote smoke free environments not included within the boundaries of smoke free legislation.
- Contribute to, and develop, local response to national and regional media campaigns to promote all elements of tobacco control work including: access to support for smoking cessation, promotion of smoke free homes and campaigns to reduce the availability of smuggled and illicit tobacco products.
- Gather and use comprehensive data (e.g. prevalence among the general population, specific target groups such as pregnant women and access to smoking cessation services) to inform tobacco control and commissioning of smoking cessation services.

Lives people lead:

- Review the schools pilot programme to reduce uptake of smoking amongst teenagers, further develop if necessary and deliver particularly in the most deprived areas.
- Deliver high impact actions to reduce smoking before, during and after pregnancy, including:
  - Promoting smoking cessation to women of child bearing age and link with the city wide infant mortality action programme.
  - Reaching pregnant smokers as soon as possible and throughout pregnancy.
  - Supporting pregnant women to stop smoking throughout pregnancy.
- Explore the feasibility of extending smoke free to public areas.
- Further extend the Smoke Free Homes Project, particularly in the most disadvantaged areas.

Services people use:

- Commission further smoking cessation services in new settings to increase the accessibility of services including: hospitals, workplaces and prisons.
- Focus the specialist element of services in the most deprived communities.
- Review current stop smoking services for specific groups e.g. South Asian Communities, pregnant women and consider recommendations for further development.
- Work with health care professionals to ensure the issue of smoking is raised in a systematic and routine manner and effective referral pathways are developed and maintained.

Community development and involvement:

- Develop work with communities around reducing accessibility to tobacco products and particularly counterfeit and smuggled tobacco products.
- Commission Voluntary, Community and Faith sector to deliver Healthy Living Activity that includes signposting to smoking cessation support and the provision of activities to support behaviour change.
- Engage service users and potential service users in the development of community based delivery of smoking cessation interventions.

3. Reduce alcohol related harm

Accountable Directors and Key Partnerships	Lead and contributing partners
Ian Cameron / Sandie Keene / Neil Evans Healthy Leeds Joint Strategic Commissioning Board – Promoting Health and Wellbeing Subgroup Safer Leeds/ Healthy Leeds Alcohol Board	**NHS Leeds** Leeds City Council Leeds Partnership Foundation NHS Trust Leeds Teaching Hospitals NHS Trust Voluntary, Community and Faith sector through Leeds Voice Health Forum
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Brenda Fullard, NHS Leeds John England, Leeds City Council Jim Willson, Leeds City Council	**Leeds Alcohol Strategy 2007 to 2010** **Safer Leeds Partnership Plan 2008 to2011** The Leeds Children and Young People's Plan 2009 to 2014

3. Reduce alcohol related harm

Indicators and targets	Measures of success
NI 39 Hospital admissions for alcohol related harm Reduce the increase in the rate of alcohol-related hospital admission by at least 1% per year	• Reduced economic loss due to alcohol • Increased understanding of the culture of alcohol use across the population of Leeds • Reduced number of prisoners needing alcohol detoxification programmes in prisons • Fewer people will perceive drunk and rowdy behaviour to be a problem • Reduced alcohol-related harm experience among children, young people and families • Reduction in alcohol-related crime and disorder and hospital admissions

3. Reduce alcohol related harm

High Level Actions 2009 - 2012

Influences on health:

- Reduce the rate of alcohol related crime and disorder, anti-social behaviour and domestic abuse.
- Promote responsible management of licensed premises through effective implementation of the Licensing Act 2003 and encourage the licensing authority to consider safeguarding issues for children and young people.
- To have data in place that will be able to demonstrate:
  - the alcohol related recorded violent crime;
  - the percentage of cases where alcohol use is linked to offending;
  - the percentage of domestic violence where alcohol is a contributing factor;
  - the use of alcohol in young people aged under 18; and
  - the rate of alcohol- specific hospital admissions in under 18s.
- Tackle domestic violence linked to the misuse of alcohol.

Lives people lead:

- Improve the quality of, and have a consistent approach to, alcohol education provision in school and non-educational settings.
- Enable parents and carers to discuss the issue of alcohol consumption with their children.
- Target vulnerable children (i.e. those excluded from school) and work with youth services.
- Ensure that support is available, in terms of housing, to those who misuse alcohol.
- Develop a communication plan about alcohol so that the population of Leeds can make informed choices about their alcohol use and shift attitudes to harmful drinking.
- Target high-risk health settings, such as primary care, A&E departments, mental health settings, sexual health settings, maternity services and older people's services.
- Provide individuals who want, or need, to reduce their alcohol consumption with self-help guides.
- Promote activity and policy change towards reducing the promotion, accessibility and availability of alcohol.
- Implement the National Youth Alcohol Action plan.

Services people use:

- Promote a model of prevention which fully addresses alcohol issues throughout the education system.
- Increase the number of staff working in health, social care, criminal justice, community and the voluntary sector who are trained to identify alcohol misuse and offer brief advice.
- Develop strategies for prisoners in Leeds district with alcohol related problems.
- Develop a programme of activities to reduce the level of alcohol related health problems, including alcohol related injuries and accidents, and to improve facilities for treatment and support.
- Ensure that a co-ordinated, stepped programme of treatment services for people with alcohol problems is effective, appropriate and accessible, with adequate capacity to meet demand, following the 4 tiered framework from Models of Care for Alcohol Misusers
- Increase in the number of high risk groups (offenders, people with mental health conditions, people admitted to A&E and/or hospital with alcohol-related disease) who are assessed, offered brief interventions and where appropriate referred to alcohol treatment services.
- Have a well informed workforce equipped to provide information on the effects of substance misuse, including smoking.

Community development and involvement:

- Develop work with communities around reducing promotion and accessibility of alcohol products.
- Develop the young people led alcohol minimisation action plan.
- Ensure commissioning of Voluntary, Community and Faith sector around healthy living activity includes signposting to services that support reduction in alcohol harm and the provision of activities to support behaviour change.
- Engage service users and potential service users in the developing community based delivery of alcohol treatment interventions.

4. Reduce rate of increase in obesity and raise physical activity for all

Accountable Directors and Key Partnerships	Lead and contributing partners
Rosemary Archer Children Leeds Integrated Strategic Commissioning Board **Ian Cameron / Sandie Keene** Healthy Leeds Joint Strategic Commissioning Board – Promoting Health and Wellbeing Subgroup	**Leeds City Council** Children Leeds Partners NHS Leeds Sport England Education Leeds Youth Sports Trust VCFS Sector
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Sarah Sinclair, NHS Leeds/ Leeds City Council John England, Leeds City Council Brenda Fullard, NHS Leeds	**Active Leeds : a Healthy City 2008 to 2012** **Taking the Lead: strategy for sport and active recreation in Leeds 2006 to 2012** **Food Matters: a food strategy for Leeds 2006 to 2010** **Leeds Childhood Obesity Strategy 2001 2016** **Adult Obesity Strategy (in preparation)** **Leeds School Meals Strategy Jan 2007** **The Leeds Children and Young People's Plan 2009 to 2014** Local and West Yorkshire Transport Plans & Cycling Strategy Parks and Green Space Strategy 2009 Leeds Play Strategy 2007 Older Better 2006 to 2011

4. Reduce rate of increase in obesity and raise physical activity for all

Indicators and targets	Measures of success
NI 57 Children and young people's participation in high quality PE and sport Baseline 91% 2007/08 Target 93% 2009/10' **NI 8** Adult participation in sport and active recreation Baseline 20.6% 2005/06 Target 21.6% March 2011	• Halt, by 2010 (from the 2002-04 baseline) the year-on-year increase in obesity among children under 11 • Reduce rate of increase in obesity in adults • More children eating healthily and participating in play, cultural activities and quality physical exercise programmes • More people of all ages participating in walking, cycling and general activities • Increase in the number of disabled people accessing sport and active recreation programmes • Improved uptake of quality sport and active recreation opportunities including those provided by provided by Leeds City Council Sport and Active Recreation Service, • Increased number of people who have an average consumption of a variety of fruit and vegetables of at least five portions per day • More mothers breastfeeding (2% annual increase) • Systematic health checks are provided in primary care for childhood and adult obesity linking to interventions provided by a variety of providers • Increase in accessible weight management services, targeted to those already obese and most at risk • More people (including older people and disabled people) taking up healthy living opportunities in care programmes or self-directed care • Developed programmes to increase physical activity levels in priority areas

4. Reduce rate of increase in obesity and raise physical activity for all

High Level Actions 2009 - 2012

Influences on health:

- Ensure that planning for the built environment, green spaces and transport encourage a more active lifestyle, complemented by attention to disability issues and to safety.
- Introduce flexibilities in planning arrangements and urban design to manage the proliferation of fast food outlets and tackle issues of poor food access.
- Complete Planning Policy Guidance 17 - 'Planning for open space, sport and recreation' assessment, ensuring that gaps in provision are identified and appropriate standards for new facilities are implemented.
- Implement the delivery plan for the 'Active Leeds: a Healthy City' strategy.
- Ensure a co-ordinated approach to food work to develop effective communication and promote consistent healthy eating messages using principles of social marketing.
- Work with employers to promote healthy eating (including LCC / NHS Leeds) and business sign up to healthy workplace programmes.
- Increased achievement of Healthy Food Mark Standard or equivalents.
- Ensure the public sector addresses issues of healthy eating, safe and sustainable food and malnutrition within its catering arrangements and food provision.

Lives people lead:

- Ensure regular physical activity is sustained beyond 16 years+.
- Increase the number of trips made by walking and cycling ensuring that safety is taken into account.
- Increase the number of older people taking part in regular physical activity.
- Expand opportunities for disabled people to lead an active life.
- Improve people's ability to choose and obtain healthy food that meets nutritional requirements that are right for their stage of life.
- Commission healthy eating cooking skills and food access programmes for targeted neighbourhoods and community groups.
- Use the National Change 4 Life social marketing programme to support and empower people to make changes to diet and activity.
- Develop and implement Leeds Strategic Maternity Matters action plan and Breastfeeding Strategy.

Services people use:

- Ensure there are appropriate pathways to identify and manage overweight and obese individuals linking to a variety of agencies.
- Invest in Putting Prevention First programmes in primary care.
- Developing healthy living services within neighbourhoods including weight management services.
- Develop further joint health and physical activity programmes for people experiencing poor health, or in danger of developing poor health to change their lifestyles and become healthy.
- Develop and implement a range of physical activity training programmes and opportunities including free swimming for young people and older people from April 2009.
- Develop healthy eating programmes within priority neighbourhoods and encourage adoption of healthy eating principles in community based facilities (all sectors).
- Implement School Meals and Packed Lunch strategies.
- Promote the use of Active Leeds Physical Activity Tool Kit.
- Ensure a proactive workforce with knowledge and skills to address healthy behaviour change including using consistent messages around behaviour change, healthy weight, balanced diet and physical activity.
- Embed the practice of screening for malnutrition in facilities and in the community by health, social care and community service providers and professionals.
- Support a range of organisations to promote and provide practical support around health lifestyle messages around being a healthy weight, eating a balanced diet and increasing physical activity.

Community development and involvement:

- Ensure user involvement in the development and continuation of all programmes and services relating to food, physical activity and weight management.
- More participants in food and exercise activities commissioned from local organisations especially in target areas.
- Voluntary, Community and Faith sector agencies commissioned to develop physical activity opportunities within a community development approach.

5. Reduce teenage conception and improve sexual health

Accountable Directors and Key Partnerships	Lead and contributing partners
Rosemary Archer Children Leeds Integrated Strategic Commissioning Board – Teenage Pregnancy and Parenthood Board **Ian Cameron / Sandie Keene** Healthy Leeds Joint Strategic Commissioning Board – Promoting Health and Wellbeing Subgroup	**Leeds City Council** Children Leeds Partners NHS Leeds Education Leeds Leeds Teaching Hospitals NHS Trust VCF sector through Leeds Voice Health Forum
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Sarah Sinclair, NHS Leeds/ Leeds City Council Victoria Eaton, NHS Leeds John England, Leeds City Council	**Teenage pregnancy and parenthood strategy 2008 to 2011** **Sexual health strategy 2009 to 2014** The Leeds Children and Young People's Plan 2009 to 2014 Alcohol Strategy 2007 to 2010

5. Reduce teenage conception and improve sexual health

Indicators and targets	Measures of success
NI 112 Under 18 conception rate *disaggregated to focus on the 6 wards in the city with the highest rates of conception* **Baseline (1998)** 50.4 per 1000 girls aged 15-17 **Leeds 2006 rate** 50.7 per 1000 girls aged 15-17 **Target (2009/10)** Target rate 42.7 per 1,000 girls aged 15-17 *Based on 15% reduction in 6 wards with highest conception rate* **Vital Signs** Guaranteed access to a GUM clinic within 48 hours of contacting a service	• Fewer unplanned pregnancies • Gonorrhoea infections reduced by 15% • Fewer girls under 18 conceiving • 217,000 people aged 15 – 24 will have been screened for Chlamydia • 10% increase year on year in number of STI and HIV tests in non GUM settings • 90% of gay men accessing all sexual health services will receive a hepatitis B vaccine

5. Reduce teenage conception and improve sexual health

High Level Actions 2009 - 2012

Influences on health:

- Campaigns to target the general population of Leeds to reduce stigma related to sexual health.
- Increase positive work with the local media.

Lives people lead:

- Develop a communications plan for both young people, adults and professionals and links between sexual health and teenage pregnancy work.
- Develop local teenage pregnancy data and set up system for sharing data across agencies.
- Review existing provision of Sex and Relationship Education within educational and non-educational settings.
- Increase parents' confidence to discuss sexual health and relationship issues.
- Review impact of transition from Youth Service Health Education Team to generic services.
- Deliver programme of improving skills, knowledge, confidence, aspirations and empowering the most vulnerable to sexual health.
- Increase programmes developing skills and knowledge of gay men, young people and African and African Caribbean communities.
- Support the health and wellbeing for those living with HIV and AIDS.

Services people use:

- Ensure access to local services that are integrated, holistic and sensitive and appropriate to people from different backgrounds.
- Develop single access point for all sexual health services.
- Increase access to and improve knowledge of contraception.
- Increase access to emergency contraception and improve the uptake of contraception post pregnancy or terminations.
- Support for parents and carers on talking to children about sex and relationship issues at Children's Centres.
- Expand the Chlamydia screening programme.
- Ensure screening programmes are accessible and acceptable to target groups.
- Ensure prevention is integral to all clinical services.
- Increase HIV testing in a range of settings.
- Increase service provision in deprived areas, through GP practices, pharmacies, prisons.
- Improve the skills and knowledge of professionals in offering all forms of contraception and STI and HIV testing, STI treatment and sex and relationships education.
- Increase access to HIV treatment for gay men and African communities.
- Review existing services against the needs and identify gaps.

Community development and involvement:

- Increase community based and outreach initiatives with vulnerable groups.

6. Improve the assessment and care management of children, families and vulnerable adults

Accountable Directors and Key Partnerships	Lead and contributing partners
Rosemary Archer Children Leeds Integrated Strategic Commissioning Board **Sandie Keene / Jill Copeland** Healthy Leeds Joint Strategic Commissioning Board – Priority Groups sub-group	**Leeds City Council** NHS Leeds Leeds Partnership Foundation NHS Trust Leeds Teaching Hospitals NHS Trust VCF sector through Leeds Voice Health Forum Children Leeds partners
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Jackie Wilson, Leeds City Council Dennis Holmes Leeds City Council Carol Cochrane, NHS Leeds	**Adult Social Care Service Plans** **The Leeds Children and Young People's Plan 2009 to 2014** **Putting People at the Centre (Learning Disability Strategy) 2009 to 2012** Carers Strategy for Leeds 2009

6. Improve the assessment and care management of children, families and vulnerable adults

Indicators and targets	Measures of success
NI 132 Timeliness of social care assessment (all adults) Baseline 80.9% 2010-11 Target 90.0% 2007 **NI 133** Timeliness of social care packages following assessment (all adults) Baseline 85% 2010-11 Target 95.0% **NI 63** Stability of placements of looked after children: length of placement Baseline 70.5% 2010-11 Target 80.0% **NI 66** Looked after children cases which were reviewed within required timescales Baseline 60.2% 2009-10 Target 90.0%	• More people, especially with long term conditions, are able to lead independent lives • Appropriate support for vulnerable adults • Carers receive appropriate and timely support • Improved patient and carer experience • Young adults are fully supported in transitions between services, especially on entering adulthood

6. Improve the assessment and care management of children, families and vulnerable adults

High Level Actions 2009 - 2012

Lives people lead:

- Improve the awareness of the needs of carers.
- Increase the number of carers who receive a health check.

Services people use:

- Provide efficient and effective out of hours service and redesign care management process.
- Reduce delayed transfers of care.
- Improve outcomes for people from BME backgrounds.
- Improve outcomes for people with personality disorders.
- Improve outcomes for young people who have committed offences.
- Ensure arrangements are in place for protecting vulnerable people from abuse through improved assessment and care management.
- Implement self directed support pilot for the full range of client groups.
- Improve care planning for young people in transition by creating a joint team from both Children's and Adult Social Care.
- Embed the Common Assessment Framework for children and young people in Children's Services to provide early assessment and multi-agency actions centred around individual children and young people's needs.
- Undertake regular reviews for vulnerable people and their carers.

Community development and involvement:

- Involve and engage service users and carers.
- Involve voluntary, community and faith sector.
- Ensure the availability of advocacy for vulnerable people.

7. Improve psychological, mental health, and learning disability services for those who need them

Accountable Directors and Key Partnerships	Lead and contributing partners
Sandie Keene / Jill Copeland Healthy Leeds Joint Strategic Commissioning Board – Priority Groups sub-group **Rosemary Archer** Children Leeds Integrated Strategic Commissioning Board	**Leeds City Council** NHS Leeds Leeds Partnership Foundation NHS Trust Children Leeds Partners Leeds Colleges VCF sector through Leeds Voice Health Forum
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Dennis Holmes, Leeds City Council John Lennon, Leeds City Council Carol Cochrane, NHS Leeds Jackie Wilson, Leeds City Council	**Leeds Mental Health Strategy 2006 to 2011** **Leeds Emotional Health Strategy 2008 to 2011 (CYP)** **Putting People at the Centre (Learning Disability Strategy) 2009 to 2012** **Social Inclusion and Mental Health Strategy (in preparation)** The Leeds Children and Young People's Plan 2009 to 2014 Carers Strategy for Leeds 2009

7. Improve psychological, mental health, and learning disability services for those who need them

Indicators and targets	Measures of success
NI 58 Emotional and behavioural health of looked after children (new indicator) **NI 130** Social Care Clients receiving self-directed support Target 30% take up of self directed support options by March 2011 **VSCO2** Proportion of people with depression and/or anxiety disorders who are offered psychological therapies. Targets and milestones to be determined by March 2009	• People from all backgrounds get timely and appropriate care • Individuals feel valued and included • Improved access to appropriate housing for vulnerable groups • Learning disabled people enjoy better health • Learning disabled people with complex health needs receive effective and person centred treatment care and support provided locally • Learning disabled people and their carers benefit from accessible and person centred services with specialist health supports in primary and secondary care • More people using and enjoying mainstream facilities • Evidence of more personalised care and support • Earlier intervention to reduce risk of crisis • More rapid and effective recognition and support for people suffering anxiety and depression. • Number of people accessing dementia services

7. Improve psychological, mental health, and learning disability services for those who need them

High Level Actions 2009 - 2012

Influences on health:

- Reduce stigma and discrimination.
- Increase opportunities to access employment and meaningful education.
- Improve access to arts and leisure activities.
- Ensure vulnerable groups to have access to a range of housing opportunities.

Lives people lead:

- Develop services from community based locations with partners and reduce reliance on use of segregated buildings.
- Increase choice and control in support including increasing the take up of self directed support and individualised budgets.
- Implement Mental Health First Aid training for employers.
- Recognise needs of more mobile population by providing appropriate support including city centre changing places.

Services people use:

- Undertake options appraisal of models of integrated care.
- Transform mental health and learning disability day services.
- Ensure people with learning disabilities have health checks and Health Action Plans.
- Develop capacity of primary and secondary health services to meet the needs of people with learning disabilities.
- Improve access, uptake and information on health and health services, by developing accessible information.
- Review specialist health services for people with learning disabilities with continuing treatment needs and develop service model.
- Implement Independent Living Project to promote social inclusion through procuring a range of housing options in local communities and transforming care and support services.
- Development of Primary Care Mental Health Services to eradicate age discrimination.
- Joint Transitions Team for children & young peoples social care and adult social care in place by March 2010.
- Implementation of Dual Diagnoses Strategy (substance use and mental health).
- Expand services in primary care to increase access to psychological therapies for people with common mental health problems.
- Improve access to early intervention services.
- Improving public and professional awareness of Dementia.
- Improve early diagnosis and intervention for people with Dementia.
- Improved quality of life and support for people with Dementia.
- Develop strategy on autism.

Community development and involvement:

- Increase opportunities to enjoy a range of social activities and networks.
- Continue community development worker service for BME communities.
- Review user carer involvement structures to ensure fitness for purpose.
- Extend network of Dementia Cafés.

8. Increase the number of vulnerable people helped to live at home

Accountable Directors and Key Partnerships	Lead and contributing partners
Sandie Keene / Jill Copeland Healthy Leeds Joint Strategic Commissioning Board – Priority Groups sub-group **Sandie Keene / Philomena Corrigan** Healthy Leeds Joint Strategic Commissioning Board – Planned and Urgent Care sub-group	**Leeds City Council** Leeds PCT Leeds Partnership Foundation NHS Trust VCFS bodies through Leeds Voice Health Forum West Yorkshire Fire and Rescue Service Leeds Colleges
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Dennis Holmes, Leeds City Council John Lennon, Leeds City Council Carol Cochrane, NHS Leeds Jackie Wilson, Leeds City Council	**Leeds Housing Strategy 2005 to 2010** **Supporting People Strategy 2005 to 2010** **Carers Strategy for Leeds 2009 to 2012** **Older Better Strategy 2006 to 2011** The Leeds Children and Young People's Plan 2009 to 2014

8. Increase the number of vulnerable people helped to live at home

Indicators and targets	Measures of success
NI 141 Percentage of vulnerable people achieving independent living Baseline 2007-8 58.6% Targets 2010-11 76% **NI 139** The extent to which older people receive support they need to live independently at home Baseline and target to be set from Place Survey **NI 136** People supported to live independently through social services (all adults) Baseline (new target) Target 66%	• Fewer inappropriate admissions to hospital • Falls reduced and more people who fall are treated at home • Stroke care pathway improved • People with mental health problems or learning disabilities can access wider range of housing, employment, training and leisure opportunities • Improved choice delivering a personalised service based on individual preferences for vulnerable groups

8. Increase the number of vulnerable people helped to live at home

High Level Actions 2009 - 2012

Influences on health:

- Use a social model approach to challenge the barriers faced by older people and disabled people to independence, inclusion and equality.
- Maintain and promote older people's and disabled people's independence for as long as possible.
- Better access to good quality housing for vulnerable people.

Lives people lead:

- Promote and increase take up of Personal Budgets.
- Increase the number of people with mental health problems and learning disabilities who are in employment , education or in voluntary activity.

Services people use:

- Expand interactive services such as telehealth, broadband/interactive access and telecare.
- Expansion of falls assessment and treatment service.
- Transform learning disability day services currently provided by LCC.
- Redevelopment of Windlesford Green hostel for people with learning disabilities.
- Provision of new, modern accommodation for people with learning disabilities through the Independent Living Project.
- Increase the number of vulnerable people utilising self directed support to deliver their care and support needs.
- Develop and improve information sources to ensure that the communication barriers affecting different groups are overcome.

Community development and involvement:

- Development of self care strategy supported by Health Trainers for people with long term conditions.

9. Increase the proportion of people in receipt of community services enjoying choice and control over their daily lives

Accountable Directors and Key Partnerships	Lead and contributing partners
Sandie Keene / Jill Copeland Healthy Leeds Joint Strategic Commissioning Board – Priority Groups sub-group **Sandie Keene / Philomena Corrigan** Healthy Leeds Joint Strategic Commissioning Board – Planned and Urgent Care sub-group	**Leeds City Council** NHS Leeds VCFS bodies through Leeds Voice Health Forum and Learning Disability Forum, Older People's Forum, Physical Disability Forum and Volition.
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Dennis Holmes, Leeds City Council John Lennon, Leeds City Council Carol Cochrane, NHS Leeds Jackie Wilson, Leeds City Council	**Adult Social Care Business Plans** **Older Better** The Leeds Children and Young People's Plan 2009 to 2014 Carers Strategy for Leeds 2009 to 2012

9. Increase the proportion of people in receipt of community services enjoying choice and control over their daily lives

Indicators and targets	Measures of success
NI 130 Social Care Clients receiving self-directed support Target 30% take up of self directed support options by March 2011	• More people aware of and accessing benefit and fuel support • People lead richer and more fulfilling lives whatever their age or condition • Increased satisfaction among service users and carers • Choice and control are enhanced by simpler access with less risk of duplication or gaps • Evidenced access to information, advice and advocacy • Better sharing of information subject to appropriate safeguards • Increased capacity for support within local communities

9. Increase the proportion of people in receipt of community services enjoying choice and control over their daily lives

High Level Actions 2009 - 2012

Influences on health:

- Continue work to promote financial inclusion.
- Develop and improve transport which meets people's needs.

Lives people lead:

- Promote Healthy Ageing with the direct involvement of older people, encouraging a positive view of old age and disability.
- Use social marketing to develop information about opportunities, accessible to all groups.

Services people use:

- Roll out of Common Assessment Framework.
- Continue work on the Self-Directed support programme.
- Promote and increase take up of Personal Budgets .
- Deliver services for older people and disabled people that are flexible and accessible and promote choice and control.
- Deliver care and support close to where people live or within their own homes.
- Ensure that older people and disabled people are treated with respect and dignity at all times.
- Take an holistic approach to care and support, joining up different elements across professions and agencies.
- Share good practice across the city, agencies, organisations and professions.
- Develop community support services for people with stroke and other neurological conditions.
- Provide excellent eye health and eye care and sight loss support in an inclusive city.

Community development and involvement:

- Ensure full participation of older people and disabled people in the decisions and processes which affect their lives.
- Enable older people and disabled people to lead an active and healthy life and be involved as citizens of the city.
- Tackle social isolation of older people .

10. Improve safeguarding arrangements for vulnerable children and adults through better information, recognition and response to risk

Accountable Directors and Key Partnerships	Lead and contributing partners
Rosemary Archer Children Leeds Integrated Strategic Commissioning Board - Children Leeds Safeguarding Board **Sandie Keene / Jill Copeland** Healthy Leeds Joint Strategic Commissioning Board -Adult Safeguarding Board	**Leeds City Council** Education Leeds NHS Leeds Children Leeds Partners VCFS bodies through Leeds Voice CYP Forum and Health Forum Leeds Colleges
Strategic Leads	**Key and Related Strategies/ Plans (see page 24 to access these plans)**
Dennis Holmes, Leeds City Council Sarah Sinclair, NHS Leeds/ Leeds City Council	**Adult Safeguarding Strategy** The Leeds Children and Young People's Plan 2009 to 2014 Carers Strategy for Leeds 2009 to 2012

10. Improve safeguarding arrangements for vulnerable children and adults through better information, recognition and response to risk

Indicators and targets	Measures of success
Number of children looked after *(expressed as a rate per 10,000 excluding unaccompanied asylum seekers)* Baseline 83.6 Target 2020-11 59.1 Estimated number of staff employed by independent sector registered care services in the council area that have had some training on protection of adults whose circumstances make them vulnerable that is either funded or commissioned by LCC - Target to be set following calculation of baseline	• Wider awareness of issues among staff and in wider communities • Risk factors are managed consistently and effectively • Arrangements for safeguarding vulnerable children and adults are effective across agencies and disciplines. • Everyone involved in safeguarding has the appropriate knowledge, skills and understanding

10. Improve safeguarding arrangements for vulnerable children and adults through better information, recognition and response to risk

High Level Actions 2009 - 2012

Influences on health:

- Increase overall awareness of safeguarding issues through communications and social marketing.

Lives people lead:

- Implement consistent assessment procedures for risk, mitigation and management.

Services people use:

- Ensure high quality safeguarding practice is embedded across partners.
- Revise and implement multi-agency adult safeguarding procedures.
- Implement mandatory specialist safeguarding training programme.
- Implement work programme of adult safeguarding board.
- Jointly appoint head of adult safeguarding.
- Establish practice standards and competencies.
- Ensure the work of the safeguarding adults partnership board is informed by the views and experiences of all stakeholders
- Improve safeguarding arrangements for children.

Community development and involvement:

- Increase general awareness of safeguarding issues and secure community support.
- Increase general awareness of capacity issues and secure community support.

Related plans

Plan title	Internet link (click to open)
NHS Leeds Strategy 2008 to 2011	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13970
Leeds Alcohol Strategy 2007 to 2010	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13938
Older Better 2006 to 2011	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13958
Leeds Housing Strategy 2009 to 2012	(under development)
Supporting People Strategy 2005 to 2010	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13956
Safer Leeds Partnership Plan 2008 to 2011	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13960
Active Leeds: a Healthy City 2008 to 2012	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13932
Leeds Food Matters 2006 to 2010	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13946
Leeds Tobacco Control Strategy 2006 to 2010	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13968
Infant Mortality Action Plan 2009	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13948
Accident Prevention Framework 2008 to 2011	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13930
Self Care Strategy 2009	(under development)
Leeds Affordable Warmth Strategy 2007 to 2016	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13934
Leeds Financial Inclusion Project	http://www.leeds.gov.uk/page.aspx?pageidentifier=cd4994f5-87a4-4935-858b-89e8a360643a
Taking the Lead 2006 to 2012	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13964
Leeds Childhood Obesity Strategy 2006 to 2016	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13942
Leeds School Meals Strategy	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13954
Adult Obesity Strategy	(under development)
Local and West Yorkshire Transport Plans and Cycling Strategy - various	http://www.leedsinitiative.org/transport/page.aspx?id=2410
Parks and Green Space Strategy 2009	(under development)
Teenage Pregnancy and Parenthood Strategy 2008 to 2011	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13966
Sexual Health Strategy 2009 to 2014	(under development)
Carers' Strategy for Leeds 2009 to 2012	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13940
Leeds Social Inclusion and Mental Health Strategy 2006 to 2011	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13962
Leeds Emotional Health Strategy 2008 to 2011	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13944
Putting People at the Centre (Learning Disability) Strategy 2009 to 2012	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=13952
Adult Safeguarding Strategy	(under development)
The Leeds Children and Young People's Plan 2009 to 2014	http://www.leedsinitiative.org/WorkArea/showcontent.aspx?id=14160

APPENDIX 2

HOUSE OF COMMONS HEALTH COMMITTEE
ALCOHOL – FIRST REPORT OF SESSION 2009/10

EXTRACTS – JANUARY 2010

SUMMARY

Over the last 60 years English drinking habits have been transformed. In 1947 the nation consumed approximately three and a half litres of pure alcohol per head; the current figure is nine and a half litres. According to the General Household Survey data from 2006, 31% of men are drinking hazardously (more than 21 units per week) or harmfully (more than 50 units) of whom 9% are drinking harmfully. 21% of women are drinking hazardously or harmfully of whom 6% are drinking harmfully. While the consumption of alcohol has increased, taxation on spirits has declined in real terms and even more so as a fraction of average earnings.

The rising levels of alcohol consumption and their consequences have been an increasing source of concern in recent years. These involve not only the consequences of binge drinking which are a cause of many serious accidents, disorder, violence and crime, but also long term heavy drinking which causes more harm to health. The President of the Royal College of Physicians told us that alcohol was probably a significant factor in 30 to 40,000 deaths per year. The WHO has put alcohol as the third most frequent cause of death after hypertension and tobacco. UK deaths from liver cirrhosis increased more than five fold between 1970 and 2006; in contrast in France, Italy and Spain the number of deaths shrank between two and four fold; this country's deaths from cirrhosis are now above all of them.. In 2003 the P M's Strategy Unit estimated the total cost of alcohol to society to be £20 bn; another study in 2007 put the figure at 55 bn.

Faced by a mounting problem, the response of successive Governments has ranged from the non-existent to the ineffectual. In 2004 an Alcohol Strategy was published following an excellent study of the costs of alcohol by the Strategy Unit. Unfortunately, the Strategy failed to take account of the evidence which had been gathered.

The evidence showed that a rise in the price of alcohol was the most effective way of reducing consumption just as its increasing affordability since the 1960s had been the major cause of the rise in consumption. We note that minimum pricing is supported by many prominent health experts, economists and ACPO. We recommend that the Government introduce minimum pricing.

There is a myth widely propagated by parts of the drinks industry and politicians that a rise in prices would unfairly affect the majority of moderate drinkers. But precisely because they are moderate drinkers a minimum price of for example 40p per unit would have little effect. It would cost a moderate drinker 11p per week; a woman drinking the recommended maximum of 15 units could buy her weekly total of alcohol for £6.

Opponents also claim that heavier drinkers are insensitive to price changes, but as a group their consumption will be most affected by price rises since they drink so much of the alcohol purchased in the country. Minimum pricing would most affect those who drink cheap alcohol, in particular young binge-drinkers and heavy low income drinkers who suffer most from liver disease. It is estimated that a minimum price of 50p per unit would save over 3,000 lives per year, a minimum price of 40p, 1,100 lives.

Minimum pricing would have other benefits. Unlike rises in duty minimum pricing would benefit traditional pubs which sell alcohol at more than 40p or 50p per unit; unsurprisingly it is supported by CAMRA. Minimum pricing would also encourage a switch to weaker wines and beers. With a minimum price of 40p per unit, a 10% abv wine would cost a minimum of £2.80p, a 13% abv. wine £3.60p.

However, without an increase in duty minimum pricing would lead to an increase in the profits of supermarkets and the drinks industry. Alcohol duty should continue to rise year on year, but unlike in recent years duty increases should predominantly be on stronger alcoholic drinks, notably on spirits. The duty on spirits was 60% of male average manual weekly earnings in 1947; in 1973 (when VAT was imposed in addition to duty) duty was 16% of earnings; by in 1983 it was 11% and by 2002 it had fallen to 5%. We recommend that the duty on spirits be returned in stages to the same percentage of average earnings as in the 1980s. The duty on industrial white cider should also be increased. Beer under 2.8% can be taxed at a different rate and we recommend that the duty on this category of beer be reduced.

An increase in prices must be part of a wider policy aimed at changing our attitude to alcohol. The policy must be aimed at the millions who are damaging their heath by harmful drinking, but it is also time to recognise that problem drinkers reflect society's attitude to alcohol. There is a good deal of evidence to show that the number of heavy drinkers in a society is directly related to average consumption. Living in a culture which encourages drinking leads more people to drink to excess. Changing this culture will require a raft of policies.

Education, information campaigns and labelling will not directly change behaviour, but they can change attitudes and make more potent policies more acceptable. Moreover, people have a right to know the risks they are running. Unfortunately, these campaigns are poorly funded and ineffective at conveying key messages; people need to know the health risks they are running, the number of units in the drink they are buying and the recommended weekly limits, including the desirability of having two days drink-free each week. The information should be provided on the labels of alcohol containers and we recommend that all alcohol drinks containers should have labels containing this information. We doubt whether a voluntary agreement, even if it is possible to come to one, would be adequate. The Government should introduce a mandatory labelling scheme.

Expenditure on marketing by the drinks industry was estimated to be c. £600–800m in 2003. The current system of controls on alcohol advertising and promotion is failing the young people it is intended to protect. Both the procedures and the scope need to be

strengthened. The regulation of alcohol promotion should be completely independent of the alcohol and advertising industries; this would match best practice in other fields such as financial services and professional conduct. In addition, young people should themselves be formally involved in the process of regulation: the best people to judge what a particular communication is saying are those in the target audience.

The current controls do not adequately cover sponsorship or new media which are becoming increasingly important in alcohol promotion. The codes must be extended to address better sponsorship. New media presents particular regulatory challenges, including the inadequacy of age controls and the problems presented by user generated content. Expert guidance should be sought on how to improve the protection offered to young people in this area. Finally, there is a pressing need to restrict alcohol advertising and promotion in places where children are likely to be affected by it.

Alcohol-related crime and anti-social behaviour have increased over the last 20 years, partly as a result of the development of the night time economy with large concentrations of vertical drinking pubs in town centres. The DCMS has shown extraordinary naivety in believing the Licensing Act 2003 would bring about 'civilised cafe culture'. In addition, the Act has failed to enable the local population to exercise adequate control of a licensing and enforcement regime which has been too feeble to deal with the problems it has faced. Some improvements have been made through the Policing and Crime Act 2009, in particular the introduction of mandatory conditions on the sale of alcohol. We urge the Government to implement them as a matter of urgency, but problems remain. It is of concern that section 141 of the Licensing Act 2003is not enforced and we call on the police to enforce it.

The 2009 Act has made it easier to review licences, giving local authorities the right to instigate a review. We support this. However, we are concerned that local people will continue to have too little control over the granting of licences and it will remain too difficult to revoke the licences of premises associated with heavy drinking. The Government should examine why the licences of such premises are not more regularly revoked.

In Scotland legislation gives licensing authorities the objective of promoting public health. Unfortunately, public health has not been a priority for DCMS. We recommend that the Government closely monitor the operation of the Scottish licensing act with a view to amending the Licensing Act 2003 to include a public health objective.

The most effective way to deal with alcohol related ill-health will be to reduce overall consumption, but existing patients deserve good treatment and a service as good as that delivered to users of illegal drugs, with similar levels of access and waiting times. As alcohol consumption and alcohol related ill health have increased, the services needed to deal which these problems have not increased; indeed, in many cases they have decreased, partly as a result of the shift in resources to dependency on illegal drugs.

Early detection and intervention is both effective and cost effective, and could be easily be built into existing healthcare screening initiatives and incentives for doing this should be provided in the QOF. However the dire state of alcohol treatment services is a significant disincentive for primary care services to detect alcohol related issues at an

early stage before the serious and expensive health consequences of regular heavy drinking have developed. These services must be improved.

The alcohol problem in this country reflects a failure of will and competence on the part of government Departments and quangos. In the past Governments have had a large influence on alcohol consumption, be it from the liberalisation which encouraged the eighteenth century 'Gin Craze' to the restrictions on licensing in the First World War. Alcohol is no ordinary commodity and its regulation is an ancient function of Government.

It is time the Government listened more to the CMO and the President of the RCP and less to the drinks and retail industry. If everyone drank responsibly the alcohol industry might lose about 40% of its sales and some estimates are higher. In formulating its alcohol strategy, the Government must be more sceptical about the industry's claims that it is in favour of responsible drinking.

History – conclusions and recommendations

29 The history of the consumption of alcohol over the last 500 years has been one of fluctuations, of peaks and troughs. From the late 17th century to the mid-19th the trend was for consumption per head to decline despite brief periods of increased consumption such as the gin craze. From the mid- to the late 19th century there was a sharp increase in consumption which was followed by a long and steep decline in consumption until the mid 20th century.

30 The variations in consumption are associated both with changes in affordability and availability, but also changes in taste. Alternative drinks such as tea and alternative pastimes affected consumption. Different groups drank very different amounts. Government has played a significant role both positive and negative, for example in reducing consumption in the First World War as well as in stimulating the 18th century gin craze by encouraging the consumption of cheap gin instead of French brandy.

31 From the 1960s consumption rose again. At its lowest levels in the 1930s and -40s annual per capita consumption was about 3 litres of pure alcohol; by 2005 it was over 9 litres. These changes are, as in past centuries, associated with changing fashion and an increase in affordability, availability and expenditure on marketing. Just as Government policy played a part in encouraging the gin craze, successive Government policies have played a part in encouraging the increase in alcohol consumption over the last 50 years. Currently over 10 million adults drink more than the recommended limits. These people drink 75% of all the alcohol consumed. 2.6 million adults drink more than twice the recommended limits. The alcohol industry emphasises that these figures represent a minority of the population; health professionals stress that they are a very large number of people who are putting themselves at risk. We share these concerns.

32 One of the biggest changes over the last 60 years has been in the drinking habits of young people, including students. While individual cases of student drunkenness are regrettable and cannot be condoned, we consider that their actions are quite clearly a product of the society and culture to which they belong. The National Union of

Students and the universities themselves appear to recognise the existence of a student binge drinking culture, but all too often their approach appears much too passive and tolerant. We recommend that universities take a much more active role in discouraging irresponsible drinking amongst students. They should ensure that students are not subjected to marketing activity that promotes dangerous binge drinking. The first step must be for universities to acknowledge that they do indeed have a most important moral "duty of care" to their students, and for them to take this duty far more seriously than they do at present.

33 Since 2004 there has been a slight fall in total consumption but it is unclear whether this represents a watershed or a temporary blip as in the early 1990s.

The Impact of alcohol on health, the NHS and society – conclusions

64. The fact that alcohol has been enjoyed by humans since the dawn of civilization has tended to obscure the fact that it is also a toxic, dependence inducing teratogenic and carcinogenic drug to which more than three million people in the UK are addicted. The ill effects of alcohol misuse affect the young and middle aged. For men aged between 16 and 55 between 10% and 27% of deaths are alcohol related, for women the figures are 6% and 15%.

65. Alcohol has a massive impact on the families and children of heavy drinkers, and on innocent bystanders caught up in the damage inflicted by binge drinking. Nearly half of all violent offences are alcohol related and more than 1.3 million children suffer alcohol related abuse or neglect.

66. The costs to the NHS are huge, but the costs to society as a whole are even higher, all of these harms are increasing and all are directly related to the overall levels of alcohol consumption within society.

NHS policies to address alcohol related problems – conclusions and recommendations

142. Alcohol related-ill health has increased as alcohol consumption has increased, but there are no more services to deal with these problems. Indeed in many cases there are fewer, partly as a result of the shift in resources to addressing dependency on illegal drugs. The most effective way to deal with alcohol related ill-health will be to reduce overall consumption, but existing patients deserve at least as good a service as that provided to users of illegal drugs, with similar levels of access and waiting times.

143. Early detection and intervention is both effective and cost effective, and could be easily built into existing healthcare screening initiatives. However, the dire state of alcohol treatment services is a significant disincentive for primary care services to detect alcohol-related problems at an early stage before the serious and expensive health consequences of regular heavy drinking have developed. The solution is to link alcohol interventions in primary and secondary care with improved treatment

services for patients developing alcohol dependency. In time we believe such a strategy will result in significant savings for the NHS but will require pump priming and intelligent commissioning of services. Specifically, the NHS needs to improve treatment and prevention services as follows

Treatment services:

- Each PCT should have an alcohol strategy with robust needs assessment, and accurate data collection.

- Targets for reducing alcohol related admissions should be mandatory

- Acute hospital services should be linked to specialist alcohol treatment services and community services via teams of specialist nurses.

- There should be more alcohol nurse hospital specialists

- Treatment budgets should be pooled to allow the cost savings from reduced admissions to be fed back into treatment and prevention, with centrally provided 'bridge' funding to enable service development.

- Access to community based alcohol treatment must be improved to be at least comparable to treatment for illegal drug addiction

- These improved alcohol treatment services must be more proactive in seeking and retaining subjects in treatment with detailed long term treatment outcome profiling.

- Funding should be provided for the National Liver Plan

Prevention services:

- Improved access to treatment for alcohol dependency is a key step in the development of early detection and intervention in primary care.

- Clinical staff in all parts of the NHS need better training in alcohol interventions.

- Early detection and brief advice should be undertaken in primary care and appropriate secondary care and other settings. Detection and advice should become part of the QOF.

- Once detected patients with alcohol issues should progress through a stepped program of care; seven out of eight people do not respond to an early intervention and it is these people who go on to develop significant health issues.

- Research should be commissioned into developing early detection and intervention in young people.

Education and Information Policies – conclusions and recommendations

154. Better education and information are the main planks of the Government's alcohol strategy. Unfortunately, the evidence is that they are not very effective. Moreover, the low level of Government spending on alcohol information and education campaigns, which amounts to £17.6m in 2009/10 makes it even more unlikely they will have much effect. In contrast, the drinks industry is estimated to spend £600-800m per annum on promoting alcohol.

155. However, information and education policies do have a role as part of a comprehensive strategy to reduce alcohol consumption. They do not change behaviour immediately, but can justify and make people more responsive to more effective policies such as raising prices. Moreover, people have a right to know the risks they are running. We recommend that information and education policies be improved by giving more emphasis to the number of units in drinks and the desirability of having a couple of days per week without alcohol. We also recommend that all containers of alcoholic drinks should have labels, which should warn about the health risks, indicate the number of units in the drink, and the recommended weekly limits, including the desirability of having two days drink-free each week. We doubt whether a voluntary agreement would be adequate. The Government should introduce a mandatory labelling scheme.

Marketing and the Drinks Industry – conclusions and recommendations

204. The current system of controls on alcohol advertising and promotion is failing the young people it is intended to protect. The problem is more the quantity of advertising and promotion than its content. This has led public health experts to call for a ban. It is clear that both the procedures and the scope need to be strengthened.

Procedures

205. The regulation of alcohol promotion should be completely independent of the alcohol and advertising industries; this would match best practice in other fields such as financial services and professional conduct. In addition young people should themselves be formally involved in the process of regulation: the best people to judge what a particular communication is saying are those in the target audience.

Scope

206. The current controls do not adequately cover sponsorship, a key platform for alcohol promotion; the codes must be extended to fill this gap. The enquiry also heard how dominant new media are becoming in alcohol promotion and the particular regulatory challenges they present, including the inadequacy of age controls and the problems presented by user generated content. Expert guidance should therefore be sought on how to improve the protection offered to young people in this area.

207. Finally, there is a pressing need to restrict alcohol advertising and promotion in places where children are likely to be affected by it. Specifically:

- Billboards and posters should not be located within 100 metres of any school (there used to be a similar rule for tobacco).
- A nine o'clock watershed should be introduced for television advertising. (The current restrictions which limit advertising around children's programming fail to protect the relatively larger proportions of children who watch popular programmes such as soaps).
- Cinema advertising for alcohol should be restricted to films classified as 18.
- No medium should be used to advertise alcoholic drinks if more than 10% of its audience/readership is under 18 years of age (the current figure is 25%).
- No event should be sponsored if more than 10% of those attending are under 18 years of age
- There must be more effective ways of restricting young people's access to new media which promote alcohol
- Alcohol promotion should not be permitted on social networking sites.
- Notwithstanding the inadequacies of age restrictions on websites, they should be required on any site which includes alcohol promotion—this would cover the sites of those receiving alcohol sponsorship. This rule should also be extended to corporate alcohol websites. Expert guidance should be sought on how to make these age controls much more effective.
- Alcohol advertising should be balanced by public health messaging. Even a small adjustment would help: for example, for every five television ads an advertiser should be required to fund one public health advertisement.

Licensing, binge- drinking, crime and disorder – conclusions and recommendations

248. Alcohol-related crime and anti-social behaviour have increased over the last 20 years as a result of the development of the night time economy with large concentrations of vertical drinking pubs in town centres; under-age drinkers in the

streets have also caused problems. The Alcohol Strategy 2004 recognised these problems and claimed that they were being addressed by a number of measures including the Licensing Act 2003. In addition, the alcohol industry established voluntary standards to govern the promotion and sale of alcohol.

249. The worst fears of the Act's critics were not realised, but neither was the DCMS's naive aspiration of establishing cafe society: violence and disorder have remained at similar levels, although they have tended to take place later at night. The principle of establishing democratic control of licensing was not realised: the regulations governing licensing gave the licensing authorities and local communities too little control over either issuing or revoking licences, as ACPO indicated. KPMG examined the alcohol industry's voluntary code and found it had failed.

250. Problems remained and the 2007 Strategy introduced new measures. Partnership schemes such as the St Neots Community Alcohol Partnership were established. The main changes are being introduced by the Policing and Crime Act 2009 which gives the police greater powers to confiscate alcohol from under 18s, introduces a mandatory code in place of the industry's voluntary code and has made it easier to review licences, giving local authorities the right to instigate a review. We support the introduction of mandatory conditions and urge the Government to implement them as a matter of urgency.

251. Despite the recent improvements, much needs to be done given the scale of alcohol-related disorder. It is of concern that section 141 of the Licensing Act 2003, which creates the offence of selling alcohol to a person who is drunk, is effectively not enforced despite KPMG's finding that this behaviour is frequently observed. We note the police and Home Office's preference for partnerships and training, but do not consider these actions should be an excuse for not enforcing a law which could make a significant difference to alcohol-related crime and disorder. We call on the police enforce s.141 of the Licensing Act 2003 more effectively.

252. We note the concerns of ACPO and other witnesses about the difficulties local authorities have in restricting and revoking licences. The Government has made some improvements in the Policing and Crime Act 2009, but must take additional measures.

253. In Scotland legislation gives licensing authorities the objective of promoting public health. Unfortunately, public health has not been a priority for DCMS. We recommend that the Government closely monitor the operation of the Scottish licensing act with a view to amending the Licensing Act 2003 to include a public health objective.

Supermarket and off-licence sales – conclusions and recommendations

279. Over recent decades an ever increasing percentage of alcohol has been bought in supermarkets and other off-licence premises. Such purchases exceed those made in pubs and clubs by a large margin. The increase in off-licence purchases has been associated with the increasing availability of, promotions of, and discounting of

alcohol. Heavily discounted and readily available alcohol has fuelled underage drinking, led to the phenomenon of pre-loading where young people drink at home before they go out and encouraged harmful drinking by older people.

280. Some areas have very large numbers of off-licences open for long hours. There are also too many irresponsible off-licences. Addressing this problem will require both better enforcement and improvements to the licensing regime. A public health objective in the licensing legislation would apply to off-licences as well as pubs and clubs and could be used to place limits on the number of outlets in an area. This aspect of the Scottish licensing legislation should be closely monitored with a view to its implementation in England.

281. Although they acknowledged that alcohol was a dangerous commodity, supermarkets told us that they used discounts and alcohol promotions because they were engaged in fierce competition with each other. In some cases, it is possible to buy alcohol for as little as 10p per unit. At this price, the maximum weekly recommended 15 units for a woman can be bought for £1.50p. This is not a responsible approach to the sale of alcohol. Retail outlets should make greater efforts to inform the public of the dangers of alcohol at the point of sale.

282. The Scottish Government has introduced controls on promotions including restricting alcohol to one aisle. These measures should be instituted in England.

Prices: taxes and minimum prices – conclusions and recommendations

325. The consumption of alcohol, like that of almost all other commodities, is sensitive to changes in price as all studies have shown. Because some countries with high alcohol prices have high levels of per capita consumption and vice versa some countries with low levels of consumption have low prices, it is sometimes implied that alcohol sales do not respond to price changes. This is economic illiteracy. Different countries, like different people and groups, respond differently to price, but they all respond. Studies have shown varying elasticities of demand. The increase in alcohol consumption over the last 50 years is very strongly correlated with its increasing affordability.

326. Increasing the price of alcohol is thus the most powerful tool at the disposal of a Government. The key argument made by the drinks industry and others opposed to a rise in price is that it would be unfair on moderate drinkers. We do not think this is a serious argument. The Sheffield study found that for the moderate drinker consuming 6 units per week a minimum price of 40p per unit would increase the cost by about 11p per week. At 40p per unit a woman drinking the recommended maximum of 15 units could buy her weekly total of alcohol for £6.

327. Opponents also claim that heavier drinkers are insensitive to price changes, but these drinkers will be most affected by price rises since they consume so much of the alcohol purchased in the country (10% of the population drink 44% of the alcohol consumed; 75% of alcohol is drunk by people who exceed the recommended limits).

328. We believe that the Government should introduce minimum pricing for the following reasons:

- It would affect most of all those who drink cheap alcohol, in particular young binge-drinkers and heavy low income drinkers who suffer most from liver disease

- It is estimated that a minimum price of 50p per unit would save over 3,000 lives per year, of 40p 1,100 lives per year.

- Unlike rises in duty (which could be absorbed by the supermarkets' suppliers and which affect all sellers of alcohol) it would benefit traditional pubs and discourage pre-loading. For this reason it is supported by CAMRA

- It would encourage a switch to weaker wines and beers.

329. However, without an increase in duty minimum pricing will lead to an increase in the profits of supermarkets and the drinks industry and an increase in marketing, promotions and non-price competition. The Treasury must take into account public health when determining levels of taxation on alcohol as it does with tobacco. Alcohol duty should continue to rise year on year above incomes, but unlike in recent years duty increases should predominantly be on stronger alcoholic drinks notably on spirits.

330. The duty on spirits per litre of pure alcohol was 60% of male average manual weekly earnings in 1947; in 1973 (when VAT was imposed in addition to duty) duty was 16% of earnings; by 1983 it was 11% and by 2002 it had fallen to 5%. We recommend that in stages the duty on spirits be returned in stages to the same percentage of average earnings as in the 1980s. Cider is an extraordinary anomaly; the duty on industrial cider should be increased. To protect small real cider producers, their product should be subject to a lower duty. Beer under 2.8% can be taxed at a different rate: we recommend that duty be reduced on these weak beers; although at present there a few producers of beers of this strength, the cut should encourage substitution.

331. In the longer run the Government should seek to change EU rules to allow higher and more logical levels of duty on stronger wines and beers; it should also seek to raise the strength of beer which can be subject to a lower duty rate from 2.8 to slightly higher levels.

332. The introduction of minimum pricing would encourage producers to intensify their marketing. This will make it all the more important to control marketing.

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Issue date: November 2007

Quick reference guide

National Institute for Health and Clinical Excellence

School-based interventions on alcohol

This quick reference guide presents the recommendations on 'Interventions in schools to prevent and reduce alcohol use among children and young people'. The guidance also looks at how to link these interventions with community initiatives, including those run by children's services. It is for teachers, school governors and practitioners with health and wellbeing as part of their remit working in education, local authorities, the NHS and the wider public, voluntary and community sectors. It may also be of interest to children and young people, their families and other members of the public.

There are no national guidelines on what constitutes safe and sensible alcohol consumption for children and young people, so the recommendations focus on:

- encouraging children not to drink
- delaying the age at which young people start drinking
- reducing the harm it can cause among those who do drink.

Practitioners will need to use their professional judgement to determine the type of content needed for education programmes aimed at different groups. They will also need to judge whether or not a child or young person is drinking 'harmful amounts of alcohol'.

For the purposes of this guidance, schools include:

- state-sector, special and independent primary and secondary schools
- city technology colleges, academies and grammar schools
- pupil referral units, secure training and local authority secure units
- further education colleges.

NICE public health guidance 7

This guidance was developed using the NICE public health intervention process.

NICE public health guidance makes recommendations on the promotion of good health and the prevention of ill health. This guidance represents the views of the Institute and was arrived at after careful consideration of the evidence available. Those working in the NHS, local authorities and the wider public, voluntary and community sectors should take it into account when carrying out their professional, managerial or voluntary duties.

Recommendations

School-based education and advice

Recommendation 1

Who is the target population?

- Children and young people in schools.

Who should take action?

- Head teachers, teachers, school governors and others who work in (or with) schools including: school nurses, counsellors, healthy school leads, personal, social and health education (PSHE) coordinators in primary schools and personal, social, health and economic (PSHE) education coordinators in secondary schools.

What action should they take?

- Ensure alcohol education is an integral part of the national science, PSHE and PSHE education curricula, in line with Department for Children, Schools and Families (DCSF) guidance.
- Ensure alcohol education is tailored for different age groups and takes different learning needs into account (based, for example, on individual, social and environmental factors). It should aim to encourage children not to drink, delay the age at which young people start drinking and reduce the harm it can cause among those who do drink. Education programmes should:
  - increase knowledge of the potential damage alcohol use can cause – physically, mentally and socially (including the legal consequences)
  - provide the opportunity to explore attitudes to – and perceptions of – alcohol use
  - help develop decision-making, assertiveness, coping and verbal/non-verbal skills
  - help develop self-esteem
  - increase awareness of how the media, advertisements, role models and the views of parents, peers and society can influence alcohol consumption.
- Introduce a 'whole school' approach to alcohol, in line with DCSF guidance. It should involve staff, parents and pupils and cover everything from policy development and the school environment to the professional development of (and support for) staff.
- Where appropriate, offer parents or carers information about where they can get help to develop their parenting skills. (This includes problem-solving and communication skills, and advice on setting boundaries for their children and teaching them how to resist peer pressure.)

Recommendation 2

Who is the target population?

- Children and young people in schools who are thought to be drinking harmful amounts of alcohol.

Who should take action?

- Teachers, school nurses and school counsellors.

What action should they take?

- Where appropriate, offer brief, one-to-one advice on the harmful effects of alcohol use, how to reduce the risks and where to find sources of support. Offer a follow-up consultation or make a referral to external services, where necessary.
- Where appropriate, make a direct referral to external services (without providing one-to-one advice).
- Follow best practice on child protection, consent and confidentiality. Where appropriate, involve parents or carers in the consultation and any referral to external services.

Partnerships

Recommendation 3

Who is the target population?

- Children and young people in schools.

Who should take action?

- Head teachers, school governors, healthy school leads and school nurses.
- Extended school services, children's services (including the Children's Trust/children and young people's strategic partnership), primary care trusts, drug and alcohol action teams, crime disorder reduction partnerships, youth services, drug and alcohol services, the police and organisations in the voluntary and community sectors.

What action should they take?

- Maintain and develop partnerships to:
  - support alcohol education in schools as part of the national science, PSHE and PSHE education curricula
  - ensure school interventions on alcohol use are integrated with community activities introduced as part of the 'Children and young people's plan'
  - find ways to consult with families (parents or carers, children and young people) about initiatives to reduce alcohol use and to involve them in those initiatives
  - monitor and evaluate partnership working and incorporate good practice into planning.

Implementation tools

NICE has developed tools to help organisations implement this guidance. For details see our website at www.nice.org.uk/PH007

Further information

You can download the following documents from www.nice.org.uk/PH007

- A quick reference guide (this document) for practitioners and the public.
- The guidance, which includes all the recommendations, details of how they were developed and evidence statements.
- Supporting documents, including an evidence review and an economic analysis.

For printed copes of the quick reference guide, phone the NHS Response Line on 0870 1555 455 and quote N1346.

Related NICE guidance

Published

- Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people. NICE public health guidance 4 (2007). Available from www.nice.org.uk/PHI004

Under development

- Promoting the mental wellbeing of children in primary education. NICE public health guidance (due March 2008).
- Mass media and point of sales measures to prevent the uptake of smoking by children and young people. NICE public health guidance (due July 2008).
- Promoting the mental wellbeing of children in secondary education. NICE public health guidance (due June 2009).
- School, college and community-based personal, social and health education, focusing on sexual health and alcohol. NICE public health guidance (due September 2009).
- Alcohol use disorders: prevention and early identification in adults and adolescents. NICE public health guidance (due 2010).
- Alcohol use disorders: management in adults and adolescents. NICE clinical guideline (due 2010).

Updating the recommendations

NICE public health guidance is updated as needed so that recommendations take into account important new information. We check for new evidence 2 and 4 years after publication, to decide whether all or part of the guidance should be updated. If important new evidence is published at other times, we may decide to update some recommendations at that time.

National Institute for Health and Clinical Excellence
MidCity Place, 71 High Holborn, London WC1V 6NA, www.nice.org.uk

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Staying Healthy

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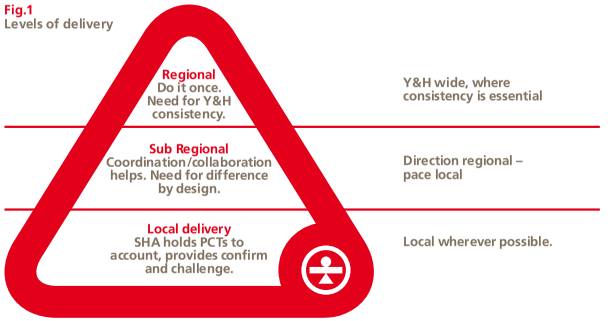
Fig.1
Levels of delivery



What did we say in Healthy Ambitions?*

1
The Staying Healthy Clinical Pathway Group recognised that the 3 biggest threats to health over the next decade in our region are:

- Alcohol abuse
- Rising levels of obesity
- Smoking

They recommended that:

- Alcohol: There should be improved screening and identification of people with alcohol problems, who should be offered tiered support services; and we should use NHS influence to reduce the availability of cheap alcohol
- Obesity: Every PCT should commission local weight management services. PCTs should work together to commission bariatric surgery where this is the best treatment for morbidly obese people. There should be programmes of local work with partners on food policy and skills for adults and to improve opportunities for active leisure.
- Tobacco: Commission free nicotine replacement therapy; and systematically use every NHS opportunity to encourage and support giving up smoking
- A shift in the focus for investment from treatment to prevention.

Who is taking this work forward?

2
Levels of delivery
PCTs across Y&H have worked with the SHA to agree which of the recommendations of the Staying Healthy pathway should be taken forward locally and which might need action at regional level. This is summarised in fig.2 on the next page.

*Full details can be found at www.healthyambitions.co.uk/staying_healthy.html

Recommendations & levels of delivery.

Fig.2 Levels of delivery

KEY
● Primary Implementation

Recommendation 1

The NHS in Y&H should improve screening and identification of people with alcohol use problems.

YH wide implementation

–

YH wide coordination & collaboration

Regional Alcohol Group

Local Delivery

Yes

Recommendation 2

PCTs should commission the systematic use of brief interventions on alcohol to 'industrialise' their use across NHS services.

YH wide implementation

–

YH wide coordination & collaboration

Regional Alcohol Group

Local Delivery

Yes

Recommendation 3

PCTs should commission a range of tiered services to cope with people who present with different levels of dependency and ensure simple referral routes are accessible from screening points.

YH wide implementation

–

YH wide coordination & collaboration

Regional Alcohol Group

Local Delivery

Yes

Recommendation 4

PCTs should commission alcohol services separately from drugs misuse services.

YH wide implementation

–

YH wide coordination & collaboration

Regional Alcohol Group

Local Delivery

Yes

Recommendation 5

NHS should work with other organisations to reduce the accessibility of alcohol.

YH wide implementation

–

YH wide coordination & collaboration

Regional Alcohol Group

Local Delivery

Yes

NHS should work with other organisations to reduce the accessibility of alcohol.

Recommendation 6

Every PCT should commission localised weight management services for their local population. To meet life expectancy targets these should focus on adults at mid-life.

YH wide implementation

–

YH wide coordination & collaboration

Promoting Healthy Lifestyles Board,Obesity Leads Group

Local Delivery

Yes

Recommendation 7

Services could be commissioned on the smoking cessation service model, using similar referral protocol so enable quicker implementation.

YH wide implementation

–

YH wide coordination & collaboration

Promoting Healthy Lifestyles Board,Obesity Leads Group

Local Delivery

Yes

Recommendation 8

NICE guidance on brief interventions should be implemented consistently by a wide range of NHS settings and staff. Ideally this would include primary care, secondary care, community services, family centres, local authority and voluntary settings.

YH wide implementation

–

YH wide coordination & collaboration

Promoting Healthy Lifestyles Board,Obesity Leads Group

Local Delivery

Yes

Recommendation 9

Surgery for people who are morbidly obese. PCTs should proactively collaborate on setting the specification and agreeing when these services should be commissioned so that there is a common standard across the region.

YH wide implementation

SCG

YH wide coordination & collaboration

Promoting Healthy Lifestyles Board,Obesity Leads Group

Local Delivery

–

Recommendation 10

There should be a systematic programme of local work to reduce the levels of obesity through the development of:

- Food policy & better food skills for adults.
- Transport and the built environment – making activity easier/safer
- More opportunities for active leisure
- Local employment
- Quality of school food, drink and activity programmes

YH wide implementation

–

YH wide coordination & collaboration

Promoting Healthy Lifestyles Board,Obesity Leads Group

Local Delivery

Yes

Recommendations & levels of delivery.

Recommendation 11

The recommendations of the SH Group – which are focused on adults – should be linked to the Gov initiative on child weight management which is aimed at tackling rising obesity levels amongst children.

YH wide implementation

–

YH wide coordination & collaboration

Promoting Healthy Lifestyles Board,Obesity Leads Group

Local Delivery

Yes

Recommendation 12

Every PCT should commission the systematic and industrialised use of brief interventions and referrals into effective smoking cessation services. In addition there should be training for as many other front line services as possible in carrying out brief interventions and referrals to services.

YH wide implementation

–

YH wide coordination & collaboration

Tobacco control network

Local Delivery

Yes

Recommendation 13

PCTs should commission free NRT for the smoking population and make it widely and freely available.

YH wide implementation

–

YH wide coordination & collaboration

Tobacco control network

Local Delivery

Yes

Recommendation 14

Change the headline measure from number of quitters to smoking prevalence in order to align incentives better to what will make the biggest impact on health.

YH wide implementation

National work underway

YH wide coordination & collaboration

Tobacco control network

Local Delivery

Yes

Fig.3 Timetable

Overall – establishing foundations	Timescale
Initial baseline gap analysis completed by all PCTs setting out where work is already underway across all 3 key risk areas	Complete
Region wide social marketing programme (based on NSR review)	Ongoing
Workforce analysis to assess potential gaps in delivering recommendations with ensuing workforce plan based on findings.	Complete
Confirmation of core role of DsPH network and reporting routes for 'Staying Healthy'	February 2009
Obesity	
Commissioning of adult weight management services: - Individual PCTs to take forward - PCT Obesity network to take the lead for Cross Government Obesity Unit on producing service specification for adult weight management services	Commenced November 2008
Alcohol	
Develop specifications for services agreed across PCTs in the region through regional alcohol group	Commenced January 2009
Smoking	
Rolling out Good System Guide ensuring systems in place to support industrialised delivery of ABC approach to brief interventions by all front line staff.	Rolling programme
Regional programme of work being discussed with DsPH, Directors of Commissioning and CEs to extend smoke free environments, cheap and illicit tobacco etc.	Ongoing
NRT – set up commissioning framework in PCTs (where needed) and implement: assess progress and impact across the region	March 2009

What is happening to take this forward?

3
The actions to be taken forward in the first year of implementation for the Staying Healthy pathway are shown in fig.3.

Local delivery

4
PCTs have prioritised the recommendations in Healthy Ambitions in light of the needs of their local community and the current position of their services.

Working with their local providers and partners, they have all set out the action that they will take to start to turn the recommendations in Healthy Ambitions into reality in their five year strategic plans.

An example of the action being taken by Bradford and Airedale tPCT is shown in fig.4.

Fig.4 SCG action on commissioning of bariatric surgery

Date	Action
During January 2009	Designation guidance, commissioning policy and service specification signed off by SCG
During January 2009	Write to existing bariatric surgery providers (Chief Executives) with designation guidance document, seeking: • intentions in respect of future provision of bariatric surgery • completion of self assessment • evidence to support self assessment
Early February 2009	Providers consider designation guidance and complete self assessment and collection of evidence
By February 27th 2009	All interested providers to have responded to Cathy Edwards at SCG
April 2009	Provisional designation of existing providers meeting core standards and confirmation of next steps

Fig.5 An example of local action being taken by Bradford and Airedale tPCT

Bradford and Airedale are:

Implementing a new tiered service model for adult obesity services that ranges from brief intervention and referral to weight management services through community based dietetic services and up to bariatric surgery for morbid obesity.

- Tier 1

will be available to all patients who wish to lose, or manage their weight, with community wide provision focusing on intervention and prevention.

- Tier 2

will use weight management clinics targeting high risk patients who are ready to change their lifestyle with education, motivational support, individual assessment and patient plans, pharmacotherapy where indicated and as preparation for bariatric surgery.

- Tier 3

bariatric surgery will be available to those patients who have demonstrated their ability to make lifestyle behaviour changes

The tPCT's obesity strategy highlights that approximately one third of Bradford's adult population are overweight (137,000 adults) and a further one fifth are obese (88,000 adults).

How could you help?

5
Everyone with an interest in improving health and healthcare can play a part in taking forward the recommendations in the Staying Healthy chapter of Healthy Ambitions.

In fig.6 we have set out some of the suggestions from staff about how people could help implement the recommendations.

As an NHS publication – this section has just focussed on the roles that NHS staff could play – but we very much recognise that our partners, e.g. local authorities and third sector, can have a much bigger impact on addressing the determinants of ill health. We are therefore committed to continuing to work jointly with our partners to make the recommendations of the Staying Healthy pathway a reality. Directors of Public Health with joint appointments between the NHS and LAs and are well placed to promote joint approaches.

Who will make sure that this work happens?

6
There are a number of leadership roles in the delivery of this pathway:

Locally
Each PCT is responsible for working with local providers and partners to ensure the delivery of recommendations in line with their local priorities and their own strategic plans.

Collaboratively and Regionally
Delivery will be overseen by a Pathway Delivery Board – as described in the chapter on governance arrangements.

For Staying Healthy the chair will be Simon Morritt, Chief Executive at Bradford and Airedale tPCT, who will act as a sponsor of the staying healthy work within the wider PCT chief executives forum. He will assist the clinical lead and SHA Director lead to promote implementation of the pathway, the framework for action (the rainbow model) and partnership working between PCTs and local authorities.

The clinical lead is Wendy Richardson, Director of Public Health at Hull, who will: oversee progress against of the Staying Healthy recommendations, act as a champion for the recommendations, advise on delivery processes and encourage DPH colleagues to continue to focus and give priority to the Staying Healthy recommendations.

Fig.6 How could you help?

Who	What
Directors of Public Health could:	• Implement NICE guidance on brief interventions (behaviour change) • Work with partners to develop a systematic programme on food policy, food skills for adults and weight management for adults •Advocate improvements in the quality of school food, drink and activity programmes • Making links across Government initiatives on child weight management
Directors of Commissioning could:	• Commission weight management services using service specification designed by the PCT obesity lead • Commission smoking cessation services • Commission free NRT for smokers, making it widely and freely available to all • Commission treatment and rehabilitation programmes for hazardous drinkers • Work to promote joint commissioining – e.g of alcohol services • Ensure effective audit processes are built into contracting processes, including the collection of systematic feedback from patients, carers and families
Health Trainers could:	• Implement NICE guidance on brief interventions • Implement PCT commissioned services on brief interventions
GPs could:	• Implement NICE guidance on brief interventions • Offer screening, identification and advice in primary care and other settings
Directors of Performance could:	• Examine ways to change headline measure from number of quitters to smoking prevalence
All professionals offering NHS care could:	• Use all opportunities to offer brief interventions as per NICE guidance
Communications Leads could be:	• Be aware of and participate in social marketing activity
Directors of HR / Workforce could:	• Workforce analysis of pathway recommendations including training for front line staff in brief interventions
Smoking cessation staff could:	• Be aware of and implement recommendations of pathway group
Obesity leads could:	• Be aware of and help implement recommendations of pathway group
Alcohol leads could:	• Be aware of and help implement recommendations of pathway group
Public Sector Staff could:	• Use all opportunities to systematise brief interventions
Local authority leads could:	• Joint working to support pathway recommendations including enforcement of under-age sales restrictions
Directors of Finance could be:	• Assessing the financial implications of local plans in response to pathway reccommendations and ensuring appropriate provision with medium term and operational finance plans. Any impact on providers of changes in care pathways or service provision would need to be appropriately communicated consistent with WCC standards and process and extant contracting arrangements

This checklist is illustrative and for guidance only.

Work has been undertaken to establish baselines for this pledge and by the end of March ’09 trajectories for improvement will have been agreed between the SHA and PCTs and will be reflected in annual operational plans.

The Regional Director of Public Health Paul Johnstone will oversee progress on implementation of the Staying Healthy pathway working with public health colleagues across the regions and with the clinical lead and the CE.

How will we measure success?

7
We have developed a “Healthy Ambitions Dashboard” based on a small number of key indicators which taken together can be used to start to measure the success of the Healthy Ambitions programme as a whole. This is underpinned by trajectories which each PCT will set to reflect their local priorities and circumstances and which will show the measurable improvements thay are making in each pathway area. This will supplement the “vital signs” indicators and trajectories which support delivery of the targets set out in the NHS Operating Framework and the selection of outcome measures which PCTs have included in their strategic plans. In many cases these measures are one and the same. All of these measures will feature in PCTs annual operating plans to be agreed with the SHA and be the basis for the SHA’s performance management regime.

Recognising that the pathway recommendations are many and various we intend start by tracking progress against the key pathway pledge, which for Staying Healthy is to promote healthy lifestyles – with a halt in the rise in obesity.

We know that this doesn’t tackle all three priorities identified in this chapter. Alcohol and smoking will be tracked through existing routes. Smoking quit rates are already included in Vital Signs, as is alcohol misuse.

The key indicators we will track will be:

- Obesity prevalence amongst reception and year 6 children
- The proportion of patients in a practice who have had their BMI recorded
- Percentage of obese people aged over 16 (once local data quality meets minimum standard).

Work has been undertaken to establish baselines for this pledge and by the end of March ‘09 trajectories for improvement will have been agreed between the SHA and PCTs and will be reflected in annual operational plans.* We intend to publish progress against individual trajectories.

*More details can be found in the performance and metrics chapter.

"Tackling obesity and encouraging healthy lifestyles is part of my day job: we need to make them part of the day job for all NHS staff."

Heidi Waters
Obesity programmes coordinator, NHS Hull

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APPENDIX 5 - Briefing Note

Licensing Act 2003 – The Council Role

Purpose

This briefing note provides information regarding the role of the Licensing Authority (Leeds City Council) under the Licensing Act 2003.

Scope

The Licensing Act 2003 provides the licensing regime for pubs, bars, nightclubs, working men's clubs, village halls and schools. It is concerned with the sale of alcohol, regulated entertainment and the sale of hot food and drink after 11pm.

Key points include:

- Flexible operating hours
- Single Premises Licence covering multiple licensable activities
- Personal Licences
- Temporary Events Notices
- Licensing objectives
- Operating schedules

There are four licensing objectives that underpin the regime:

- Prevention of crime and disorder
- Prevention of public nuisance
- Public safety
- Protection of children from harm

The licensing objectives are considered by the applicant and provide the structure for an operating schedule they must submit as part of the application form. The objectives are also taken into consideration by the Licensing Authority when the licence is determined and when enforcing the Licensing Act 2003 during planned and unplanned visits.

The objective of Public Health, which is featured in the Scottish Licensing Act was not included in the Licensing Act 2003 despite being discussed during the early stages of the legislative process.

Our role as a Licensing Authority

The Licensing Authority operates on three main levels:

- Full Licensing Committee (15 elected members)
    - Assumes ultimate responsibility for Licensing, makes final decisions regarding Licensing Policy.

- Licensing Sub-Committee (3 of 15 elected members)
    - Makes decisions regarding individual applications which have received objections, or licences which have been brought up for review. Also deals with most other contentious matters.

- Licensing Officers (employees of Leeds City Council)
    - Responsible for the administrative process surrounding licensing applications and ensuring that licence holders are compliant with their operating schedules (Enforcement Officers). Has a duty to grant licences where no relevant representations are received.

Our role as Enforcement:

Leeds City Council have a dedicated Liaison and Enforcement Team within Entertainment Licensing. The team of seven officers ensure licence holders are compliant with the operating schedules attached to their licences by undertaking a risk based inspection programme. They prevent unauthorised licensable activities from taking place and ensure licence holders operate to promote licensing objectives.

Various means are employed by our Enforcement Officers however, the most notable of these are:

- Issuing of warnings (both formal & informal)
- Prosecution for offences under The Act
- Closure Notices (Section 19 Criminal Justice & Police Act 2001)

Officers also attend Pubwatch, which is a scheme whereby licence holder meet regularly to discuss issues relating to the trade, as well as undertaking multi agency visits to premises along with West Yorkshire Police, Trading Standard and West Yorkshire Fire and Rescue Service.

Definitions:

"**Responsible authority**" means any of the following—

(a) the chief officer of police for any police area in which the premises are situated,

(b) the fire authority for any area in which the premises are situated,

(c) the enforcing authority within the meaning given by section 18 of the Health and Safety at Work etc. Act 1974 for any area in which the premises are situated,

(d) the local planning authority within the meaning given by the Town and Country Planning Act 1990 (c. 8) for any area in which the premises are situated,

(e) the local authority by which statutory functions are exercisable in any area in which the premises are situated in relation to minimising or preventing the risk of pollution of the environment or of harm to human health,

(f) a body which—

(i) represents those who, in relation to any such area, are responsible for, or interested in, matters relating to the protection of children from harm, and

(ii) is recognised by the licensing authority for that area for the purposes of this section as being competent to advise it on such matters,

(g) any licensing authority (other than the relevant licensing authority) in whose area part of the premises is situated,

(h) in relation to a vessel—

(i) a navigation authority (within the meaning of section 221(1) of the Water Resources Act 1991 (c. 57) having functions in relation to the waters where the vessel is usually moored or berthed or any waters where it is, or is proposed to be, navigated at a time when it is used for licensable activities,

(ii) the Environment Agency,

(iii) the British Waterways Board, or

(iv) the Secretary of State,

(v) a person prescribed for the purposes of this subsection.

"**Interested party**" means any of the following—

(a) a person living in the vicinity of the premises,

(b) a body representing persons who live in that vicinity,

(c) a person involved in a business in that vicinity,

(d) a body representing persons involved in such businesses,

(e) member of the relevant licensing authority.

Licence Conditions

During the application process the applicant offers an operating schedule which shows how the applicant will promote the four licensing objectives. Should the responsible authorities feel the operating schedule is inadequate, they can make a representation against the application and suggest conditions to be placed on the licence.

Interested parties are also able to make representations.

The Licensing Authority are only able to accept representations from either responsible authorities or interested parties, both of which are defined in the Act. All representations must be relevant; relating to one or more of the four licensing objectives.

Should the applicant disagree with the proposed conditions the matter is heard before a Licensing Sub-committee of 3 members who are able to apply conditions to the licence that are relevant and proportional. The Sub-committee may chose to add conditions that mitigate the concerns raised in the relevant representations. The Sub-committee is not able to add conditions which duplicate the requirements of existing legislation – for example requirements under the Health and Safety at Work etc Act 1974.

Carrying on a licensable activity in breach of a condition on an authorisation is an offence under the Licensing Act 2003 which is liable, on summary conviction, to a fine not exceeding £20,000 and/or six months imprisonment.

Reviewing a Licence

Occasionally things go wrong once a premises licence has been granted. The bad management of premises may lead to problems such as noise, litter or antisocial behaviour.

A premises licence can be reviewed at any time and the review process forms one of the main safeguards in the Licensing Act. It investigates if a premises licence or a club premises certificate is having an ongoing negative impact on one or more of the licensing objectives. Both interested parties and responsible authorities can request a review.

Prosecution

An alternative to reviewing the premises licence is prosecuting either the premises licence holder or the designated premises supervisor.

The two main offences under the Licensing Act are:

- Carrying on a licensable activity without the required authorisation (premises licence, club premises certificate or temporary event notice);

and

- Carrying on a licensable activity in breach of a condition in an authorisation;

Summary conviction of either of these offences can lead to six months imprisonment and/or a fine of £20,000 (S136).

Other offences include the following:-

- Conducting licensable activities without authorisation or in breach of an authorisation (s136)
- Putting alcohol on display for sale without a licence (S137)
- Keeping alcohol on a premises for unauthorised sale (S138)
- Allowing disorderly conduct on a licensed premises (S140)
- Selling alcohol to someone who is drunk (S141) or obtaining alcohol for someone who is drunk (S142)
- Failing to leave licensed premises without reasonable excuse when drunk and disorderly and when requested to do so by a constable, a licence holder or their authorised agents (S143)
- Entering or attempting to enter licensed premises without reasonable excuse if drunk and disorderly after a constable, a licence holder or authorised agent has requested him not to enter (S143)
- Allowing children under 16 years of age on the premises when alcohol is being sold, without being accompanied by a person of over 18 years old (S145)
- Allowing the sale of alcohol to children under the age of 18 (S146)
- Selling liqueur confectionary to children under 16 (S147)
- Buying or attempting to buy alcohol whilst under the age of 18 but note the exemption for trading standards officers and police officers to conduct test purchases (S149)
- Buying or attempting to buy alcohol for children under 18 unless the child is over 16, accompanied by a person over 18, and beer, wine or cider has been purchased with a table meal (S149)
- Consuming alcohol by children under 18 on licensed premises unless the same exceptions as above apply (S150)
- Knowingly deliver alcohol to children under 18 (S151)
- Sending a child under 18 to obtain alcohol from off-licences but note the exception for police and trading standards officers to conduct test purchasing (S152)
- Knowingly allow a person under the age of 18 to sell alcohol unless the sale has been specifically approved by the licence holder or another responsible person (S153)

Most offences are punishable by a fine of up to level 1 or level 2 on the standard scale (£200 and £500 respectively), although offences relating to disorder on licensed premises or children can attract maximum penalties of up to level 5 (£5000).

Both Leeds City Council and West Yorkshire Police have the authority to bring prosecutions under the Act (S186). Trading Standards have authority to bring prosecutions in relation to test purchasing under S146 and S147, which they have a legal duty to enforce.

Review or Prosecution?

Deciding which way to handle a breach of a licence is a difficult choice. A Licensing Authority must decide on a case by case basis which is the most appropriate penalty as each has their strengths and weaknesses.

A prosecution can lead to a large fine and/or imprisonment, however either the premises licence holder or designated premises supervisor is prosecuted and the licence is unaffected. A prosecution can take a long time but has lasting consequences especially if that person then needs to undertake a criminal records bureau check.

A review is quicker, only takes 60 days but if there is serious crime or disorder the Police can request a summary review which provides immediate sanctions. However it is the licence that

is affected, not the management. The penalty provided by a review is not punishment, in the same way as prosecution is, but allows the premises time to change its operating practices in such a way as to not have a detrimental affect on the four licensing objectives.

Case law now shows us that we should only prosecute for serious breaches or unlicensed activity. Any issues relating to the management of the premises should be dealt with by a review of the premises licence.

More Information

More information is available on the Council's website at:

Making a representation:

http://www.leeds.gov.uk/Business/Licences_and_street_trading/Licence_alcohol_and_entertainment/Licensing_Act_2003_Guidance_on_making_representations_(objections).aspx

This page includes a separate guidance note on making representations, including the action you might like to take if asked to make a representation on behalf of a resident. It also hosts the form IP1 which has been designed to help interested parties in making a representation.

Requesting a review:

http://www.leeds.gov.uk/Business/Licences_and_street_trading/Licence_alcohol_and_entertainment/Licensing_Act_2003_Guidance_for_the_public_on_problem_premises_.aspx

This page includes information on the action to take when dealing with problem premises. It includes the contact details of other departments who can handle nuisance complaints, and more detailed information on requesting a review.

Should you have any questions, require clarification on any point, or would like to request any of the forms mentioned in this briefing note please contact Entertainment Licensing on the number below.

Contact details:

Entertainment Licensing Section

Phone: 0113 247 4095
Email: entertainment.licensing@leeds.gov.uk

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Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 16 February 2010

Subject: Updated Work Programme 2009/10

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

1.0 Purpose

1.1 The purpose of this report is to present and update members on the current activity across a number of work areas and present an outline work programme. The Board is asked to consider, amend and agree its work programme, as appropriate.

2.0 Background

2.1 At its meeting on 30 June 2009, the Board received a number of inputs to help members consider the Board's priorities during the current municipal year. This included specific inputs from:

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

2.2 At that meeting a number of potential work areas were identified by members of the Board. These potential areas were confirmed in a further report, along with an outline work programme, presented at the Board meeting held on 28 July 2009.

2.3 Subsequently, the outline work programme, including any emerging issues, is routinely presented to the Scrutiny Board for consideration, amendment and/or agreement: The work programme was most recently presented and agreed at the Scrutiny Board meeting held on 26 January 2010.

2.4 At that meeting, the Scrutiny Board received a comprehensive update against the main work areas currently under consideration, including:

- The role of the Council and its partners in promoting good public health – Scrutiny Inquiry
- Renal services in Leeds
- Provision of dermatology services at Ward 43 (Leeds General Infirmary (LGI))
- Use of 0844 Numbers at GP Surgeries
- Health Proposals Working Group
- Children's cardiac and neurosurgery services – national reviews
- Openness in the NHS

2.5 The Scrutiny Board also considered the requirement for all providers of NHS services to publish Quality Accounts – an annual public report on the quality of health care services delivered. The Scrutiny Board agreed to include consideration of draft quality accounts as an extension to the recently established arrangements for reporting performance to the Board and incorporate this aspect within its work programme for the current year.

2.6 As such, arrangements are being progressed to present draft quality account statements in March 2010.

3.0 Work programme (2009/10)

3.1 A revised outline work programme is presented at Appendix 1 for consideration.

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

3.3 As such, the Scrutiny Board is asked to consider the attached outline work programme for the remainder of the year and agree / amend as appropriate.

4.0 Recommendations

4.1 Members are asked to consider the details presented in this report and agree / amend (as appropriate) the outline work programme presented at Appendix 1.

5.0 Background Documents

Scrutiny Board (Health) – Updated Work programme (26 January 2010)

APPENDIX 1

Scrutiny Board (Health)
Work Programme 2009/10

Item	Description	Notes	Type of item
Meeting date – 16 February 2010			

Scrutiny Inquiry – promoting good public health	**Session 3:**
	To consider issues associated with ***promoting responsible alcohol consumption***, such as:
	• The role of the Council in terms of licensing policy and associated enforcement/ control procedures.
	• The role of the Council and its NHS health partners in developing and delivering an alcohol strategy that:
	  ○ Raises general public awareness of the health risks associated with alcohol consumption.
	  ○ Identifies and targets those groups most at risk from the affects of alcohol abuse, ensuring they have access to the most appropriate services and treatments.
	  ○ Assesses the quality and effectiveness of services and treatments associated with reducing alcohol related harm.
	• The social responsibility role of breweries, retailers and licensees and how this shapes the consumption of alcohol in Leeds.
			B/RP

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

APPENDIX 1

Scrutiny Board (Health)
Work Programme 2009/10

Item	Description	Notes	Type of item
Meeting date – 16 March 2010			
Renal services in Leeds	To consider the responses to the Scrutiny Board's statement and specific recommendations.	Statement published – December 2009.	MSR
Provision of dermatology services	To consider further progress in developing future plans for delivery of the service.	Previously considered in November 2009.	PM
Quarterly Accountability Reports and update on local NHS priorities	To receive quarter 3 performance reports and consider an update on the previously identified priorities for each local NHS Trust.	Updates from: • NHS Leeds • Leeds Teaching Hospitals NHS Trust • Leeds Partnerships NHS Foundation Trust	PM
Quality Accounts	To consider draft quality account submissions	Added to work programme in January 2010.	PM
Recommendation Tracking	To monitor progress against the recommendations agreed following previous Scrutiny Board inquiries.		MSR

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APPENDIX 1

Scrutiny Board (Health)
Work Programme 2009/10

Item	Description	Notes	Type of item
Meeting date – 27 April 2010			
Scrutiny Inquiry – promoting good public health	To agree the Board's final inquiry report.	Timing to be confirmed	
Annual Report	To agree the Board's contribution to the annual scrutiny report		

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APPENDIX 1

Scrutiny Board (Health)
Work Programme 2009/10

Working Groups			
Working group	**Membership**	**Progress update**	**Dates**
Health Proposals Working Group	*All Scrutiny Board members. Core membership of Cllr. Dobson and Cllr. Chapman*	• Working group re-established and terms of reference agreed. • Membership established • First meeting held on 3 December 2009	*3 December 2009*
Supporting working age adults with severe and enduring mental health problems		**This inquiry is being undertaken by the Scrutiny Board (Adult Social Care) with nominated representatives from Scrutiny Board (Health)** • Working group re-established and terms of reference agreed. • Membership established • Initial meeting dates arranged	*19 October 2009* *15 December 2009*
Scrutiny Inquiry – promoting good public health	*All Scrutiny Board members*	Proposed working group to consider issues around smoking and any other outstanding matters associated with the inquiry and identified by the Scrutiny Board	*To be agreed*

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Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Foundation Trust Status	To consider the outcome of the recent consultation exercise, including the key messages and any emerging issues.	To include the 'next steps' and anticipated costs associated with administering any new arrangements. Added to work programme in January 2010. Timing to be confirmed
Use of 0844 Numbers at GP Surgeries	To consider the impact of the recent Government guidance on local GP practices and any implications for patients.	Various correspondence exchanged and clarification sought. The Board to maintain a watching brief and kept up-to-date with any developments
Openness in the NHS	To consider how the Department of Health guidance is interpreted and implemented locally.	An outline of the approach adopted by the local NHS Trusts requested. Responses from NHS Leeds and LPFT received. Reply from LTHT awaited.

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Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Children's Cardiac Surgery Services	To contribute to the national review and consider any local implications.	First newsletter published (August 2009) National stakeholder event held 22 October 2009. Draft clinical standards issued for consultation. Clarification sought on local involvement and engagement activity.
Children's Neurosurgery Services	To contribute to the national review and consider any local implications.	First bulletin published (September 2009) National stakeholder event held 30 November 2009. Clarification sought on local involvement and engagement activity.
Narrowing the Gap	To consider the impact of the 'Narrowing the Gap' initiative, in terms of improving healthy outcomes.	Added to the work programme: December 2009

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Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Primary Care Service Development and use of the Capital Estate	In the light of NHS Leeds' decisions to withdraw from projects in Kirkstall and Holt Park, to consider the PCT's longer-term strategy for developing services through its capital estate.	Added to the work programme: December 2009
Health Scrutiny – Department of Health Guidance	To receive and consider revised guidance associated with health scrutiny and any implications for local practice.	Guidance was due to be published in November 2009. Indications are that this is likely to be delayed. No firm publication dates are yet available.
Specialised commissioning arrangements	To consider the current arrangements for specialised commissioning within the region and the role of scrutiny.	The planned Department of Health (DoH) consultation on developing / strengthening Health Scrutiny may have an impact.
Hospital Discharges	To consider a follow up report on progress against the recommendations (i.e. 15, 16 and 17) detailed in the Independence, Wellbeing and Choice inspection report	Consider report in September/ October 2009.
Out of Area Treatments (Mental Health)	To consider the report prepared by Leeds Hospital Alert and the response from LPFT.	Leeds Hospital Alert report received 1 July 2009. Response from LPFT requested on 1 July 2009.

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