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Leeds CITY COUNCIL

SCRUTINY BOARD (HEALTH)

Meeting to be held in Civic Hall, Leeds on
Friday, 25th June, 2010 at 10.00 am

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

MEMBERSHIP

Councillors

D Congreve - Beeston and Holbeck;
M Dobson (Chair) - Garforth and Swillington;
P Ewens - Hyde Park and Woodhouse;
P Harrand - Alwoodley;
J Illingworth - Kirkstall;
G Kirkland - Otley and Yeadon;
M Lobley - Roundhay;
J Matthews - Headingley;
A McKenna - Garforth and Swillington;
E Taylor - Chapel Allerton;

Co-opted Members (Non-Voting)

Arthur Giles - Leeds LINk
Razwanah Alam - Leeds Voice

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

Agenda compiled by:
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Principal Scrutiny Advisor:
Steven Courtney
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A G E N D A

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

Item No	Ward/Equal Opportunities	Item Not Open		Page No
3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATIONS OF INTEREST** To declare any personal/prejudicial interests for the purpose of Section 81 (3) of the Local Government Act 2000 and paragraphs 8 to 12 of the Members Code of Conduct.	
5			**APOLOGIES FOR ABSENCE** To receive any apologies for absence.	
6			**MINUTES - 25TH MAY 2010** To confirm as a correct record the attached minutes of the meeting held on 25th May 2010.	1 - 6
7			**CO-OPTED MEMBERS ON SCRUTINY BOARDS** To receive and consider the attached report of the Head of Scrutiny and Member Development.	7 - 10
8			**CHANGES TO THE COUNCIL'S CONSTITUTION IN RELATION TO SCRUTINY** To receive and consider the attached report of the Head of Scrutiny and Member Development.	11 - 12
9			**INPUT INTO THE BOARD'S WORK PROGRAMME 2010/11 - SOURCES OF WORK AND ESTABLISHING THE BOARD'S PRIORITIES** To receive and consider the attached report of the Head of Scrutiny and Member Development.	13 - 144

Item No	Ward/Equal Opportunities	Item Not Open		Page No
10			**KIRKSTALL JOINT SERVICE CENTRE** To receive and consider the attached report of the Head of Scrutiny and Member Development.	145 - 164
11			**DETERMINING THE BOARD'S WORK PROGRAMME 2010/11** To receive and consider the attached report of the Head of Scrutiny and Member Development.	165 - 194
12			**DATES AND TIMES OF FUTURE MEETINGS** Tuesday 27th July 2010 Tuesday 21st September 2010 Tuesday 26th October 2010 Tuesday 23rd November 2010 Tuesday 21st December 2010 Tuesday 25th January 2011 Tuesday 22nd February 2011 Tuesday 22nd March 2011 Tuesday 26th April 2011 All at 10.00a.m. (Pre-Meetings 9.30a.m.).	

SCRUTINY BOARD (HEALTH)

TUESDAY, 25TH MAY, 2010

PRESENT: Councillor M Dobson in the Chair

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

Co-optees Arthur Giles – Leeds LINk
Razwanah Alam – Leeds VOICE

87 Late Items

In accordance with his powers under Section 100B(4)(b) of the Local Government Act 1972, the Chair admitted to the agenda the following late reports and supplementary information relating to the following agenda items:-

Agenda Item 8 – Foundation Trust Costs – Summary Briefing.

Agenda Item 9 – Renal Services in Leeds – Report following the Leeds Teaching Hospitals Trust Board on 20 May 2010.

Agenda Item 10 – Copy of the Scrutiny Board's proposed final Inquiry Report into Promoting Good Public Health, together with the advice and comments of the Directors and Chief Officers in respect of the Board's recommendations.

Agenda Item 11 – Copy of the Chair's Summary to preface the Board's contribution to the composite Annual Scrutiny Report for submission to Council.

None of the above documents had been available at the time of the agenda despatch.

88 Declarations of Interest

Councillor Chapman declared a personal interest in relation to Agenda Items 9 and 10 in respect of a relative who worked in the health care sector.

89 Minutes - 16th March 2010

RESOLVED – That the minutes of the meeting held on 16th March 2010 be confirmed as a correct record.

90 Draft Quality Accounts 2009/10 - Leeds Teaching Hospitals NHS Trust and Leeds Partnership Foundations Trust

Further to Minute No. 66, 26th January 2010, the Head of Scrutiny and Member Development submitted for the Board's consideration and comment the draft 2009/10 Quality Account Reports of the Leeds Teaching Hospitals NHS Trust (LTHT) and Leeds Partnership Foundations Trust (LPFT).

In attendance at the meeting, and responding to Members' queries and comments, were:-

- Guy Musson, Deputy Chief Executive, LPFT
- Julia Roper, Quality Improvement Manager, LTHT

In brief summary, the main areas of discussion were:-

- A current lack of targets in respect of the LPFT document.

  It was explained that this was the first full year of producing the statutory Quality Accounts and there was currently no baseline data for comparison purposes. However, the point was acknowledged and the Board could expect to see targets in future years.

- The current dual monitoring and assessment arrangements, involving both the official Monitor and the Care Quality Commission, and the slightly different assessment regimes involved. It was to be hoped that, possibly, these arrangements might be rationalised in the future.

- The numbers and percentage of re-admissions of patients within 28 days of discharge and some of the reasons underlying the statistics.

- A suggestion that when the Quality Accounts were published, they should be supplemented by a glossary explaining the various acronyms used, and a simplified bullet point summary of each document.

- The LTHT report referred to accessibility, and the view was expressed that this should apply equally to information and not just service provision. Whilst understanding the need for some patient confidentiality, it was felt to be important to keep close relatives and carers informed of developments.

- Reference was made to the Board's previously expressed and continuing concerns regarding the present consultation methods of LTHT, e.g. the lack of meaningful consultation on the issue of the provision of renal services at Leeds General Information (LGI). It was suggested that some sort of reflection on this issue on the part of the LTHT should, perhaps, be included in the Quality Account Statement.

- Recognising and responding to acutely ill patients – reference was made to efforts to embed, locally, national best practice in this area.

RESOLVED –

a) That the officers be thanked for their attendance and the manner in which they have responded to Members' queries and comments.

b) That the Principal Scrutiny Adviser, in consultation with the Chair, prepare and circulate to Board Members a draft Board Submission on the Quality Accounts for submission to both LPHT and LTHT.

91 Leeds Teaching Hospitals NHS Trust - Foundation Trust Status - Update Report

Further to Minute No. 65, 26th January 2010, the Board received an update on the progress of the public consultation exercise regarding LTHT's proposal to achieve Foundation Trust status.

Ross Langford, Head of Communications, LTHT, was in attendance at the meeting and responded to Members' queries and comments. In brief summary the main issues discussed were:-

- Ross Langford outlined some of the agreed changes as a result of the consultation to date. The more significant ones were an increase in the number of Elected Governors, from 21 to 23, and the Appointed Governors, from 9 to 11, making a revised total of 40 Governors. It had also been agreed to amend the proposed constituency boundaries from 9 to 10, and these would be aligned with Council Area Committee boundaries.

- Many of the Scrutiny Board's subsequent comments and concerns reflected the main concerns identified in the overall public consultation exercise, in particular :-

- The costs of implementing Foundation Trust status and the resultant bureaucracy;

- A lack of clarity regarding any perceived direct benefit for patients; and

- The cost of the consultation exercise and whether it was real or cosmetic.

  Members requested comparative figures for the current administration costs of LTHT and the estimated costs of the new arrangements.

- Concern was also expressed regarding current communication and consultation difficulties between LTHT and its patients and, to an extent, the Scrutiny Board (Health), and whether the new arrangements would actually improve those areas.

- Whilst Members accepted the principles which lay behind the exercise, and that democracy came at a price, overall they remained to be convinced, and would require further details regarding costs, how the

proposals would work in reality, especially the LTHT Board/Board of Governors arrangements/relationships, and the perceived benefits to front-line services.

RESOLVED –

a) That, subject to the above comments and requests for further information, the progress report be received and noted.

b) That Ross Langford be thanked for attending the meeting and the manner in which he has responded to Members' queries and comments, and he be invited to update the Board again at a future meeting.

(NB: Councillor Yeadon left the meeting at 11.02 am, during the consideration of this item.)

92 Renal Services in Leeds

Further to minute 85, 16th March 2010, the Head of Scrutiny and Member Development submitted a report advising the Board that, at its meeting held on 20th May 2010, the LTHT Board had decided not to proceed with the development of a renal haemodialysis unit at LGI.

In summary, the Scrutiny Board remained extremely concerned and unhappy at the decision, the rejection of its own finding and recommendations, and at what it regarded as wholly inadequate consultation and supporting evidence on the part of LTHT.

The Scrutiny Board considered the options now available to it, in particular taking into account the advice of the Head of Scrutiny and Member Development contained in paragraph 4.3 of his report regarding referrals to the Secretary of State for Health.

RESOLVED – (a) That further to the full Council resolution on 21st April 2010, the decision of LTHT not to provide a satellite renal dialysis unit at LGI be formally referred to the Secretary of State for Health, on the basis of the decision not being in the interest of the local health services.

(b) That, as part of the formal referral, the Principal Scrutiny Advisor prepares and circulates a brief statement setting out the Board's concerns regarding the recent Trust Board decision.

93 Scrutiny Inquiry Report: Promoting Good Public Health

The Board considered its proposed final Inquiry Report, together with the comments and advice of Directors and chief Officers regarding the proposals.

RESOLVED – That, subject to the acceptance of the advice from the Director of Adult Social Services in respect of Recommendations 4 and 7, the Board's proposed final Inquiry report be approved and published.

94 Annual Report

RESOLVED – That the Board's proposed contribution to the composite Annual Scrutiny Report be approved, as updated to reflect decisions taken at today's meeting.

95 Chair's Closing Remarks

The Chair thanked Members, present and past, and officers for their contributions to the work of the Board during what had been a challenging year in which the Board had tackled some significant issues in a meaningful way.

In particular, he paid tribute, endorsed by the Board, to the tremendous work performed by Steven Courtney, Principal Scrutiny Adviser, on the Board's behalf.

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Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board: Scrutiny Board (Health)

Date: 25 June 2010

Subject: Appointment of Co-opted Members

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

1.0 Purpose of the report

1.1 The purpose of this report is to seek the Scrutiny Board's formal consideration for the appointment of co-opted members to the Board.

2.0 Background

2.1 For a number of years the Council's Constitution has made provision for the appointment of co-opted members to individual Scrutiny Boards. For those Scrutiny Boards where co-opted members have previously been appointed, such arrangements have tended to be reviewed on an annual basis, usually at the beginning of a new municipal year. However, the appointment of co-opted members has not always been considered consistently across all Scrutiny Boards.

Leeds City Council Scrutiny Review (May 2009)

2.2 As part of their 2008/09 Audit and Inspection Plan, KPMG (the Council's external auditors) carried out a review of the Council's Overview and Scrutiny function. A specific aspect of the review related to the appointment of co-opted members to Scrutiny Boards.

2.3 The relevant extract and associated recommendation from the KPMG report is detailed below:

Having attended Scrutiny meetings at LCC that had both co-opted Members on the Board and no co-opted Members there appeared to be a greater level of participation by all when the Boards contained co-opted Members. In addition the contribution made by the co-opted Members was very valuable as these Members were able to draw upon their experiences and provide a different perspective.

Currently the constitution of LCC does allow all Scrutiny Boards to have co-opted members it is just something that is not widely exercised. This is almost the opposite at Bristol City Council where there are a large number of Scrutiny Boards with co-opted Members. The Scrutiny Support Unit has however been proactive in this area and have recently taken a paper to the Scrutiny Advisory Group highlighting the benefits of having co-opted Members on Scrutiny Boards.

Recommendation Six

Each of the Scrutiny Boards should assess more formally whether co-opted Members should be invited to participate in their Board so to allow them to draw from the benefits of their involvement.

2.4 In response to this recommendation, it was agreed that each year, all Scrutiny Board would be formally asked to consider the potential involvement of co-opted members throughout the year.

3.0 Arrangements for appointing co-opted members

General arrangements

3.1 It is widely recognised that in some circumstances, in particular where there is some specialist knowledge or skill, co-opted members can significantly aid the work Scrutiny Boards. This is currently reflected in Article 6 (Scrutiny Boards) of the Council's Constitution, which outlines the options available to Scrutiny Boards in relation to appointing co-opted members. In general terms, Scrutiny Boards can appoint:

- Up to five non-voting co-opted members for a term of office that does not go beyond the next Annual Meeting of Council ; and/or,
- Up to two non-voting co-opted members for a term of office that relates to the duration of a particular and specific scrutiny inquiry.

Specific arrangements

3.2 In the majority of cases the appointment of co-opted members is optional and is determined by the relevant Scrutiny Board, however, there are some particular legislative exceptions. Such cases are also set out in Article 6 (Scrutiny Boards) of the Council's Constitution and summarised below:

Education Representatives

3.3 In addition to elected Members appointed by Council, the relevant Scrutiny Board dealing with education matters shall include in its membership the following voting representatives, in accordance in accordance with statutory requirements set out in the Local Government Act 2000:

- One Church of England diocese representative[1]
- One Roman Catholic diocese representative[1]
- Three parent governor representatives[2]

Where the Scrutiny Board deals with other non-educational matters the co-opted members may participate in any discussion but shall not be entitled to vote on those matters.

[1] Article 6 states this appointment shall be for a term of office that does not go beyond the next Annual Meeting of Council

[2] Article 6 states these appointments shall be for a four-year term of office

Crime and Disorder Committee

3.4 In accordance with the requirements of the Police and Justice Act 2006, the Council has designated the Scrutiny Board (Environment and Neighbourhoods) to act as the Council's crime and disorder committee.

3.5 In its capacity as a crime and disorder committee, the Scrutiny Board (Environment and Neighbourhoods) may co-opt additional members to serve on the Board, providing they are not an Executive Member

3.6 The Scrutiny Board (Environment and Neighbourhoods) may limit the co-opted member's participation to those matters where the Scrutiny Board is acting as the Council's crime and disorder committee.

3.7 Unless the Scrutiny Board (Environment and Neighbourhoods) decides otherwise, any co-opted member shall not be entitled to vote and the Board may withdraw the co-opted membership at any time.

4.0 Issue to consider when seeking to appoint co-opted members

4.1 Currently, there is no overarching national guidance or criteria that should be considered when seeking to appoint co-opted members. As a result, there is a plethora of methods employed within Councils for the appointment of co-optees to Overview and Scrutiny Committees (Scrutiny Boards). For example, some councils use "job descriptions", some carry out formal interviews and some advertise for co-optees in the local press, with individuals completing a simple application form which is then considered by Members.

4.2 In considering or seeking the appointment of co-opted members, Scrutiny Boards may find it useful to consider that co-opted members should:

- Add value to the work of the Scrutiny Board and/or specific inquiry, by having some specialist skill or knowledge
- Be considered as representatives of wider groups of people. For example, service user representatives, voluntary or community groups etc.
- Not be seen as a replacement to professional advice from officers;
- Be mindful about the extent of any potential conflicts of interest;

4.3 Despite the lack of any national guidance, what is clear is that any process for appointing co-opted members should be open, effective and carried out in a manner which seeks to strengthen the work of Scrutiny Boards.

4.4 In addition, when considering the issue of co-opted members, Scrutiny Boards should also be mindful of the role of expert witnesses and seeking information / evidence from a variety of different sources to help fulfill the objectives of the work programme and/or a specific inquiry.

5.0 Scrutiny Board (Health)

5.1 For a number of years, Scrutiny Board (Health) has consistently appointed non-voting co-opted members on an annual basis. In the previous year, in reviewing its arrangements for co-opted members, the Scrutiny Board agreed to allocate and seek nominations for co-opted members from the following organisations:

- Leeds Voice (Health Forum); and,

- Leeds Local Involvement Network (LINk)..

5.2 A representative to act as a non-voting co-opted member was subsequently confirmed by each organisation.

5.3 In December 2009, the Leeds Voice (Health Forum) representative retired and ended a long-standing association with the Scrutiny Board (Health). As an interim measure, the coordinator supporting the work of Leeds Voice (Health Forum) was subsequently nominated to act as the organisation's representative for the remainder of the municipal year (2009/10).

5.4 However, the term of office for these appointments has now come to an end and the Scrutiny Board (Health) is now asked to consider its preferred arrangements for the current municipal year (i.e. 2010/2011).

6.0 Recommendation

6.1 Taking into account the information and advice provided in this report, the Scrutiny Board (Health) is asked to consider its preferred arrangements for the appointment of non-voting co-opted members for the current municipal year (i.e. 2010/2011).

7.0 Background Papers

- The Council's Constitution
- Police and Justice Act 2006
- KPMG Scrutiny Review May 2009

Leeds CITY COUNCIL

Originator: P N Marrington

Tel: 39 51151

Report of the Head of Scrutiny and Member Development

Scrutiny Board: Scrutiny Board (Health)

Date: 25 June 2010

Subject: Changes to the Council's Constitution in relation to Scrutiny

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

1.0 Purpose of Report

1.1 This report provides the Board with information on recent amendments to the Council's Constitution, as agreed by Council on 27th May 2010, which directly relate to and/or impact on the work of Scrutiny Boards.

2.0 Background

2.1 The annual review of Scrutiny more often than not identifies a number of areas for amendment within Article 6 of the Constitution, the Scrutiny Boards' Terms of Reference and the Scrutiny Board Procedure Rules. These are either to ensure consistency in wording, to reflect legislative changes or to provide procedural clarity.

2.2 The more significant amendments agreed by Council were:

Article 6

- Additional bullet point to clarify that value for money reviews on particular services, functions or issues relating to their area of responsibility may be undertaken by Scrutiny Boards.

- Amendment to reflect the designation and duties of the Council's Scrutiny Officer.

- Amendment to the power to co-opt onto the Crime and Disorder Committee, following recent amendments to legislation,

Scrutiny Board Terms of Reference

- That there are six Scrutiny Boards achieved by the deletion of Scrutiny Board (City and Regional Partnerships). These functions will be taken up by all Boards, with the lead for City Region and Leeds Initiative resting with Scrutiny Board (Central and Corporate Functions).

- Additional bullet point to clarify that value for money reviews on particular services, functions or issues relating to their area of responsibility may be undertaken by Scrutiny Boards.

Scrutiny Board Procedure Rules

- Minor amendments and re-ordering of paragraphs to distinguish between reviews and other items of work which may result in reports and recommendations, and full Scrutiny Inquiries which involve formal terms of reference, the use of the Inquiry selection criteria and formal discussion with the relevant Executive Board Member.

- Inclusion of specific reference to "Partner Authorities", including new powers for Scrutiny Boards to require information, reflecting legislation.[1] .

- Clarification that should a Member withdraw their signature from a Call In and no further signatures are obtained within the required time period, the Call In will fall.

- That substitutions are permitted for all Scrutiny Boards. Substitutes are to be drawn from the pool of Scrutiny Board Members.

3.0 Recommendations

3.1 In fulfilling the role and function of the Scrutiny Board, Members are requested to note the amendments to the Council's Constitution outlined in this report.

4.0 Background Papers

- The Council's Constitution

[1] Local Authorities (Overview and Scrutiny Committees)(England) Regulations 2009

Leeds CITY COUNCIL

Originator: Steven Courtney
Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board: Scrutiny Board (Health)

Date: 25 June 2010

Subject: Input to the Work Programme 2010/11 – Sources of Work and Establishing the Board's Priorities

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

1.0 Purpose of Report

1.1 This report provides information and guidance to assist the Board develop its work programme for 2010/11.

2.0 Background

2.1 For reference and/ or information purposes, a copy of the Board's terms of reference is attached at Appendix 1. A copy of the previous Board's annual report (2009/10) is attached at Appendix 2.

2.2 In addition, relevant information from the following key sources have been extracted appropriate to this Board's responsibilities and attached (Appendix 2) to this report to assist Members in developing the Board's work programme for 2010/11:

- Leeds Strategic Plan 2008 -2011 – Executive Summary – (Appendix 3a);
- Combined extract from Leeds' Director of Public Health Annual Reports (2008 and 2009) – outlining recommendations for action to reduce health inequalities (2008) and associated progress (2009) – (Appendix 3b);
- List of scrutiny inquiries relevant to the Board's portfolio undertaken since 2003 – (Appendix 3c).

2.3 Once agreed, the Scrutiny Board's work programme should be considered as a live document that will evolve over time to reflect any changing and/or emerging issues identified throughout the year. As such, other sources of work, such as 'requests for scrutiny' and corporate referrals are likely to continue.

3.0 Health and Well– Being Partnership Plan (2009 – 2012)

3.1 Health and wellbeing is one of eight key themes within the Leeds Strategic Plan (2008-2011). The Health and Wellbeing Partnership Plan (2009 – 2012) is part of the broader Leeds Strategic Plan, and is based on the outcomes and priorities agreed by the Council and its partners and shaped by local people.

3.2 The Health and Wellbeing Partnership Plan (2009 – 2012) 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 4).

3.3 During the previous year, the Scrutiny Board undertook an inquiry that examined the role of the Council and its Partners in promoting good public health – by examining three specific areas of public health, namely sexual health, obesity and alcohol related harm.

3.4 In light of the work undertaken by the previous Board, members are asked to consider the improvement priorities identified in the Health and Wellbeing Partnership Plan (2009 – 2012).

3.5 In addition, in March 2010, it should be noted that the Department of Health (DH) published the Chief Medical Officer's Annual Report (2009) which includes general comment on the state of public health. It also provides comment on specific issues and public health activity across the regions. In relation to Yorkshire and the Humber, specific reference is made to the challenge of financial inclusion – citing some specific work undertaken in Leeds. This publication may provide a useful source of information to both inform the work programme and provide evidence for any specific inquiries. A copy of the publication is attached at Appendix 5.

4.0 Guidance

4.1 Over the last few years of Scrutiny Board work, experience has shown that the process is more effective if the Board seeks to minimise the number of substantial inquiries running at any one time. This view was echoed within the findings of the recent KPMG external report on the Scrutiny function in Leeds.

4.2 The Board is advised to consider the benefits of single item agendas (excluding miscellaneous information and minutes) in order to focus on all the relevant evidence and complete an inquiry in a shorter period of time. There are various mechanisms available to assist the Board in concluding inquiries quickly, such as working groups and site visits.

4.3 The agreed Memorandum of Understanding between Executive Board and Overview and Scrutiny which sits within the Council's Constitution states;

The responsibility of those setting scrutiny work programmes is, therefore, to ensure that items of work come from a strategic approach as well as a need to challenge service performance and respond to issues of high public interest.

It is recognised that Scrutiny Boards have a 'watching brief' role. In addition information is required for members' own development process, particularly as membership of the Boards is changed annually.

However, it is also recognised that agendas are often filled up with reports for this purpose, which takes up time for both officers and Members. Where Scrutiny Boards wish to ask questions at a general or more strategic level and/or be updated on issues already considered in detail, the facility of Members' Questions – where a verbal exchange replaces written reports - should be used.

It is expected that where ever possible prior notification is given of the likely questions to be asked".

4.4 Over recent years the Children's Services Board in particular has continued to develop the approach of devoting one meeting per quarter to performance management and 'horizon scanning' issues. This includes discussing relevant issues with Executive Members and officers, and has been acknowledged as good practice.

4.5 During the previous year, the Scrutiny Board (Health) worked towards establishing similar arrangements for considering performance, which included formal consideration of the Quality Accounts produced by Leeds Teaching Hospitals NHS Trust (LTHT) and Leeds Partnerships NHS Foundation Trust (LPFT).

4.6 The Board is advised to consider further development and strengthening of such arrangements.

5.0 Work programming

5.1 To assist the Scrutiny Board and contribute to the discussions about the Board's work programme for 2009/10, the following have been invited to attend the meeting:

- The Executive Member for Adult Health and Social Care (Councillor Lucinda Yeadon);
- The Director of Adult Social Services (or nominee);
- The Chair and Chief Executive of local NHS Trusts.

5.2 Following discussions detailed elsewhere on the agenda, the Board will be asked to determine an outline work programme that prioritises the issues the Board wishes to consider in more detail

6.0 Recommendations

6.1 Members are requested to use the attached information and the discussion with those present at the meeting to develop its work programme.

7.0 Background Papers

- The Council's Constitution
- Council Business Plan 2008 – 2011
- Leeds Strategic Plan 2008 – 2011
- Leeds Health and Well– Being Partnership Plan (2009 – 2012)

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Appendix 1

Scrutiny Board (Health)[1]

Terms of Reference[2]

1. To review any matter relating to the planning, provision and operation of health services in relation to:

   - arrangements made by local NHS bodies[3] and the authority to secure hospital and community health and health related services to the inhabitants of the authority's area;
   - the provision of such services to those inhabitants;
   - the provision of family health services (Primary Care Trust), personal medical services personal dental services, pharmacy and NHS ophthalmic services;
   - the public health arrangements in the area including arrangements by local NHS bodies for the surveillance of, and response to, outbreaks of communicable disease or the provision of specialist health promotion services;
   - the planning of health and health related services by local NHS bodies and the authority, including plans made in co-operation with partners for setting out a strategy for improving both the health of the local population and the provision of health care to that population;
   - the arrangements made by local NHS bodies and the authority for consulting and involving patients and the public under the duty placed on them by Section 11 of the Health and Social Care Act 2001;
   - any proposals for a substantial development or variation of health services within the authority's area.

2. To consider such proposals as are referred to it by local NHS bodies and the authority and to report back the result of its considerations to the referring body and others as appropriate.

3. To review how and to what effect health policy is being implemented, and health improvement achieved, by the authority and local NHS bodies and to make reports and recommendations as appropriate.

4. To receive representations from Area Committees or relevant groups of interest and to report to the authority and local NHS Bodies as appropriate.

5. In relation to matters in respect of which a local NHS body consults more than one scrutiny committee within its area, or in relation to matters which a number of West Yorkshire Metropolitan Councils elect to jointly scrutinise a function or service provided by the NHS body, to:

   (i) nominate Members to a joint committee, such nominations to reflect the political balance of the Board;

   (ii) delegate its scrutiny functions to another local authority.

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[1] Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002 as amended.

[2] Subject to the amendments outlined in the Constitutional Changes report elsewhere on the agenda.

[3] In Leeds this means the Primary Care Trust (NHS Leeds), the Leeds Teaching Hospitals NHS Trust, the Leeds Partnership Foundation Trust and NHS Yorkshire and the Humber

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Scrutiny Board (Health)

Councillor Mark Dobson
Chair of Scrutiny Board
(Health)

Membership of the Board:
Councillor Mark Dobson (Chair)
Councillor Sue Bentley
Councillor Judith Chapman
Councillor David Congreve
Councillor David Hollingsworth (part year)
Councillor John Illingworth
Councillor Mohammed Iqbal
Councillor Graham Kirkland
Councillor Alan Lamb
Councillor Graham Latty (part year)
Councillor Linda Rhodes-Clayton (part year)
Councillor Paul Wadsworth (part year)
Councillor Lucinda Yeadon

Co-opted Members:
Mr Eddie Mack (part year)
Mr Arthur Giles (part year)

The Chair's summary

In my first year as Chair of the Health Scrutiny Board, it is with a great deal of satisfaction and sense of pride that I submit this year's annual report.

The year has been particularly challenging as we have strived to make a significant contribution to the well being of the people of Leeds. The Board has taken a very proactive role in raising and responding to public concerns over some proposals put forward by some of our key NHS partners. In order to protect local health services and the patients they support, we have robustly challenged proposals and sought clarity from a wide range of NHS organisations on a number of issues.

We have covered a considerable range of areas and different issues over the course of the year. The main issues and areas covered include:

- Scrutiny inquiry into Promoting Good Public Health;
- Renal Services in Leeds;
- Dermatology Services; and,
- Leeds Teaching Hospitals NHS Trust – Foundation Trust proposals.

A brief outline of these areas is provided elsewhere in this report, along with an summary of the Board's full work programme. However, I think some of the Boards highlights over the year have been:

- Identifying the need to strengthen the consideration of 'health implications' within the Council's decision-making processes – similar in nature to legal and financial implications;
- Recognition of the Board's work, leading to a positive profile across an increasing range of local, regional and national NHS organisations;
- Successfully championing the views of patients – demonstrated through the work around dermatology and renal services. Specifically in terms of renal services, this included a public apology that collectively, the local NHS had failed to fully engage with the Scrutiny Board and other interested parties early enough in the process.
- Being instrumental in a significantly improved working relationship between LTHT and dermatology patients – which included the forming of a recognised dermatology patients panel;
- Receiving assurance from the Strategic Health Authority (NHS Yorkshire and the Humber) that the issues highlighted by the Board's work around renal services would be considered as part of appropriate accountability processes for both NHS Leeds and LTHT.
- Amended constituency boundaries and a clear commitment to improving patient involvement and engagement arrangements as part of LTHT's revised Foundation Trust proposals: This was a direct result of the Board's consultation response on the original proposals, which drew on the experience of the Board's work around renal services and dermatology services;

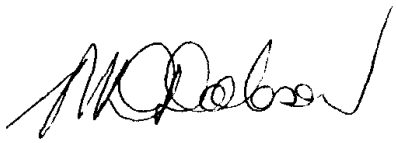
I feel that the Board has also established an approach to some aspects of its work programme that need to be maintained and developed over coming years. These include:

- Regular discussions with each of the local NHS trusts;
- Improved quarterly performance management arrangements – which includes a joint NHS Leeds and Leeds City Council performance report;
- Re-establishment of arrangements to consider potential service changes and/or developments.

However, there is still work to do – and the Board needs to be flexible to adapt to the ever changing environment it operates in. As public finances take the strain of the global economic downturn, I feel the work of the Board and the role it plays will be increasingly important. Clearly, responsibility for decisions within local NHS Trusts is not just the responsibility of Executive Directors: Trust Boards and Non-Executive Directors play a significant role, and I believe it is important to establish better working relationships in this area – by establishing clearer, and more consistent terms of engagement. In this regard, and with the Board's consent, I have written to the current Chair of each local NHS Trust seeking their views on how these relationships can be more clearly established and developed. I see this as an area for further development over the coming year.

In summary, through our work as the Council's watchdog for health, I believe that Board has effectively and significantly raised the public profile of its work – receiving regular and frequent coverage through the local media. In addition, the Board has been successful in looking beyond the traditional boundaries of our local NHS partners for contributions to its work – highlighting the cross-cutting nature of health issues. As such, I would like to thank everyone who has contributed to the work of the Board during the year, including internal and external witnesses, scrutiny and governance officers and to Members of the Board for completing our busy work programme with such enthusiasm and commitment.

I look forward to the improved ways of working continuing to develop and become more established over the coming year.



Cllr Mark Dobson, Chair of Scrutiny Board (Health)

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The Role of the Council and its Partners in Promoting Good Public Health

Summary

The overall aim of our inquiry was to make an assessment of the role of the Council and its partners in developing, supporting and delivering improvements to public health. In this regard, the specific targets set out in the Leeds Health and Wellbeing Plan (2009-2012) and its associated strategies were used and considered to inform our discussions. For practical reasons we focused on the following specific areas of public health:

- 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; and,
- Promoting responsible alcohol consumption.

Anticipated service benefits

The outcome of this inquiry adds to the existing body of evidence aimed at delivering improvements to public health. It also serves to further raise the profile of the importance of public health matters – publicly, professionally and politically.

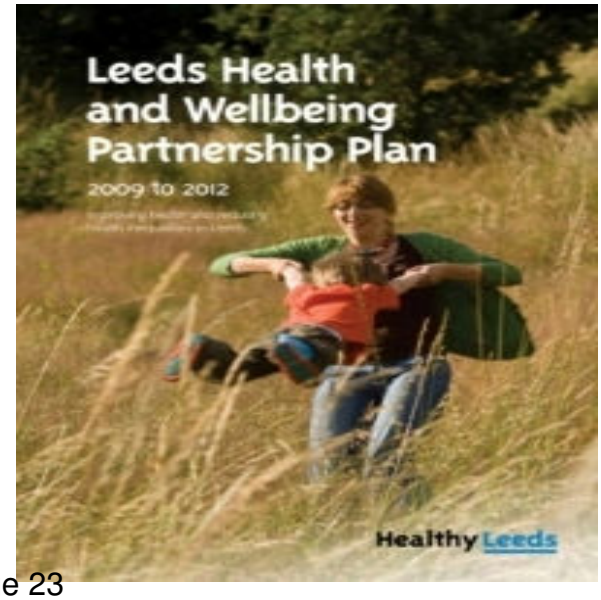
Our main recommendations

That, as soon as practicable, the Director of Children's Services writes to the appropriate Minister and Government Department in an attempt secure a national direction for the delivery of consistent and high quality Sex and Relationship Education (SRE) in local schools.

That, as part of the overall Leeds Development Framework and prior to formal submission, the Director of City Development and the Director of Public Health ensure that the public health agenda and relevant *NICE* recommendations are appropriately addressed and reflected in the Core Strategy.

That, by July 2010, the Department of Health (in collaboration with any other appropriate Government Department) be strongly urged to work towards the introduction of a minimum price per unit of alcohol, as soon as practicable: This may include, but should not be restricted to, a review of current competition laws and regulations, as appropriate.

That, as soon as practicable, the Director of Public Health and the Head of Licensing and Registration, jointly write to the appropriate Minister and Government Department in an attempt to secure changes to the current licensing legislation, that would result in 'public health' considerations becoming material consideration within the licensing application process.



Statement on Renal Services in Leeds

Summary

In June 2009,we were extremely concerned to hear about proposals to abandon plans to re-provide the dialysis facilities at Leeds General Infirmary (LGI). The delivery of a 10–station renal dialysis unit at (LGI) has been a long awaited development for Leeds' kidney patients and had been a long-standing commitment of Leeds Teaching Hospitals NHS Trust (LTHT) since 2006. Despite receiving a range of information from key stakeholders, including regional and local service commissioners, LTHT and transport providers, we were not satisfied with the rationale presented and strongly opposed the approach adopted by LTHT.

In May 2010, despite our best efforts to seek a local resolution to this issue, the LTHT Board decided not to proceed with the previously agreed proposals. As such, we were left little option but to refer this matter to the Secretary of State for Health. We will eagerly await the outcome of any further review of the decision.

Anticipated service benefits

In the case of renal services, the needs of patients were seemingly a secondary issue and largely ignored. By acting swiftly we sent a clear message that these cannot be ignored when planning changes to services.

Our main recommendations

Leeds Teaching Hospitals NHS Trust immediately re-affirms its commitment to re-provide dialysis facilities at Leeds General Infirmary and finalises plans for replacement dialysis facilities at Leeds General Infirmary and deliver these as soon as practicable, but no later than December 2010.

Prior to finalising the draft Yorkshire and Humber Renal Network Strategy for Renal Services (2009-2014), the Yorkshire and the Humber Specialised Commissioning Group review current consultation arrangements and, through dialogue with overview and scrutiny committees across the region, develop an extensive 12-week consultation plan.

"By not providing this unit, there is no local dialysis for the population of West/Northwest Leeds who require dialysis. Inpatients at the LGI who require dialysis will continue to be treated by a locally based renal support team, which is less cost effective, in staffing, than treating the patients from a static dialysis unit"

Extract from LTHT Business Case November 2007

"We believe that kidney patients have waited long enough for the promised re-provision of dialysis facilities at Leeds General Infirmary: The Trust should stop prevaricating and deliver what has been agreed and promised".

Councillor Mark Dobson
Chair Scrutiny Board Health

Other work of the Board

Local NHS Priorities

We received and discussed in some detail a number of briefing papers which identified key issues and priorities for NHS Leeds, Leeds Partnerships NHS Foundation Trust, and Leeds Teaching Hospitals NHS Trust. Initially helping us to develop our own work programme, we have also focused on local priorities through the established quarterly monitoring arrangements.

Leeds General Infirmary – Brotherton Wing

Foundation Trust Proposals

We considered LTHT's initial proposals as part of its plans to achieve Foundation Trust status and submitted a formal consultation response. Based on our experiences around renal services and dermatology we had grave concerns about the Trust's capacity around patient and public involvement. We were also concerned about the Trust's proposed constituencies and felt these should match the Council's already established Area Committee boundaries. The Trust accepted this point and revised its proposals.

Dermatology Patients

In October 2009, we were faced with a number of dermatology patients fearing for the future of the dedicated ward at Leeds General Infirmary. Significant concern about the impact of proposed changes or closure of the service was also expressed by the British Association of Dermatologists (BAD). Our intervention was pivotal in LTHT re-thinking proposals and subsequently engaging patients and carers in the redesign of the service. While final plans are still to be confirmed, we are pleased that our involvement has had a positive impact.

The Leeds Teaching Hospitals NHS
NHS Trust

Proposed constituencies

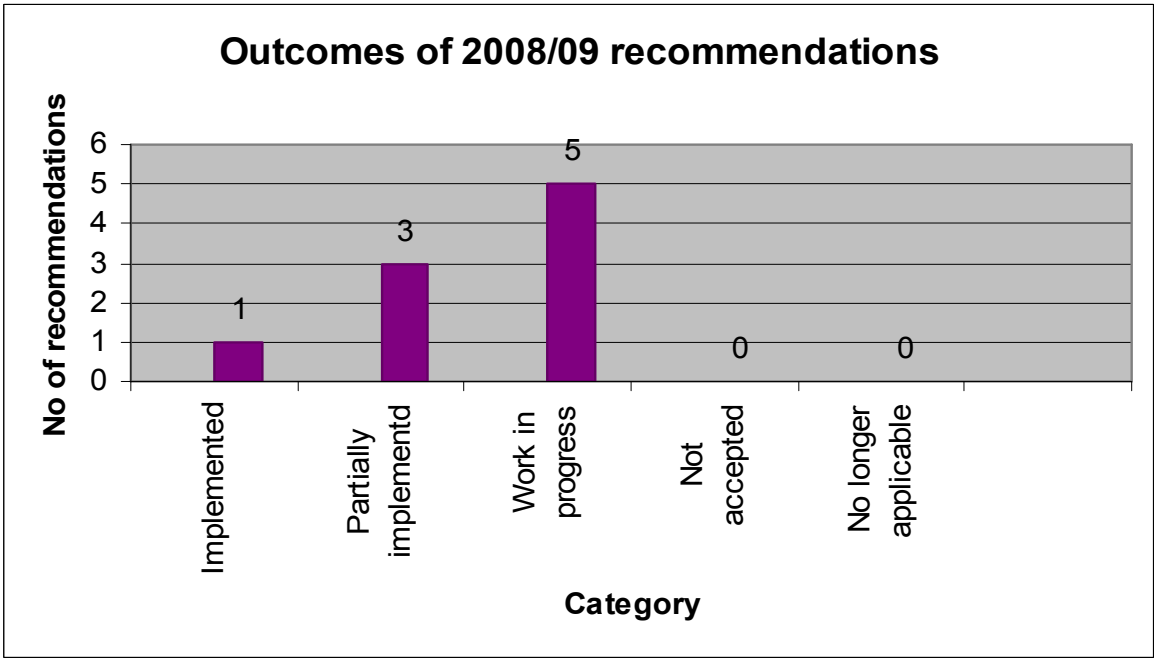
Outcome of recommendations made in 2008/09

The previous Scrutiny Board (Health) carried out an inquiry in 2008/09 on improving sexual health among young people. The Board identified 9 recommendations and this section highlights some examples of where these recommendations have resulted in service benefits, or otherwise added value.

We recommended that NHS Leeds and Leeds City Council work together to establish a local data set as soon as possible, and that this information is regularly made available to everyone who has a role to play in tackling teenage conception.

This has resulted in an Information Sharing Agreement between all relevant partners being established. Work has commenced on establishing a local data set, identifying data leads within each partner agency and agreeing timescales to ensure the data is shared and made widely available. Partners are using the nationally recommended local dataset and ensuring all service level agreements have identified data to collect with associated performance measures to ensure the effectiveness of schemes in place. The Leeds local data set is being used to identify local teenage conception hotspots and trends to help target existing resources. NHS Leeds is providing public health information to support service planning.

The relevant departments and partner organisations have made a commitment to fully implement all 9 recommendations in the future and satisfactory progress has been made to date. We are continuing to monitor those recommendations which remain outstanding.



In addition in 2009/10 we continued to monitor a number of recommendations from inquiries held in 2007/08 which were outstanding in relation to the NHS Dental contract, Localisation and Community Development. We were pleased that 10 out of a total of 17 recommendations had been fully implemented and progress was continuing to be made with the others.

The Board's full work programme 2009/10

A summary of the Board's full work programme is presented below.

Requests for scrutiny

- Provision of Dermatology Services
- Renal Services - Provision at Leeds General Infirmary

Review of existing policy

- Renal Services - Patient Transport Service
- Renal Services - Statement
- Role of the Council and its partners in promoting good public health
- Scrutiny Board response to the Leeds Teaching Hospitals NHS Trust - Foundation Trust Consultation
- Health Proposals Working Group to examine likely service change proposals

Development of new policy

- Joint Health Scrutiny Protocol - Yorkshire and the Humber

Monitoring scrutiny recommendations

- Scrutiny inquiry report – improving sexual health among young people
- Scrutiny inquiry report - community development and localisation
- Scrutiny Board Statement – renal services in Leeds

Performance management

- Joint performance quarterly reports

Briefings

- Appointment of co-opted Members
- Legislation & constitutional changes
- Leeds Local Involvement Network (LINk) - Annual Report
- KPMG Audit Report on scrutiny
- KPMG Health Inequalities report
- Update on local NHS priorities
- Leeds Teaching Hospitals NHS Trust - Foundation Trust Consultation
- The local health economy – Priorities for NHS Leeds

Presentations

- Leeds Partenrships NHS Foundation Trust
- NHS Leeds
- Leeds Teaching Hospitals NHS Trust

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Leeds Strategic Plan 2008 to 2011

Executive Summary

About the Leeds Strategic Plan

The Leeds Strategic Plan 2008 to 2011 sets out the strategic outcomes – the real changes we want to see in people's lives and the city by 2011, and improvement priorities – the key areas where we want to focus our efforts over the next three years. Clear targets have been set to measure the progress we will make over the next three years. The contents of the Plan are aligned with the eight themes in the Vision for Leeds 2004 to 2020, the sustainable community strategy for Leeds. The Leeds Strategic plan can be seen as the delivery plan for the Vision for Leeds.

Working in partnership through the Leeds Initiative, Leeds' local strategic partnership, the Council and its key partners have agreed, following extensive consultation with councillors, stakeholder groups and the public across the city, a single shared set of outcomes and priorities for the city.

The targets in the Leeds Strategic Plan have been selected after thorough study of the prospects, opportunities and challenges facing Leeds and agreed with partners in the city and with central government. The Leeds Strategic Plan is also the Local Area Agreement for Leeds, a formal agreement with central government about how to improve outcomes on our shared priorities..

At the heart of the Leeds Strategic Plan is our ambition to transform the quality of life in Leeds to see:

- people happy, healthy, safe, successful and free from the effects of poverty;
- our young people equipped to contribute to their own and the city's future well being and prosperity;
- local people engaged in decisions about their neighbourhood and community and help shape local services;
- neighbourhoods that are inclusive, varied and vibrant offering housing options and quality facilities and free from harassment and crime;
- an environment that is clean, green, attractive and above all, sustainable; and
- a city-region that is prosperous, innovative and distinctive enabling individuals and businesses to achieve their economic potential.

Our long and successful record of partnership working is a sure foundation for the delivery of these ambitious targets for Leeds. Leeds is one of only three authorities nationally to have been awarded Beacon status for the quality of partnership working and, as a Beacon authority, we will help other authorities all over the country develop effective partnerships to represent local wishes and meet local needs.

How we will deliver this plan

Leeds City Council will play a key role engaging the public and other stakeholders to shape the contents of the Leeds Strategic Plan, managing performance and reporting progress to local people. The Leeds Strategic Plan is a partnership plan and Leeds Initiative and its groups, including the Strategy Group which brings together the major public sector partners in the city as well as key representatives from the business and voluntary, community and faith sectors, will monitor and manage progress and keep the contents of the Plan relevant to the needs of Leeds. Each partner will also integrate the targets and priorities in this Plan into their work plans. Leeds City Council has produced a Business Plan to support its contribution to the Leeds Strategic Plan.

Leeds CITY COUNCIL

Beacon Authority 2008-2009 Local Strategic Partnerships and Local Area Agreements

Working in partnership through the Leeds Initiative

Leeds Strategic Plan 2008 to 2011

Strategic Outcomes The real changes we want to see	Improvement Priorities – our key focus for the next three years
Culture	
• Increased participation in cultural opportunities through engaging with all our communities. • Enhanced cultural opportunities through encouraging investment and development of high quality facilities of national and international significance.	• Enable more people to become involved in sport and culture by providing better quality and wider ranging activities and facilities. • Facilitate the delivery of major cultural schemes of international significance.
Enterprise and the Economy	
• Increased entrepreneurship and innovation through effective support to achieve the full potential of people, business and the economy. • Increased international competitiveness through marketing and investment in high quality infrastructure and physical assets, particularly in the city centre.	• Increase innovation and entrepreneurial activity across the city • Facilitate the delivery of major developments in the city centre to enhance the economy and support local employment • Increase international communications, marketing and business support activities to promote the city and attract investment.
Learning	
• An enhanced workforce that will meet future challenges through fulfilling individual and economic potential and investing in learning facilities.	• Enhance the skill level of the workforce to fulfil individual and economic potential • Improve learning outcomes for all 16 year olds, with a focus on narrowing the achievement gap. • Improve learning outcomes and skill levels for 19 year olds. • Increase the proportion of vulnerable groups engaged in education, training or employment. • Improve participation and early learning outcomes for all children, with a focus on families in deprived areas.
Transport	
• Increased accessibility and connectivity through investment in a high quality transport system and through influencing others and changing behaviours	• Deliver and facilitate a range of transport proposals for an enhanced transport system, including cycling and walking. • Improve the quality, use and accessibility of public transport services in Leeds. • Improve the condition of the streets and transport infrastructure by carrying out a major programme of maintenance and improvements. • Improve road safety for all our users, especially motor cyclists, pedal cyclists and pedestrians.
Environment	
• Reduced ecological footprint through responding to environmental and climate change and influencing others. • Cleaner, greener and more attractive city through effective environmental management and changed behaviours.	• Increase the amount of waste reused and recycled and reduce the amount of waste going to landfill. • Reduce emissions from public sector buildings, operations and service delivery, and encourage others to do so. • Undertake actions to improve our resilience to current and future climate change. • Address neighbourhood problem sites; improve cleanliness and access to and quality of green spaces. • Improve the quality and sustainability of the built and natural environment.

Strategic Outcomes The real changes we want to see	Improvement Priorities – our key focus for the next three years
Health and Wellbeing	
• Reduced health inequalities through the promotion of healthy life choices and improved access to services. • Improved quality of life through maximising the potential of vulnerable people by promoting independence, dignity and respect. • Enhanced safety and support for vulnerable people through preventative and protective action to minimise risks and maximise wellbeing.	• Reduce premature mortality in the most deprived areas. • Reduction in the number of people who smoke. • Reduce rate of increase in obesity and raise physical activity for all. • Reduce teenage conception and improve sexual health. • Improve the assessment and care management of children, families and vulnerable adults. • Improved psychological, mental health, and learning disability services for those who need it. • Increase the number of vulnerable people helped to live at home. • Increase the proportion of people in receipt of community services enjoying choice and control over their daily lives. • Improve safeguarding arrangements for vulnerable children and adults through better information, recognition and response to risk.
Thriving Places	
• Improved quality of life through mixed neighbourhoods offering good housing options and better access to services and activities. • Reduced crime and fear of crime through prevention, detection, offender management and changed behaviours. • Increased economic activity through targeted support to reduce worklessness and poverty.	• Increase the number of “decent homes”. • Increase the number of affordable homes. • Reduce the number of homeless people. • Reduce the number of people who are not able to adequately heat their homes. • Increase financial inclusion in deprived areas. • Create safer environments by tackling crime • Improve lives by reducing the harm caused by substance misuse • Reduce offending by managing offending behaviour better • Reduce bullying and harassment. • Reduce worklessness across the city with a focus on deprived areas. • Reduce the number of children in poverty. • Develop extended services, using sites across the city, to improve support to children, families and communities
Harmonious Communities	
• More inclusive, varied and vibrant communities through empowering people to contribute to decision making and delivering local services. • Improved community cohesion and integration through meaningful involvement and valuing equality and diversity.	• An increased number of local people engaged in activities to meet community needs and improve the quality of life for local residents. • An increase in the number of local people that are empowered to have a greater voice and influence over local decision making and a greater role in public service delivery. • Enable a robust and vibrant voluntary, community and faith sector to facilitate community activity and directly deliver services. • An increased sense of belonging and pride in local neighbourhoods that help to build cohesive communities.

Partners who have helped to draw up this Plan

Arts Council
Education Leeds
English Heritage
Environment Agency
Health and Safety Executive
Highways Agency
Jobcentre Plus
Learning and Skills Council
Leeds chamber of Commerce and Industry
Leeds Colleges
Leeds Partnership Foundation Trust
Leeds Primary Care Trust
Leeds Teaching Hospitals Trust
Leeds Voice
Museums, Libraries, Archives Yorkshire
Natural England
Re'new
Sport England
West Yorkshire Fire and Rescue Service
West Yorkshire Metro
West Yorkshire Police
West Yorkshire Police Authority
West Yorkshire Probation Service
Yorkshire Forward
Youth Offending Service

For enquiries about the Leeds Strategic Plan or to obtain a copy of the plan please:

Email: **leedsstrategicplan@leeds.gov.uk**

Telephone: **0113 224 346 2**

Visit our website: **www.leedsstrategicplan.org.uk**

Write to:
Leeds Strategic Plan
Planning, Policy and Improvement
2nd Floor East
Civic Hall
Leeds LS1 1UR

If you do not speak English and need help in understanding this document, please phone: **0113 224 346 2** and state the name of your language. We will then put you on hold while we contact an interpreter. We can assist with any language and there is no charge for interpretation.

An audio cassette of the Leeds Strategic Plan can also be obtained by contacting us via one of the methods above.

Leeds CITY COUNCIL

Working in partnership through the Leeds Initiative

Beacon Authority 2008-2009 *Local Strategic Partnerships and Local Area Agreements*

APPENDIX 3b

Combined extract from Leeds' Director of Public Health Annual Reports (2008 and 2009)

Recommendations for action to reduce health inequalities (2008) and associated progress (2009)

	Action needed	By Whom:				Progress reported in 2009	
		NHS Leeds	LCC	Leeds Initiative	PBC*		
1	Demonstrate how the set of new national performance indicators and the new Local Area Agreement and Local Area Delivery Plans are being used to target action on health inequalities		✓	✓		☺	Good progress
2	Demonstrate how the new operating framework and the NHS 'vital signs' are being used to target action on health inequalities	✓			✓	☺	Good progress
3	Continue using the most deprived SOA[1]s as the basis of a geographic focus for action	✓	✓	✓	✓	☺	Good progress
4	Work together, using the Joint Strategic Needs Assessment, to agree on the most vulnerable and disadvantaged population groups within the city	✓	✓	✓	✓	😐	Progress made but more is still needed
5	Ensure that the Joint Strategic Needs Assessment reflects health inequalities at local level and that this is embedded into commissioning, service planning and decision making	✓	✓		✓	😐	Progress made and work on further improvements has started

[1] Super Output Areas - Geographical areas that are now used for collecting and publishing statistics for a small area. In the past, health statistics were based on electoral wards. However, electoral wards vary in size, whereas SOAs are of a consistent size. Lower layer SOAs have a population of around 1500. Middle layer SOAs (which may contain two or more lower layer SOAs) have a population of around 7200. Statistics are based on lower layer or middle layer SOAs, depending on what is being analysed.

	Action needed	By Whom: NHS Leeds	LCC	Leeds Initiative	PBC*	Progress reported in 2009	
6	Ensure that there is an understanding of the health inequalities between practice populations and that priority is given to action in commissioning plans				✓	😐	Progress made but more is still needed
7	Incorporate action on the high impact changes on life expectancy and infant mortality in a targeted systematic way in the more deprived communities	✓	✓	✓	✓	☺	Good progress
8	Prioritise tackling vascular disease and smoking related illness in order to help achieve the national 2010 health inequalities target on life expectancy[2]	✓			✓	☺	Good progress
9	As commissioners, ensure that service providers have the incentives to meet the needs of the more disadvantaged populations	✓	✓		✓	☹	Isolated examples of good progress
10	Provide incentives and support for people to look after their own health	✓	✓		✓	☹	Limited progress only

***** Practice based commissioners

[2] Prioritising vascular disease and smoking-related illness means:

- ensuring that prevention and treatment services for cancer and coronary heart disease (CHD) reach those in greatest need or with poorest health outcomes, including disadvantaged groups and ethnic groups with high prevalence; for CHD, in particular, reducing high blood pressure and increasing prescription of statins to reduce blood cholesterol
- increasing smoking cessation interventions
- reducing excess winter deaths, particularly those related to long term respiratory conditions by linking proactive treatments to weather forecasting and increasing influenza immunisation.

Scrutiny Board (Health)

Previous Inquiries

Date	Scrutiny Board	Report Title	Full report/ statement	Recommendation tracking[1] / status
May-10	Health	***Promoting Good Public Health: The Role of the Council and its Partners***	Report	• 10 recommendations: Report to Executive Board scheduled for August 2010. • Formal response: Due Sept. 2010 • Progress updates: TBC
Apr-10	City and Regional Partnerships	***Kirkstall Joint Service Centre***	Statement	• 5 recommendations: Report to Executive Board scheduled for June 2010. • Formal response: Due June 2010 • Progress updates: TBC
Dec-09	Health	***Renal Services in Leeds***	Statement	• 7 recommendations • Formal response: March 2010 • Matter referred to Secretary of State: June 2010 • Progress updates: TBC
Apr-09	Health	***Improving Sexual Health among Young People***	Report	• 9 recommendations: Report to Executive Board in July 2009. • Formal response: Sept. 2009 • Progress updates: Formed part of the inquiry into Promoting Good Public Health. • Monitoring continuing on 8 recommendations. Next report scheduled for July 2010

[1] Formal tracking of recommendations was first introduced in December 2006. Shading indicates where recommendation tracking continues.

Date	Scrutiny Board	Report Title	Full report/ statement	Recommendation tracking[1] / status
May-08	Health & Adult Social Care	***Localisation of Health & Social Care services***	Report	• 12 recommendations. • Formal response: Sept. 2008 • Progress updates: April 2009, July 2009 • Monitoring continuing on 4 recommendations: Next report scheduled for July 2010
Apr-08	Health & Adult Social Care	***Teenage Pregnancy***	Statement	• 4 recommendations. • Informed the Scrutiny Inquiry: *Improving Sexual Health among Young People*. • No further monitoring.
Apr-08	Health & Adult Social Care	***Obesity in Leeds***	Statement	• No specific recommendations • Suggested that the matter be included in the Health Scrutiny Board's work programme for 2008/9.
Nov-07	Health & Adult Social Care	***NHS dental contract in Leeds – 1 year on***	Statement	• 3 recommendations. • Formal response – February 2008. • No further monitoring.
Jul-07	Health & Adult Social Care	***Community development in health & wellbeing***	Report	• 7 recommendations. • Formal response: Oct. 2007 • Progress updates: March 2008; April 2009; July 2009 • Monitoring continuing on 3 recommendations.
May-07	Overview & Scrutiny	***Narrowing the gap***	Report	• 8 recommendations. • Formal response: • Progress updates: Sept. 2007
May-07	Health & Adult Social Care	***NHS Dental Contract***	Report	• 8 recommendations. • Formal response: July 2007 • Progress updates: Sept. 2007 and Dec. 2007

Date	Scrutiny Board	Report Title	Full report/ statement	Recommendation tracking[1] / status
Apr-06	Scrutiny Commission	***Avoiding alcohol misuse***	Report	• 23 recommendations. • Formal response: July 2006 (OSC) • Progress updates: Jan. 2007 (OSC) and April 2007 (W/G)
Apr-06	Health & Wellbeing	***Childhood obesity prevention & management***	Report	• 8 recommendations. • Formal response: July 2006 • Progress updates: Feb. 2007 and Dec. 2007
Apr-06	Health & Wellbeing	***Older People's Mental Health Services***	Report	• 7 recommendations. • Formal response: July 2006
May-05	Social Care	***Delayed Hospital Discharges***	Report	• 8 recommendations. • Formal response: Sept. 2005 • Progress updates: Feb. 2006
May-05	Health	***MRSA***	Report	• 7 recommendations. • Formal response: July 2005
May-05	Health	***Sexual Health in Leeds***	Report	• 12 recommendations. • Formal response: Sept. 2005 • Progress updates: Feb. 2006
May-05	Health	***Smoking in Public Places***	Report	• 5 recommendations. • Formal response: July 2005 • Progress updates: Oct. 2005 and Nov. 2005
Apr-04	Health	***Child and Adolescent Mental Health Services***	Report	• 7 recommendations. • Formal response: September 2004
Dec-03	Health	***NHS Dentistry***	Report	• 5 recommendations. • Formal response: March 2004 • Progress updates: Nov. 2004 and Sept. 2005

Date	Scrutiny Board	Report Title	Full report/ statement	Recommendation tracking[1] / status
Oct-03	Health	***Influencing Health Determinants***	Report	• 14 recommendations. • Formal response: • Progress updates:

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:

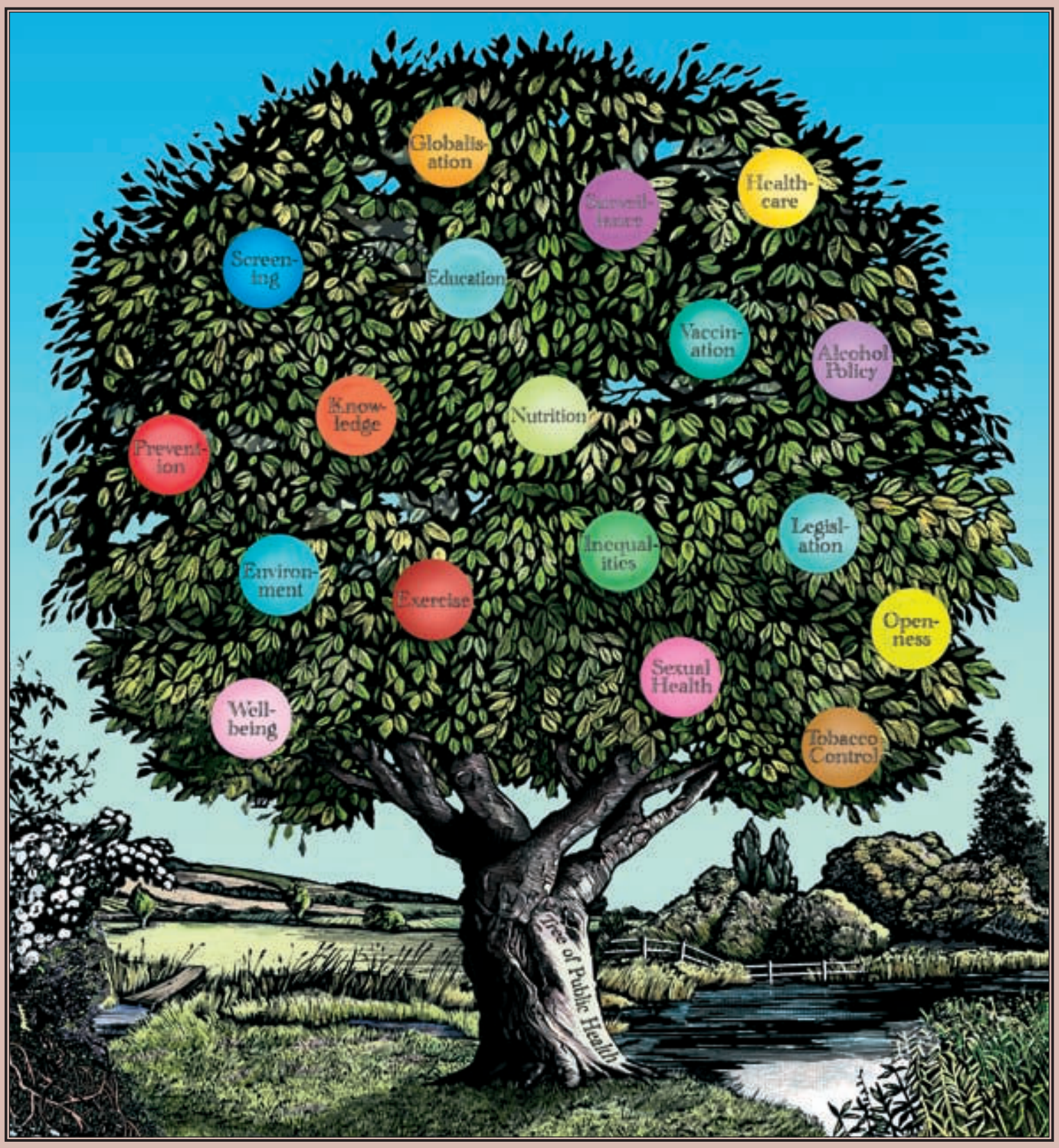
- Ensure high quality safeguarding practice is embedded across partners.
- Revise and implement multi-agency adult safeguarding procedures.
- Implement mandatory specialist safeguarding training programme.
- Implement work programme of adult safeguarding board.
- Jointly appoint head of adult safeguarding.
- 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



Department of Health

2009 ANNUAL REPORT
OF THE CHIEF MEDICAL OFFICER

2009 ANNUAL REPORT
OF THE CHIEF MEDICAL OFFICER

Contents

On the State of Public Health

The Chief Medical Officer post was created in the mid-19th century in response to the great cholera epidemics that swept Victorian England. Addressing the major health challenges of the time, the early Annual Reports of the first Chief Medical Officer, Sir John Simon, described the high childhood mortality caused by infectious diseases. They addressed the need for sanitary reform and vaccination.

The Chief Medical Officer has produced an Annual Report in most years since that time. Last year, my Annual Report celebrated the 150th anniversary of the Chief Medical Officers' reports. I am the 15th Chief Medical Officer in this line of succession that stretches back to 1855.

In December 2009, I informed the Government that I intend to step down in the summer of 2010. I will have been in post for 12 years. I have prolonged my intended departure by a year to lead the response to the influenza pandemic that started in April 2009. This Annual Report is therefore my last.

In each of its predecessors, and in this current report, I have tried to focus on health problems, challenges and subjects where I believe that action is necessary or that awareness needs to be raised. Through one means or another, these reports have sought to achieve progress to improve the health of the population, the quality of care for patients, and the working lives and careers of healthcare professionals. The main topics of my earlier Annual Reports are listed in an annex to this introduction.

During my time in post, I have provided a wide range of other policy recommendations to the Government. Many of these have been conveyed in formal documents and reports. Most have been implemented – some through legislation, such as smoke-free public places, embryonic stem cell research and consent for organ and tissue retention – others through reform to the structure and functioning of the health service, for example the establishment of the Health Protection Agency, the Expert Patients Programme and the National Patient Safety Agency. Others have been achieved by creating a new philosophy of medical practice, including the introduction of clinical governance, changes to the General Medical Council and revalidation of doctors. Others have prompted more specific ways to protect patients, such as the abolition of general anaesthetics in the dentist's chair, and the introduction of standards to reduce the risk of paralysis and death resulting from errors in the spinal injection of cancer drugs. In a second annex to this introduction, I have listed the special reports in which these policy recommendations were first put forward. In a third annex I have listed additional reports that I commissioned during my time in office.

Other initiatives prompted by a Chief Medical Officer flow from ideas, proposals or suggestions made to Ministers that are not necessarily part of a formal Chief Medical Officer document or report but may appear in other government documents. In my time, these have included the school fruit scheme, legislation to control healthcare-associated infection, and establishment of the Public Health Observatories.

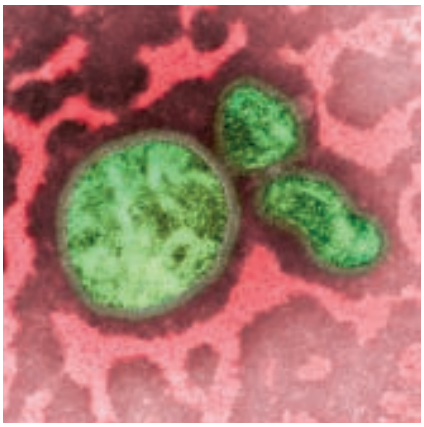
In last year's Annual Report, I promised to describe the work of the Chief Medical Officer over my time in post. I am publishing this as a separate report, available electronically. The issues and challenges will continue to evolve from one decade to the next. This report illustrates the breadth and value of the Chief Medical Officer post.

The predominant challenge of 2009 was the emergence of the first influenza pandemic for 40 years. All who know the history of 'flu pandemics felt a twinge of fear in April 2009, when news came from Mexico of atypical pneumonia cases scattered around the country. From Mexico, the illness spread fast around the world. England was amongst the first countries to have cases of what was rapidly confirmed as a new 'flu virus – influenza A/H1N1 2009. The World Health Organization indicated that a pandemic was imminent. For weeks, the spread of 'swine 'flu' ran at the top of the news worldwide.

England was well prepared. In the first weeks of the pandemic, the Health Protection Agency coordinated efforts to isolate those affected by the virus. They traced the people with whom those infected had been in contact and treated them with antiviral medication. A number of schools were temporarily closed. These efforts to slow transmission were maintained for several weeks. Inevitably, the number affected grew. Evidence of severe cases emerged. A growing number of people were admitted to hospital. In June 2009, the country sadly saw its first death.

Demonstrating the unusual way in which pandemic 'flu viruses behave, rates of infection continued to swell into the summer months. General practice felt much of the strain, and handled it well.

When the strain was approaching a critical level, the National Pandemic Flu Service was activated. This was an entirely novel concept for the country, and formed an important part of the pandemic plan. The public had never previously been able to access an internet and telephone-based diagnostic and treatment service that provided medication when appropriate. The National Pandemic Flu Service was well used, and relieved significant pressure on the mainstream NHS.



As summer turned to autumn, the picture was mixed. There had been deaths. Hospital capacity had been stretched significantly, particularly in intensive care. But rates of infection had peaked in August 2009 and were falling. For most people, the disease was milder than had been anticipated based on the early information from Mexico. The number of deaths was small compared with what it might have been with a more virulent virus.

Each of the three 'flu pandemics of the 20th century behaved in a different way. The 2009 pandemic has been different again. Our Government took the approach, as did many governments around the world, of hoping for the best but preparing for the worst. The pandemic has brought illness, anxiety, disruption and tragedy – but not on the scale that it could have done. 'Flu viruses are unpredictable and we have been right not to let down our guard. But we are now approaching a time in the UK when we can breathe a sigh of relief, for the most part. This pandemic could have been far worse.

I have been heartened by the response of colleagues throughout the NHS in the most difficult periods, and pay tribute to them. The pandemic has not tested them to the extremes that it might have done. Nevertheless, I am confident that they would have fared well had the situation been worse.

Much has changed since the previous pandemic in 1968–70. Advances in critical care medicine have saved lives in the current pandemic. Advances in virology and vaccination technology enabled us to start vaccinating those most at risk within just a few months of the disease emerging. Real-time data have allowed us to track the pandemic in primary and secondary care, and respond accordingly.

Some have called the public health response to the pandemic an overreaction. In so doing, they draw attention to the overall costs of antiviral drugs and vaccines. They speak of the relatively small number of deaths compared with previous influenza pandemics and seasonal influenza outbreaks. In describing the number of deaths in the present pandemic, they often use the prefix 'only'. In response, it is important to ask a number of questions. Would it have been acceptable not to plan as well as we did for a pandemic nor procure countermeasures? Having done so, and in the face of emerging, worrying evidence from the first phase of the pandemic in Mexico, would it have been right not to deploy existing countermeasures and not to strengthen our holdings? Would it have been acceptable to hide and conceal statistical projections provided by statistical modellers of international standing, even though releasing them publicly caused alarm in some quarters? Would it have been right to take the view that it was acceptable to 'tolerate' a certain number of deaths, considering them low enough to accept, when a way of preventing them was available?

The reality is that much of the prior planning and investment was an 'insurance' against a range of possible scenarios, including worst-case scenarios. From the BSE catastrophe, the 'precautionary principle' emerged. This principle is not free of cost, and, if the threat does not fully materialise, leads some to cast stones at the originators of the plan. That is inevitable. Public health professionals cannot afford to be gamblers hoping to be wise after the event.

Moreover, although the number of deaths was relatively small, the virus killed younger people and those who had previously been healthy. This is different from the 'flu we experience each winter. Deaths amongst younger adults from pandemic ('swine') 'flu were more than 30 times higher than those in the last 'flu season. In the 20th-century pandemics, there was no choice other than to accept the illness – and the deaths associated with the illness. In the first pandemic of the 21st century, we had the option of fighting the illness to protect children and adults from

its adverse consequences. It is vital that we learn from what we have seen in this pandemic, for the sake of those who find themselves tackling – and affected by – the next. It is likely to be worse.

The pandemic has occupied a great deal of time for many in 2009, but much else has also been achieved.

In the years since the first Chief Medical Officer took up post, England's vaccination programme has grown to become a central pillar of public health. Today's children are vaccinated against many conditions with which their parents and even grandparents are unfamiliar, thanks to the success of the programme. A further important vaccination was added in 2009. Every year, 2,000 women are diagnosed with cervical cancer. Sadly, approximately 800 die. It is a disease that often affects women in the middle years of life. Infection with human papillomavirus is responsible for 70% of cases. The introduction of a vaccine against human papillomavirus for teenage girls promises to markedly reduce the incidence of this disease in the future.

My 2008 Annual Report highlighted the problem of passive drinking. Alcohol consumption does not affect only drinkers – it has a substantial negative effect on the rest of society. I made several recommendations, including the introduction of a minimum price per unit of alcohol. I have been pleased to see public health and medical leaders engaging so widely with this issue. Many of its representative bodies have spoken out in favour of a minimum price policy, including the Royal College of Physicians and the British Medical Association. In July 2009, I gave evidence to the parliamentary Health Select Committee's inquiry into alcohol. Its report, published in January 2010, also calls for a minimum price per unit. I remain convinced of the need for this. The price of alcohol is a crucial determinant of its consumption. Tackling the substantial harms caused by alcohol in this country requires this decisive action.

I remain concerned about young people's drinking. The evidence shows that 11 to 17 year olds drink 20 million units of alcohol (the equivalent of 9 million pints of beer or 2 million bottles of wine) every week. Young people who binge drink in adolescence are more likely to be binge drinkers as adults, and have an increased risk of developing alcohol dependence. In December 2009, I published guidance on the consumption of alcohol by children and young people. I did so at the request of the Secretaries of State for Health and Children, Schools and Families, and the Home Secretary. Based on a review of the scientific evidence, I advised that an alcohol-free childhood is the healthiest and best option. Children under the age of 15 years should certainly drink no alcohol. If young people aged 15 to 17 years do consume alcohol, it should always be with the guidance of a parent or carer, in a supervised environment. I hope that this advice is valuable to parents, helping them to establish a healthy mindset about alcohol with their children. It should also provide information to help health professionals and support services when talking to parents about alcohol and their children. On the basis of my advice, the Department for Children, Schools and Families has launched a major media campaign entitled 'Why Let Drink Decide?' to communicate these important messages widely.

Published in 2008, Lord Darzi's report *High Quality Care for All* marked an important milestone. Its central tenet is that quality should be the 'organising principle' of the NHS. It aims to set the health service on a path defined by the quality of its care. It seeks to promote quality from being the focus of specific workstreams to being at the heart of how the service operates and thinks. In 2009, the health service began working on a particularly key means of achieving this. It has been collecting the necessary data to produce 'Quality Accounts' for 2009/10. Trusts will report their key measures of quality in the same way in which they report their key measures of financial performance. This is vitally important. Focus shifts to where measurement is made. The act of making and reporting measurements of quality will itself catalyse improvement, helping the NHS to continue developing the quality of the service that it provides to patients.

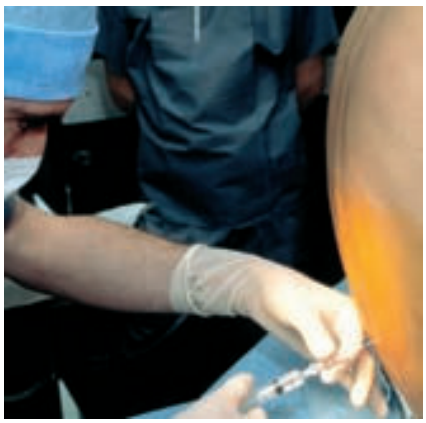
In 2009, two hospitals found their names becoming synonymous with low-quality care. In March 2009, Stafford Hospital was the focus. In November 2009, it was Basildon University Hospital. Such care is unacceptable and it is right that quality should be at the forefront of the public's minds. Excellent quality needs to be a goal to strive for continually, as well as poor quality being identified early and rooted out.

Patient safety problems remain all too common in healthcare systems around the world. The National Patient Safety Agency continues to do important work in highlighting and tackling these problems within the NHS. My 2007 Annual Report, describing surgical safety, highlighted the fact that over 100,000 errors involving surgical patients were reported to the National Patient Safety Agency in that year.

My report recommended that clinical teams should pilot the World Health Organization's Surgical Safety Checklist. A subsequent pilot study of this checklist involved hospitals in London and seven other locations around the world. It demonstrated that using the checklist could reduce the risk of death and post-operative complications significantly. In 2009, the National Patient Safety Agency started to implement its use nationwide.

The use of checklists is common in other high-risk industries, such as aviation and nuclear power. The practice has much to offer healthcare. From May 2009, the National Patient Safety Agency led 19 pilot sites in implementing a checklist in their intensive care units. This checklist was developed in the United States, where it was shown to contribute to a dramatic reduction in the number of central venous catheter-associated bloodstream infections in intensive care units, and so to save lives. In late 2009, 80% of hospital trusts in England joined the implementation of this important work.

I remain Chair of the World Health Organization's Patient Safety Programme, a programme with which the National Patient Safety Agency works closely. Such international collaboration allows the benefits of leading work to be shared rapidly around the world. England has adopted solutions from other countries, but has also made important contributions to patient safety improvement internationally. In November 2009, the National Patient Safety Agency announced a world-leading initiative to tackle a particularly tragic form of medical error. Currently, there is no physical barrier preventing a doctor injecting the wrong medication into the spine. The connectors



between syringes and spinal needles are the same as those between syringes and venous needles. Medications intended for a vein can accidentally be injected into the spine. The tragic consequences of this have been seen repeatedly around the world. I highlighted this in my report *An Organisation with a Memory* and in my 2002 Annual Report. A series of interim actions were taken, such as using a 'minibag' rather than a syringe to reduce the risk of wrong-route error, re-labelling packaging, and issuing a safety alert that required the NHS to restrict the number of individuals authorised to give spinal injections. But still, there has been no 'fail-safe' physical barrier to prevent the error. The National Patient Safety Agency's latest initiative will lead to physical solutions to this problem being designed for use throughout the NHS.

The task of bringing clinical quality, including safety, to the heart of the health service demands clinical leadership. Doctors and other clinicians need to be skilled in thinking about the whole service, not just individual patients. I am pleased to have played some part in assisting this. For the last four years, I have had junior doctors seconded to my office for a period as clinical advisors. The benefit has been mutual. They have brought a welcome clinical perspective to the work of the Department of Health, whilst gaining skills and experience of health policy and management. The Clinical Advisor scheme offers the opportunity to new individuals every year to work with me and with senior colleagues elsewhere in the Department of Health, the NHS and national health agencies. Twenty doctors have been appointed, selected from over 600 applicants. I see strong evidence that many in the current generation of young doctors are hungry to engage with the task of improving health and healthcare more broadly than through clinical work alone. Giving them the skills and confidence that they need to succeed is an important investment for the future.

The proportion of doctors who are women has been climbing rapidly over recent years. It now stands at 41%. In my 2006 Annual Report, I discussed some of the particular issues that this group faces. I formed a National Working Group on Women in Medicine to consider the issues and to develop solutions. I was pleased to receive its report in October 2009. The group proposes a series of steps to enhance opportunities for female doctors. The report makes clear recommendations for a number of bodies, including government departments, universities and NHS employers. I look forward to seeing the fruits of many people's labour.

On a similar theme, my 2007 Annual Report drew attention to the barriers of racial discrimination that still exist within the medical profession. Substantial improvements have occurred in recent years, but work remains to be done. In 2009, I chaired a series of round-table meetings on this issue. These brought together high-level representatives from the NHS, the General Medical Council and medical Royal Colleges, amongst others. Both junior and senior doctors were represented. I am pleased by the progress that many of the national bodies are making in this area. I hope that this important issue

will continue to receive the attention it deserves throughout the country.

I am also pleased with the progress that is being made to introduce revalidation for doctors. In 2009, the General Medical Council introduced the necessary categories of registration that will allow doctors to obtain and renew their licence to practise. The Department of Health has established a series of pilot sites through which the operational details of revalidation will be tested and refined. I hope that doctors will welcome revalidation. Between qualification and retirement, competence is simply assumed at present. For the vast majority, this assumption is justified. The revalidation process will allow doctors to move from assumption to demonstration. The process will also play an important part in identifying the small number for whom the current assumption is flawed. It is in the best interest of patients, and of the medical profession as a whole, that we properly ensure that every doctor is a good doctor. However, for doctors revalidation will be most successful if we fulfil our aim of making it generally a supportive and positive experience, helping them to make their good practice even better.

In this year's Annual Report, I address five new health topics.

First, I address the importance of establishing and maintaining regular physical activity throughout life. The benefits of exercise are well known. Health benefits include: stopping and reversing weight gain; reducing the risk of diabetes, heart disease, stroke and some cancers; and preventing osteoporosis and reducing falls in older people. Indeed, at every stage of life, physical activity has something to offer. It is never too late to begin and we are never too old to continue. Over the last 50 years, activity levels, particularly amongst the young, have fallen. As individuals and as a society we pay a high price for inactivity. Despite knowing the importance of exercise, we have not created an active society. In this chapter I review the benefits of physical activity at different life stages, and make recommendations on how to promote a culture of activity throughout life. Although this is a frequently reviewed topic, the potential benefits of nature's finest cure are still not widely appreciated.

Cold weather kills. A one degree drop in average winter temperature results in an additional 8,000 deaths in England. This is mainly through increased cardiac deaths, strokes and respiratory problems. In a bad winter, this could amount to an additional 50,000 deaths or more. After a cold snap, it takes 40 days for levels of illness and death to return to normal. In my second chapter I show how this is not inevitable. Colder countries, such as Finland, experience much smaller rises in deaths in winter. Staying warm both indoors and outside is essential for winter health. Tracking cold weather data would allow better planning and coordination of health services to prevent and treat ill health caused by cold weather.

Third, approximately 3 million people in the United Kingdom are affected by rare diseases. Each individual rare disease affects fewer than five in 10,000 people, but taken together they are common, with one in 17 people affected by a rare disease. Although there are many thousands of different rare diseases, they share common characteristics. These include a severe, chronic, often degenerative and life-threatening course. Most rare diseases are incurable and lack effective treatment. Services for children with rare diseases have improved, increasing life expectancy, but the transition into adult services is often unsatisfactory. Rare diseases have reached public consciousness, with a Rare Disease Day in February 2009. However, there is a lack of focus in services, an absence of coordinated care, and a paucity of research to improve the quality of life of those with rare diseases, and of their relatives.

Fourth, grandparents are a great asset to children, and are frequently overlooked in discussions about child health. Grandparents are in a special position of love and respect, which creates a unique opportunity for them to support young people in adopting healthy lifestyles. The role of grandparents in family life has grown over the last century. People are living longer and enjoying a longer retirement. The two-parent family is now only one model of family life, and children benefit from the additional support and care of grandparents. Having greater life experience gives grandparents a knowledge of life's tribulations that they can pass on to children. They can support children through emotionally difficult periods and gently advise them on being healthy and safe in a world where cigarettes, alcohol and drugs, violence and injury are all too common. Finally, what could be a better role model for children than a healthy grandparent, living actively and well to a ripe old age, helped by the good life choices they made when they were younger?

Climate change is a much-discussed topic. Health does not feature in most of these discussions. It should. In the fifth chapter of this report, I explore the complex relationship between climate change and health. World Health Organization figures demonstrate that climate change is already

robbing millions of healthy years of life every year. Amongst many other things, it is causing malnutrition, childhood infection and the spread of diseases such as malaria. Its impact is everywhere, but unjustly distributed. The health impact in Africa is almost 600 times as great as the health impact here. Fortuitously, a number of the measures that England can take to reduce climate change also offer the promise of improving the country's health in other ways. This country has the ability to play a leading role in minimising the impact of climate change as a global health disaster. We have a responsibility to be bold in doing so.

A number of colleagues within and outside the Department of Health have contributed to the production of this report. I am most grateful to all of them. As always, the opinions expressed and the conclusions drawn are my own.

As I write this, a few months from leaving my post, I look back on those who preceded me as Chief Medical Officer.

I think of the first in the line, Sir John Simon, architect and champion of many of the public health laws that laid the foundation for improved longevity and better health. I think of Sir Wilson Jameson, who gave the first radio broadcast to the nation during the dark days of the Second World War and who worked tirelessly to help secure the establishment of the National Health Service. I think of a man whom I had the honour to know, Sir George Godber. Described as a 'colossus', he made an immense contribution to public health and to the development of healthcare in the 1960s. He died in 2009 at the age of 100.

I remember Sir Donald Acheson – my predecessor but one – who died a few months ago. I worked closely with Donald during my days as a Regional Director of Public Health. His strong leadership when HIV and AIDS emerged helped mitigate the impact of a new and frightening threat to health.

I look back and think myself fortunate and privileged to have been able to follow these illustrious predecessors into a post that works within government but is not political, that works for the Government but has an independent dimension, and that serves and speaks to the people and to those in power without fear or favour.

Looking forward, I hope that some of my unfinished business will be concluded. The introduction of smoke-free public places in July 2007 was a public health landmark. It marked a recognition that people should not have to suffer the health consequences of somebody else's smoking. I look forward to an equivalent realisation about alcohol. The alcohol pricing recommendation that I made in last year's Annual Report has gained wide support more rapidly than did my 2002 call for smoke-free public places. I hope that it will pass into legislation more rapidly too. In my 2006 Annual Report, I recommended the introduction of an 'opt-out' organ donation system. People are still needlessly dying whilst on the waiting list for an organ transplant. I greatly look forward to the day when this important change is made. Patient safety and clinical governance have become important foci for the NHS, but I look forward to the time when they are such deeply embedded concepts that the terms themselves are almost redundant.

The work of public health practitioners is never complete. I hope that I have advanced awareness of the obesity health time bomb and, in this report, of the disastrous health impacts of climate change. Both of these – and more besides them – will be ongoing health issues for the 21st century. I look forward and think about the day when I hand the baton of history to my successor. I wish them every success, whoever they – she or he – may be. I urge them to be ambitious – not for headlines, but for the prize of better health and better, safer healthcare that can be won by the strong and the brave.

In signing off, I must express my deep gratitude to all who, as a result of reading my reports, have been inspired to help advance the causes and actions that I have championed. The fight goes on to save lives, reduce human suffering and increase the years spent in the glow of health, rather than the shadow of disease. I would ask you to play your role in ensuring that the important issues covered in this report receive the same attention.

Sir Liam Donaldson
Chief Medical Officer
March 2010

Annex 1: Content of the present Chief Medical Officer's Annual Reports

2001

Health inequalities
High blood pressure
Alcohol and liver cirrhosis
E. coli O157
Epilepsy

2002

Second-hand smoke
West Nile virus
Obesity
Intrathecal chemotherapy
Poor medical performance

2003

Smoking and health
Smoke-free: the economic case
Better blood transfusion
Focus on academic medicine
Early diagnosis of HIV

2004

Smoking and borders
Chronic obstructive pulmonary disease
Public sector food procurement
Gastroschisis
Patient safety alert compliance

2005

Variation in clinical practice
Patient safety and aviation
Early recognition of kernicterus
Public health spending and staffing levels
Planning for the 'flu pandemic

2006

Healthcare-associated infection
Organ transplantation
Radiotherapy errors
Intrapartum-related deaths
Women in medicine

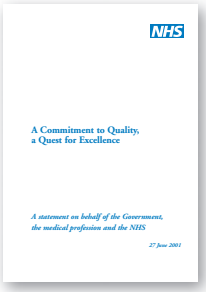
2007

Teenage health
Making surgery safer
Vaccines for the future
Oesophageal cancer increases
Racial equality in medicine

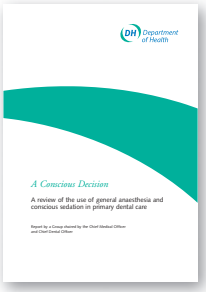
2008

Passive drinking
Prostate cancer
Chronic pain
Antimicrobial resistance
Safer medical practice through simulation

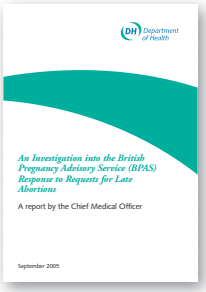
Annex 2: Special reports produced by the present Chief Medical Officer



A Commitment to Quality, A Quest for Excellence: A statement on behalf of the Government, the medical profession and the NHS (2001)
Set out the first systematic framework to ensure the quality of NHS services, including standard setting, guidance, action on patient safety and a commitment to collaborative working

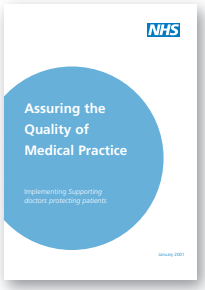


A Conscious Decision: A review of the use of general anaesthesia and conscious sedation in primary dental care (2000)
Led to a series of actions aimed at eliminating deaths of unconscious patients in the dentist's chair

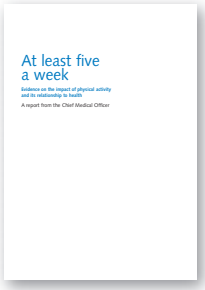


An Investigation into the British Pregnancy Advisory Service (BPAS) Response to Requests for Late Abortions (2005)
Led to changes in the handling of requests for late abortions, improving the speed of referral and provision of information to patients

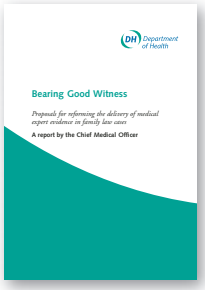
An Organisation with a Memory: Report of an expert working group on learning from adverse events in the NHS (2000)
Established a comprehensive patient safety programme in the NHS, one of the first in the world



Assuring the Quality of Medical Practice: Implementing *Supporting doctors protecting patients* (2001)
Led to the establishment of effective assessment and retraining for doctors and other health professionals with problems, thereby improving quality of care

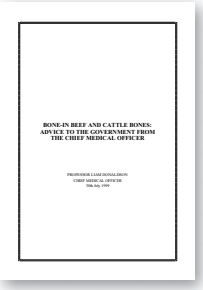


At Least Five a Week: Evidence on the impact of physical activity and its relationship to health (2004)
Demonstrated the compelling evidence for recommending increased physical activity and the resulting health benefits



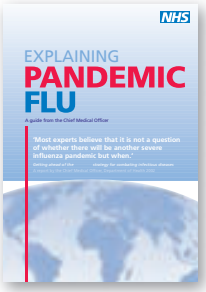
Bearing Good Witness: Proposals for reforming the delivery of medical expert evidence in family law cases (2006)
Improved the quality and supply of health expert witnesses through piloting new ways of commissioning witnesses to family courts in public law childcare proceedings

Best and Safest Care: Report on the quality and patient safety national workstream of the NHS Next Stage Review (2008)
A report presented by the Chief Medical Officer to Lord Darzi, which informed the quality and safety element of the NHS Next Stage Review

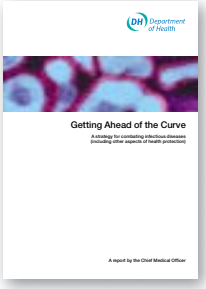


Bone-in Beef and Cattle Bones: Advice to the Government from the Chief Medical Officer (1999)
Took a cautious approach to the timing of the removal of a ban on potentially high-risk material that had been excluded from the food chain as part of BSE controls

Building a Safer NHS for Patients: Implementing *An Organisation with a Memory* (2001)
Established the National Patient Safety Agency, which has gathered more than 2 million incident reports of unsafe care and has used them for learning and to take action to reduce the risk to patients



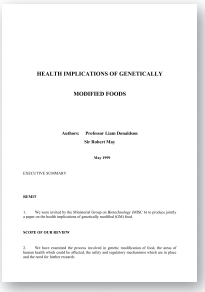
Explaining Pandemic Flu: A guide from the Chief Medical Officer (2005)
Explained the need to prepare for pandemic influenza and set out the steps to do so effectively



Getting Ahead of the Curve: A strategy for combating infectious diseases (including other aspects of health protection) (2002)
Set out a major reform of health protection arrangements, leading to the establishment of the Health Protection Agency, improving surveillance and control of infections, and responding effectively to serious incidents

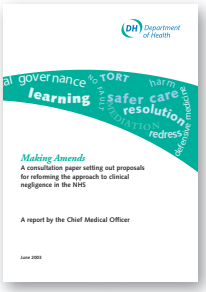
Good Doctors, Safer Patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients (2006)
Established a far-reaching programme of reform of medical regulation, including changes to the General Medical Council and the revalidation of doctors

Guidance on the Consumption of Alcohol by Children and Young People: From Sir Liam Donaldson, Chief Medical Officer for England (2009)
First ever evidence-based advice for children, their parents and health professionals recommending an alcohol-free childhood. Informed a major awareness campaign



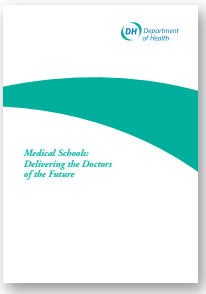
Health Implications of Genetically Modified Foods (1999)
Found that genetically modified foods were unlikely to be harmful, but recommended key safeguards to be taken forward by the Food Standards Agency

Health is Global: Proposals for a UK Government-wide strategy (2007)
Led to the first comprehensive UK Government-wide strategy for global health, launched in May 2009



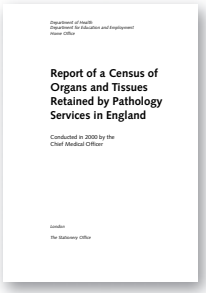
Making Amends: A consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS (2003)

Set out a new scheme to help those suffering harm as a result of clinical treatment; however, the NHS Redress Scheme has not yet been implemented



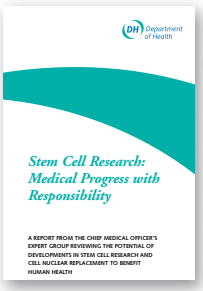
Medical Schools: Delivering the doctors of the future (2004)

Provided a comprehensive review of medical education, the expansion in medical schools, and measures to make future doctors more representative of the populations they serve



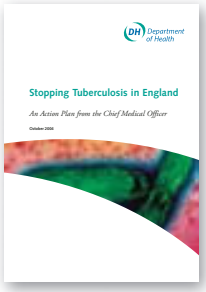
Report of a Census of Organs and Tissues Retained by Pathology Services in England (2001)

Identified the scale and nature of the problem of retained organs and tissues in response to public concern, and set out the need for corrective action



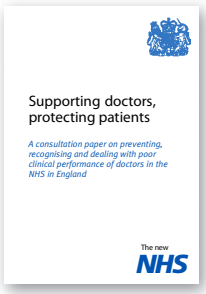
Stem Cell Research: Medical progress with responsibility (2000)

Led to new legislation that allowed research into therapeutic cloning and other techniques aimed ultimately at treating incurable diseases and injury



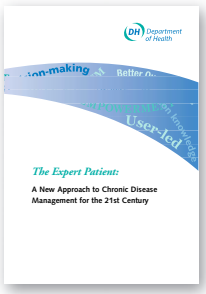
Stopping Tuberculosis in England: An action plan from the Chief Medical Officer (2004)

Set out action to tackle the resurgence of tuberculosis, including prevention, treatment and control



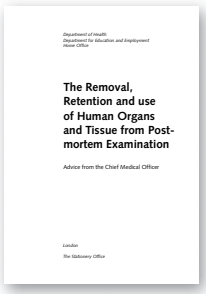
Supporting Doctors, Protecting Patients: A consultation paper on preventing, recognising and dealing with poor clinical performance of doctors in the NHS in England (1999)

Gave early protection to patients from poor practice and reduced the emphasis on long suspensions of doctors



The Expert Patient: A new approach to chronic disease management for the 21st century (2001)

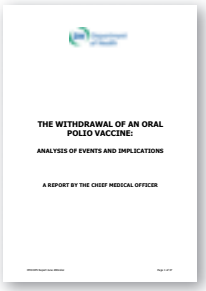
Created a programme to give patients the skills to manage their own illnesses, improving their quality of life and reducing their dependency on services



The Removal, Retention and Use of Human Organs and Tissue from Post-mortem Examination (2001)

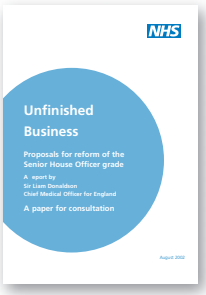
Initiated comprehensive changes in practice, including legislative change, to prevent a repetition of organ retention scandals such as Alder Hey

The Report of the Chief Medical Officer's Project to Strengthen the Public Health Function (2001)
Reinvigorated the public health system in England, strengthening national, regional and local public health delivery

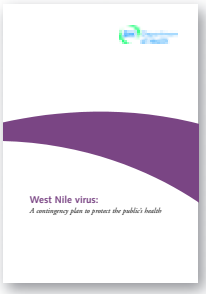


The Withdrawal of an Oral Polio Vaccine: Analysis of events and implications (2002)
Examined the circumstances leading to the withdrawal of oral polio vaccine and initiated a review of procedures to ensure the validity of information supplied by pharmaceutical companies on the safety of their products

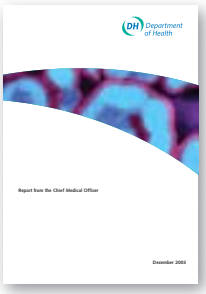
Towards Excellence in Assessment in Medicine: A commitment to a set of guiding principles (2007)
Put forward for comment a set of guiding principles for assessment in the training of doctors



Unfinished Business: Proposals for reform of the Senior House Officer grade (2002)
Initiated much-needed reform to the training of doctors in the first years after qualification

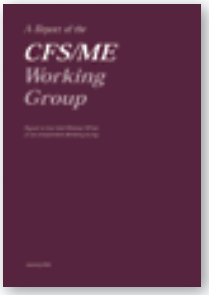


West Nile Virus: A contingency plan to protect the public's health (2004)
Ensured full preparation against a possible future new disease threat



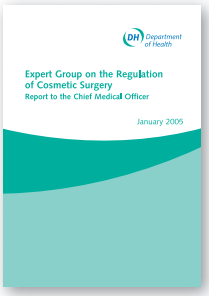
Winning Ways: Working together to reduce healthcare associated infection in England (2003)
Established the first systematic and comprehensive campaign to reduce healthcare-associated infection in the NHS

Annex 3: Special reports commissioned by the present Chief Medical Officer

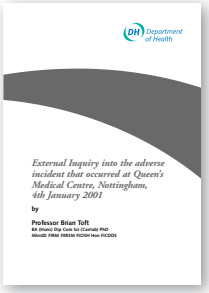


A Report of the CFS/ME Working Group (2002)
Examined in depth how the NHS could improve care for people who suffer from chronic fatigue syndrome or myalgic encephalomyelitis

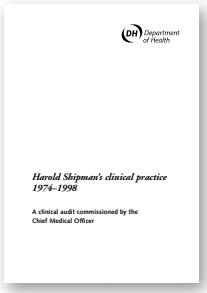
Association of Public Health Observatories Indications series
A series of quantitative analyses presenting data from the English regions in a form that has assisted policy development in a range of public health domains



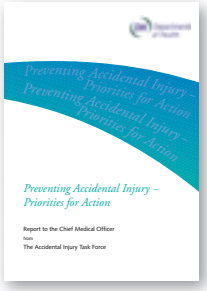
Expert Group on the Regulation of Cosmetic Surgery: Report to the Chief Medical Officer (2005)
A comprehensive review of cosmetic surgery regulation. Progress has been slow and controversial in this area



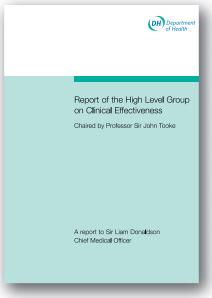
External Inquiry into the Adverse Incident that Occurred at Queen's Medical Centre, Nottingham, 4th January 2001 (2001)
A detailed investigation into the tragic death of teenager Wayne Jowett. This report was pivotal in establishing patient safety concepts in the UK



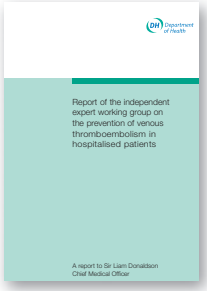
Harold Shipman's Clinical Practice 1974–1998: A clinical audit commissioned by the Chief Medical Officer (2001)
The first convincing demonstration that Shipman was responsible for many more deaths than those he was convicted of, confirming that his behaviour had remained undetected for many years



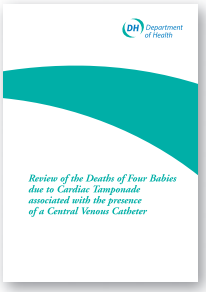
Preventing Accidental Injury – Priorities for action: Report to the Chief Medical Officer (2002)
Report by the Accidental Injury Task Force, recommending specific cross-government actions to help prevent accidental injury



Report of the High Level Group on Clinical Effectiveness (2007)
Flowed from the 2005 Chief Medical Officer's Annual Report. This group examined variations in clinical practice and made important research, clinical and policy recommendations

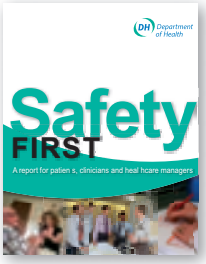


Report of the Independent Expert Working Group on the Prevention of Venous Thromboembolism in Hospitalised Patients (2007)
Set in train a national approach to reduce the 25,000 deaths a year from venous thromboembolism in NHS hospitals. This approach is now firmly embedded in NHS policy and practice



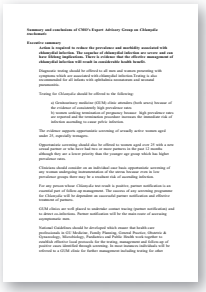
Review of the Deaths of Four Babies due to Cardiac Tamponade Associated with the Presence of a Central Venous Catheter (2001)

Enhanced awareness of this safety problem, and led to advice being issued to the NHS about avoiding recurrence



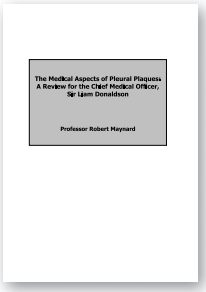
Safety First: A report for patients, clinicians and healthcare managers (2006)

Reviewed progress in patient safety within the NHS since the publication of An Organisation with a Memory *in 2000, and set out a comprehensive action plan which has now been almost completely implemented*



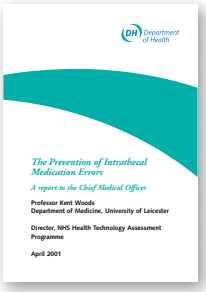
Summary and Conclusions of CMO's Expert Advisory Group on *Chlamydia trachomatis* (1998)

Led to the introduction of an opportunistic screening programme to tackle low awareness of, and testing for, sexually transmitted chlamydial infection in young people



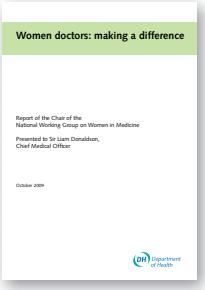
The Medical Aspects of Pleural Plaques: A review for the Chief Medical Officer (2009)

Set out recommendations based on a review of the published research evidence to establish the extent to which people who are diagnosed with pleural plaques are likely to develop asbestos-related conditions



The Prevention of Intrathecal Medication Errors: A report to the Chief Medical Officer (2001)

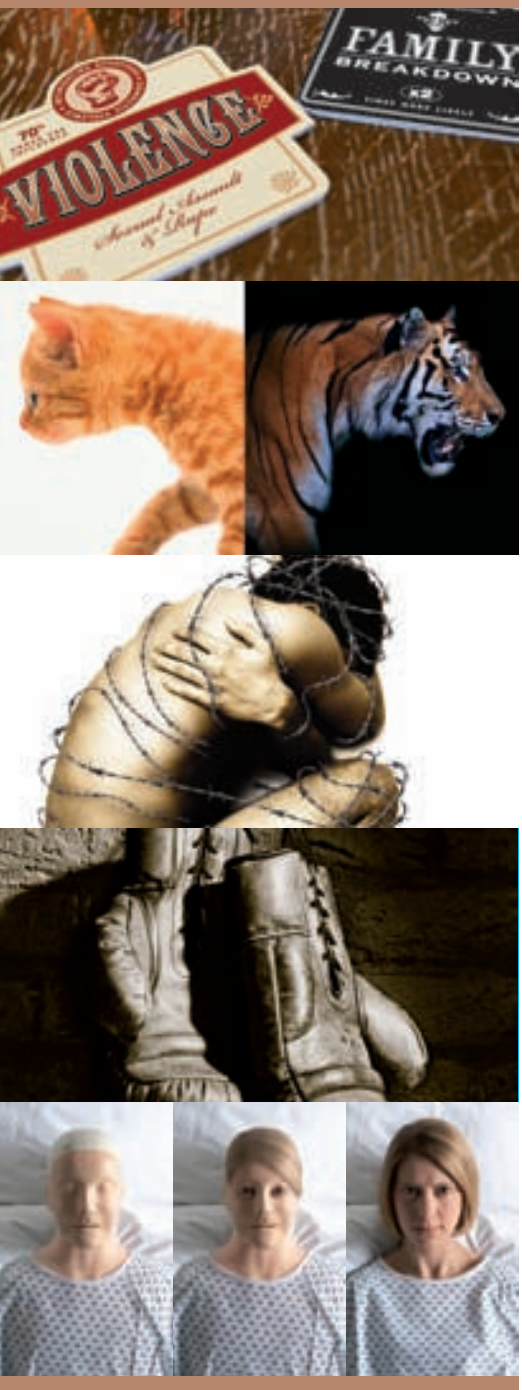
Led to a comprehensive series of actions designed to prevent recurrence of this important safety issue



Women Doctors: Making a difference. Report of the Chair of the National Working Group on Women in Medicine (2009)

This working group, established as a result of the Chief Medical Officer's 2006 Annual Report, formulated practical solutions to tackle the barriers that female doctors may face

Progress check: Last year's Annual Report



Passive drinking: the collateral damage from alcohol

Last year my Annual Report highlighted the harm that alcohol causes to society. Alcohol does not just harm those who drink it. It causes family problems. It causes crime and disruption in our streets. It places a huge burden on the NHS. In my report, I put forward the case for these 'passive drinking' effects being taken more seriously. Alcohol harms even those who do not drink, and this should represent a strong rationale for action. I made a series of recommendations to reduce the collateral damage that alcohol causes.

One of my recommendations was that the Government should institute a minimum price per unit of alcohol. I suggested that this might be set at 50 pence. This proposal has a strong evidence base. The evidence is that such a policy would barely affect those who drink moderately. It would have a far greater impact on those who drink heavily.

During my 12 years as Chief Medical Officer, my Annual Reports have attracted a good deal of political, media and public attention. This topic attracted more attention than any previous Annual Report topic and ignited a much-needed debate.

The Government initially rejected my minimum price recommendation outright. Over the course of the year, however, opinion within government and public opinion have both shifted palpably. I am particularly pleased by the strong and vocal support from key medical institutions. The Royal College of Physicians spoke out powerfully in favour of the proposal. At the annual meeting of the British Medical Association, members voted in clear favour of supporting the minimum price recommendation.

Individually these voices are strong. Together they have real volume. The Alcohol Health Alliance UK brings together the Royal College of Physicians, the Royal College of Surgeons, the Academy of Medical Royal Colleges, the Faculty of Public Health and 20 other such organisations. To see such a group of medical bodies speaking together with one voice is very powerful. They speak in particular of the passive harms of drinking. They, too, call for a minimum price per unit.

Other professionals have echoed this call. The Faculty of Public Health represents 3,000 public health specialists from the United Kingdom and elsewhere. The Royal Society for Public Health has 6,000 members from health-related professions. In January 2010, these two institutions joined forces to publish a public health manifesto. It listed 12 actions that government could, and should, take to tackle a range of public health concerns. The first action on the list was a minimum price per unit of alcohol.

In mid-2009, the parliamentary Health Select Committee held an inquiry into alcohol. It also concluded that the Government should introduce a minimum price per unit of alcohol.

It is quite clear that action is needed. Alcohol continues to cause needless ill health and misery across this country. No individual measure is going to tackle this problem in isolation – instead, a package of actions is required. The evidence consistently shows that two factors in particular affect alcohol consumption – access and price. Price is a crucial mechanism by which the Government can have a positive impact on the country's alcohol consumption, and therefore its health.

Over the last year, support for a minimum alcohol price has increased rapidly. Support for smoke-free public places, for example, which I called for in my 2003 Annual Report, took far longer to build.

I reiterate the call for action. The introduction of a minimum price per unit of alcohol will save lives and improve health.

Prostate cancer: what to do with the pussycats?

Prostate cancer is the most common cancer amongst men. Last year I drew attention to the difficulties faced by many men diagnosed with prostate cancer. Prostate cancer behaves differently to other cancers. It grows slowly and often does not cause symptoms or harm. Affected men are three times more likely to die of something other than the prostate cancer itself.

Whilst there are effective treatments for prostate cancer, such as surgery or radiotherapy, they produce impotence or incontinence. This leaves many men with a difficult decision about whether to treat their cancer and risk experiencing these symptoms or to delay treatment and risk the cancer spreading beyond the prostate and causing death.

The ability to accurately differentiate the cancers that will spread and cause extensive disease from those that will remain localised to the prostate is important. Last year I called for ongoing work on the early identification of which low- and intermediate-risk tumours will progress to life-threatening tumours to be monitored closely. I am pleased to see that work is continuing into methods to differentiate these cancers. Projects such as the Bristol-based ProtecT trial are looking at the effectiveness of different treatment approaches for low-risk prostate cancer. ProtecT has recently finished recruiting subjects, although the results are still many years away.

My report also considered a national screening programme for prostate cancer. The prostate specific antigen (PSA) test may identify prostate cancer at an early stage. However, most cancers identified by screening fall into the low-risk category, and their management is uncertain. In 2009, two major studies were published that looked at the effectiveness of screening: one from the United States and one from Europe. The American study found no benefit from screening. The European study found a slight reduction in mortality. However, 1,400 men would need to be screened and 50 men treated to save one life. Many of those 50 men would be left impotent or incontinent following their treatment. Since publishing my Annual Report, I have asked the UK National Screening Committee to review the results of these trials and assess the implications for screening for prostate cancer in England.

I also found that men living in the most affluent parts of the country were more likely to have a radical prostatectomy, the main form of surgical treatment for prostate cancer. It is unlikely that the true incidence of prostate cancer is greater in men living in the most affluent parts of the country. The higher rates of surgery may represent some unnecessary treatment for these men, with its associated risk of impotence or incontinence. Equally, they may reflect that men in the least affluent areas are not getting appropriate treatment. The South West Public Health Observatory in Bristol will be carrying out an investigation into inequalities in prostate cancer care across the country at my request. It is due to report later this year.

Pain: breaking through the barrier

Each year, 5 million people in the United Kingdom develop chronic pain, but only two-thirds will recover. Chronic pain can ruin the lives of those living with it and those close to them. People with chronic pain need high-quality services. However, service provision is variable across the country, and over a third of patients have reported inadequate control of their pain. In England, there is currently only one pain specialist for every 32,000 people in pain.

In last year's Annual Report, I recommended that training in chronic pain should be

included in the curricula of all health professionals. The British Pain Society recently launched a survey of the curricula of United Kingdom health professions, looking at the content of material related to pain. The shortcomings identified will no doubt give further impetus for improvement.

I also recommended that all chronic pain services should supply comprehensive information to a National Pain Database. In September 2009, Dr Foster Research and the British Pain Society launched a three-year audit of pain services, which should form the backbone of data collection in the future.

In my Annual Report, I proposed that chronic pain should be addressed as a public health problem. I am pleased that a group has now been established at the Royal College of General Practitioners to examine my suggestions in more detail.

In July 2009, the Department of Health launched a consultation on new Essence of Care benchmarks on pain. An important component is ensuring that people have an 'ongoing, comprehensive assessment of their pain' based on initial and ongoing identification of pain by trained staff and assessment using evidence-based tools.

Much has been achieved through the work of a voluntary coalition of organisations that have worked with my office to pursue the agenda I set out in my report. Together, these organisations – the British Pain Society, the Chronic Pain Policy Coalition, the Faculty of Pain Medicine, the Patients Association and the Royal College of General Practitioners – have drafted three important proposals.

First, they have applied for funding from the national e-Learning for Healthcare programme to develop online educational material for all health workers who come into contact with patients. Everyone, from care assistants to senior clinicians, should be able to assess pain and know how best to respond.

Second, the group has produced a submission to the National Quality Board of the National Health Service, whose task it is to set priorities within the service and select areas that require national attention and input in order to develop excellent services for all.

Finally, the possibility of holding a National Pain Summit has been raised. In other countries, such as Australia, this has been important in bringing together expertise and experience to develop a coherent national plan for pain services. I support this initiative, and believe it will be an important step in revitalising pain services in this country.

There is no question that a great deal of work remains to be done. However, I hope that through my report, and the hard work of those who are striving to implement its recommendations, there is the potential to improve the lives of the millions of people who live with chronic pain.

Antimicrobial resistance: up against the ropes

Antibiotics have had a dramatic effect on reducing infection and disease, saving many lives since their discovery. But in the 21st century, resistance to antibiotics is becoming a significant problem. In last year's Annual Report, I discussed the problem of antibiotic resistance, and made recommendations to improve the situation.

I was pleased that my recommendation to consider novel ways to stimulate research into and development of new antibiotics was considered in December 2009 by the European Council. Its conclusions included a requirement for the European Commission to develop proposals to create new effective antibiotics and ways to secure their rational use. I had suggested that antibiotic packages should contain a warning about the importance of taking antibiotics responsibly and appropriately. This may require a change in European Union regulations, and I hope that the United Kingdom will take a lead in championing these changes.

My report also called for the prohibition of the use of certain types of antibiotics in animals. I am pleased to note that the Committee for Medicinal Products for Veterinary Use at the European Medicines Agency has taken steps to promote rational prescribing of fluoroquinolones in animals. Precautionary phrases are also to be included on the labels of all veterinary medicines for animals bred for food.

Closer to home, there is much that can be done. There has been much progress on my recommendation to raise the profile of existing public education campaigns. The Advisory Committee on Antimicrobial Resistance and Healthcare Associated

Infection has developed plans to use video systems in general practitioner surgeries and slots on television to highlight antimicrobial resistance. The Department of Health continues to promote its public campaign on sensible antibiotic use, as well as supporting the annual European Union Antibiotic Awareness Day.

Another recommendation was that no further antibiotic classes should be made available over the counter without careful consideration. Since then, applications to reclassify antibiotics for pharmacy that were being considered last year have been withdrawn.

Certain resistant strains of bacteria can often be imported from other countries, and some, such as *Neisseria gonorrhoeae* (a common cause of sexually transmitted infections), are becoming increasingly common in England. Action at an international level will be necessary. I hope that the summit between the European Union and the United States on antimicrobial resistance will be an opportunity to address some of the issues at an international level.

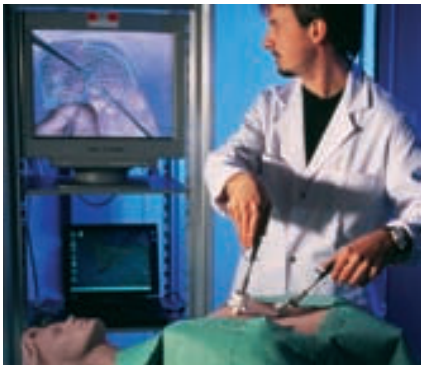
Safer medical practice: machines, manikins and Polo mints

Medical simulation offers an important route to safer care for patients, and in last year's Annual Report I called for it to be more fully integrated into the health service.

I was extremely pleased to see that the Health Select Committee report on patient safety, published in July 2009, called for improved training in patient safety for clinicians, with an emphasis on non-technical skills. Simulation was specifically singled out in the evidence as a potential means to achieve this.

Since publication of my report, there have been a number of simulation conferences. The National Association of Medical Simulators met in Manchester to define the role of simulation in clinical education and in the NHS. The London Deanery's Simulation and Technology-enhanced Learning Initiative (STeLI) conference focused on human factors and training for safer medical practice. Both events showcased the cutting edge of simulation use in medical education.

Additionally, new simulation centres have been established, such as the one at the Whittington Hospital in London, which opened in December 2009. Funded by the London Deanery, this high-tech training and assessment facility will collaborate with nine other simulation centres across the capital to meet the growing demand for scenario-based training.



The 2009 Health Service Journal Award for Patient Safety was given to STeLI, while the Royal College of Obstetricians and Gynaecologists appointed its first director of simulation and recently held the first European conference on simulation in women's health.

I hope that these separate strands will continue to develop in order to embed simulation as a core element in medical training.

Moving to nature's cure

The benefits of regular physical activity to health, longevity, well being and protection from serious illness have long been established. They easily surpass the effectiveness of any drugs or other medical treatment. The challenge for everyone, young and old alike, is to build these benefits into their daily lives.

Key points

- Inactivity affects 60–70% of the adult population: that is more people than obesity, alcohol misuse and smoking combined.
- The physical fitness of children is declining by up to 9% per decade.
- By increasing the risk of developing more than six major diseases, inactivity poses a significant risk to the population's health.
- Physical activity tends to decline with age, but this decline is not inevitable.
- The potential benefits of physical activity to health are huge. If a medication existed which had a similar effect, it would be regarded as a 'wonder drug' or 'miracle cure'.

Table 1: Incidence of ischaemic heart disease in bus drivers and bus conductors

Age (years)	**Conductors** Incidence rate per 100 men in 5 years	**Drivers** Incidence rate per 100 men in 5 years
40–49	1.6	7.6
50–59	5.1	9.8
60–69	7.4	7.9
Total	**4.7**	**8.5**

Source: Morris JN, Kagan A, Pattison DC and Gardner MJ. Incidence and prediction of ischaemic heart-disease in London busmen. *Lancet* 1966; 2(7463): 553–9

On 28 October 2009, Professor Jerry Morris died aged 99 years in London. In the 1950s and 1960s, his inspirational study of heart disease amongst sedentary drivers and more active conductors on London buses provided early evidence of a link between physical activity and health (see **Table 1**). Since this time, the evidence for a positive effect of activity on health has grown inexorably. Levels of physical activity have not increased in tandem.

According to the Health Survey for England 2008, over 60% of the adult population in England fail to meet the minimum recommendation of 30 minutes of physical activity five times a week. This poses a substantial risk to public health. Everyone, irrespective of their age, can take action to reverse this dangerous trend, with significant benefits to their health and general well-being.

The human body evolved to move; physical activity should be as much a part of everyday life as breathing or eating. Why, then, are so many people continuing to ignore nature's cure?

The size of the problem

Inactivity pervades the country. It affects more people in England than the combined total of those who smoke, misuse alcohol or are obese (see **Table 2**). On average, inactivity costs each primary care trust £5 million per year due to health consequences. In 2008, 61% of men and 71% of women aged over 16 years failed to meet the minimum adult recommendations for physical activity, according to self-reported surveys. Such reports are of grave concern. Even these figures are likely to underestimate the true burden of inactivity. When a sample of respondents in the Health Survey for England had their physical activity levels measured directly, only 8–10% of adults who claimed to exercise for 30 minutes at least five times a week actually did so.

Levels of inactivity amongst children are startlingly high. Amongst 2–15 year olds, 68% of boys and 76% of girls do not meet the minimum recommendation of an hour of moderate physical activity per day. As a result, children are being exposed to health risks including obesity, weak bones and future heart disease.

The proportion of the population meeting recommended levels has increased in recent years, but the change is small. The Government aims to get 2 million adults more active by 2012. The latest Government strategy, *Be Active, Be Healthy* (2009), describes collaborative working and targeted local delivery. This will move the population closer to this goal. Achieving this target will require more than central and local government commitment. Such rapid increases in activity have not been seen before in any country. What is needed is nothing less than a societal shift so that physical activity, rather than inactivity, becomes the norm in everyone's behaviour.

The trend of inactivity

In recent years, the role of physical activity in daily routines has significantly reduced. During the last century, the proportion of

Table 2: Inactivity is a major public health threat

	Alcohol misuse	**Smoking**	**Obesity**	**Inactivity**
Percentage of adult population affected in England	6–9%	20%	24%	61–71%
Estimated cost to the English economy per year	£20 billion	£5.2 billion	£15.8 billion	£8.3 billion
Estimated cost to the NHS per year	£2.7 billion	£2.7 billion	£4.2 billion	£1–1.8 billion

Source: Adapted from a number of reports of official statistics and other published work

people employed in non-active professional or managerial roles has more than doubled. There has been a corresponding decline in the number of people employed in more active partly skilled or unskilled jobs (from 49% to 28%). This has been only partly offset by a small increase in the number of people taking part in physical activity for leisure. Time pressures and accessibility have influenced transport patterns. Over the last 25 years, the average number of miles per year travelled on foot has fallen by 25% and by cycle 33%. In stark contrast, the average number of miles per year travelled by car has increased by 70%. Fear of traffic and concerns over 'stranger danger' combine with pressures on childcare to promote sedentary childhood leisure activities within the home environment. Two-thirds of adults are sedentary for six or more hours on weekdays and the average adult watches 2.8 hours of television per weekday, increasing on weekends. This is 16 times greater than the average time currently spent in physical activity which would count towards the recommendations. This is a substantial threat to health, given that high levels of sedentary behaviour have been associated with increasing risk of mortality. These days, sport is largely a spectator activity providing entertainment by watching, rather than participating.

General health risks of inactivity

In my 2004 report, *At Least Five a Week*, I described the evidence for the impact of physical activity on health. Physical inactivity is estimated to cause 1.9 million deaths globally, making it one of the top 10 leading risk factors contributing to death in developed countries. In Europe, 10.4% of all premature deaths would be prevented if everyone who is currently inactive became active. It also significantly increases the risk of chronic diseases, including type 2 diabetes, heart disease, stroke, osteoporosis and some cancers (see **Table 3**). The relationship between inactivity and obesity is well recognised. In my 2002 Annual Report, I highlighted the need for action to arrest the obesity epidemic. It is of concern that the prevalence of obesity has continued to increase in recent years. The majority of the adult population and 30% of children are either overweight or obese. Almost a quarter of adults are now obese. These increases are partly due to declining levels of physical activity. More heart disease deaths are due to inactivity than due to smoking or high blood pressure, and up to 3,000 cases of cancer per year could be prevented by becoming more active.

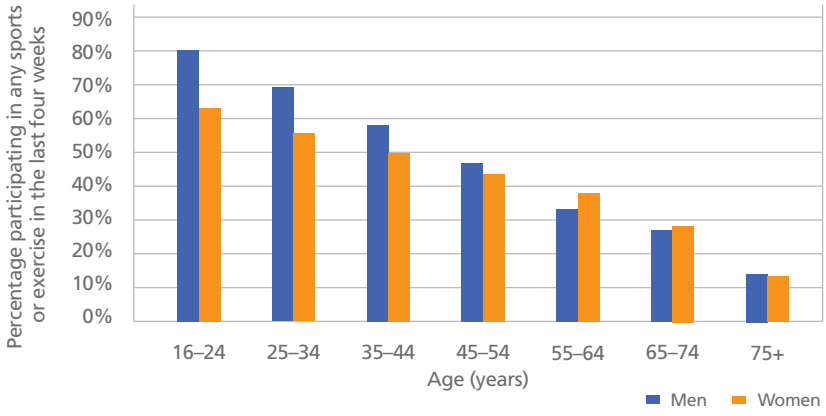
The London 2012 Olympic and Paralympic Games provide a unique opportunity to encourage individuals to commit to an active lifestyle. If the Government's target of 2 million more adults active by 2012 can be achieved, this will provide a lasting legacy for health by reducing the burden of disease in years to come.

Table 3: Physical activity substantially reduces the risk of common diseases

Disease	Effect of physical activity
Coronary heart disease	Moving to moderate activity could reduce risk by 10%
Stroke	Moderately active individuals have a 20% lower risk of stroke incidence or mortality
Type 2 diabetes	Active individuals have a 33–50% lower risk
Colon cancer	The most active individuals have a 40–50% lower risk
Breast cancer	More active women have a 30% lower risk
Osteoporosis	Being physically active reduces the risk of later hip fracture by up to 50%

Sources: Chief Medical Officer's report on physical activity and a range of published studies – full references listed at the end of this Report

Figure 1: The relationship between age and physical activity



Source: *Health Survey for England 2008*

Wider benefits of physical activity

Becoming more active will not only improve the nation's health. Engaging in social physical activities also enhances mental and social well-being and reduces adverse reactions to stress. Physical activity is associated with a reduced risk of developing depression and may be as effective as medication in its treatment. Engaging in physical activity also keeps the brain active, particularly in older age.

In younger age groups, increasing fitness may mean that an individual can now play a new sport or run faster. For an older person, maintaining fitness levels may mean the difference between independent living and needing help to climb the stairs or get out of bed. This has a huge impact on quality of life in the older years.

Physical activity: age matters

Age is the best predictor of participation in physical activity (see **Figure 1**). With increasing age, the proportion of adults who are physically active reduces. This is not inevitable. Unsurprisingly, the prevalence of obesity, cardiovascular disease and falls significantly increases with age. By encouraging physical activity throughout life and instilling exercise skills and attitudes, the course of these diseases can be modified. The health and wider benefits of physical activity are not restricted to a sub-group of the population. Anyone at any age can significantly improve their health and general well-being by becoming more active.

This influence of age on physical activity reflects diverse motivating factors and barriers at different stages of life. The benefits of physical activity are also not uniform through the life course (see **Table 4**). By understanding these influences, targeted strategies can be developed to encourage individuals of all ages to become and remain active.

Educating parents and carers is central to promoting activity in the early years. By school age, the focus needs to shift to making physical activity more accessible,

Table 4: The seven stages of an active person

	Specific benefits	Key motivating factors	Likely barriers
Pre-school	• Communication • Exploration • Motor development	• Parental influence	• Influence of parents/carers
School age	• Maintain healthy weight • Develop core skills (eg throwing and catching) • Teamwork	• Parental influence • Variety of activities in and out of school	• Access • Promotion of sedentary activities
Adolescence	• Bone mineralisation • Reduce risk of mental health problems • Promote healthy habits	• Team and peer influences • Role models	• 'Buddies' • Popular sedentary activities
Young adult	• Modify cardiovascular risk factors • Maintain healthy weight • Reduce stress	• Accompanying children	• Motivation • Availability and accessibility of facilities
Middle age	• Maintain flexibility • Limit weight gain • Reduce stress	• Weight loss • Accompanying children	• Time • Motivation and prioritisation
50–65 years	• Reduce cardiovascular risk • Reduce osteoporosis risk	• Perceived health risks • Improved quality of life	• Perceived inability and lack of fitness • Health concerns
Over 65 years	• Social benefits • Improve activities of daily living and mobility • Improve cognition	• Social/enjoyment • Help with injury and disability	• Health concerns

including emphasising its importance within the school curriculum. Increasing physical activity within the curriculum does not adversely affect academic outcomes. In fact, it may actually improve educational attainment.

At puberty, the mineralisation of bones increases rapidly. The greatest benefits of exercise on bone health are therefore seen at this time. Weight-bearing activities that stress the bone may increase bone mineralisation by up to 15% with substantial reduction in the risk of osteoporotic fractures in later life. This is an important target for action, with significant health and economic benefits. Peer influences are particularly important at this time and team activities are often well received. The effects of activity on boosting self-esteem, promoting health and reducing stress and anxiety may protect against adverse social and health behaviours. Children are more active than adults. Over the adolescent period, sport drop-out rates are high. This has informed a recent Sport England target to have 25% fewer 16–18 year olds dropping out of at least five selected sports.

With increasing age, the risk of heart disease is reduced by keeping physically active. Weight gain increasingly motivates individuals to become more active, but the time pressures of hectic lifestyles prevent regular participation. This is reflected in the growing trend of non-attendance despite gym membership: one-fifth of gym members attend once a month or less. As age increases further, health may become a limiting factor to activity. In the Active People Survey, 'health isn't good enough' was the main reason given for non-participation in an active sport. This is a vicious cycle: although ill health may limit physical activity, inactivity can also lead to a decline in health and physical functioning.

Many people accept weakness, pain and loss of function as inevitable consequences of ageing. Many of these are not due to increasing age however, but are due instead to the accompanying inactivity. A quarter of women aged 70–74 years do not have sufficient strength in their legs to get out of a chair without using their arms. However, there is strong evidence that this decline can be halted and even reversed by regular training. This has informed recommendations in Scotland and the United States. By maintaining strength, the risk of falls decreases and overall mobility improves, enabling older people to preserve their independence and participation in the activities of daily living, such as climbing the stairs, using the bathroom and getting dressed. Low-impact activities to improve flexibility and muscle strength can also help to reduce the pain

Table 5: Comparison of current minimum recommendations on physical activity in different countries

	Early years	For children of school age, moderate intensity activity:	For young adults, moderate intensity activity:	For older adults, moderate intensity activity:
England	Not specified	For 60 minutes each day	For 30 minutes five times a week	For 30 minutes five times a week
Scotland	Not specified	For 60 minutes on most days of the week	For 30 minutes on most days of the week	For 30 minutes on most days of the week + Three bouts of strength and balance exercises per week
Wales	Not specified	For 60 minutes five times a week	For 30 minutes five times a week	For 30 minutes five times a week
Northern Ireland	Not specified	For 60 minutes each day	For 30 minutes five times a week	For 30 minutes five times a week
United States	Not specified	For 60 minutes each day	For 150 minutes each week or 75 minutes of vigorous activity each week + Strength activities two days per week	For 150 minutes each week or 75 minutes of vigorous activity each week + Strength activities two days per week
Australia	Draft guidelines under consultation	For 60 minutes each day	For 30 minutes on most days of the week	For 30 minutes on most days of the week

Source: A variety of official guidance from the respective governments

and loss of function caused by injury and physical impairment. These activities must therefore be a core component of regular physical activity for older adults in England.

By focusing interventions on each life stage, participation in physical activity can be improved. It is crucial to encourage a culture of physical fitness in the population which spans all ages.

Current recommendations

Current recommendations on physical activity differ between countries (see Table 5). In England, the current recommendation is to engage in a minimum of 30 minutes of physical activity of at least a moderate intensity on five or more days a week. This can be achieved either by doing all the daily activity in one session, or through multiple shorter bouts of 10 minutes or more. However, recent recommendations from the United States suggest that this volume of physical activity – 150 minutes – can be spread over the week in a variety of ways. Some people may prefer to be active for 50 minutes on three occasions per week, while others who like vigorous exercise may achieve comparable health benefits from just 75 minutes per week. Moving to a weekly

Box 1: Change4Life and physical activity

- **60 Active Minutes campaign:** encourages children to do at least 60 minutes of physical activity per day, such as jumping, skipping, dancing, running or swimming.
- **Up and About:** aims to decrease the amount of time children spend in sedentary activities.
- **Start4Life:** provides ideas for active infant play.
- **Let's Dance with Change4Life:** offers free taster dance classes across the country.

target may prove more convenient for some people in planning their physical activity. However, there are some concerns: the current recommendation is consistent with other public health messages, which provide daily recommendations for fruit and vegetable consumption or alcohol intake. The simplicity of a 'prescribed' amount is easy to understand. By unravelling the intricacies of moderate versus vigorous exercise and the relative contributions to the weekly target, the overall message may lose its clarity. However, in light of this new evidence, it is timely to review the current recommendations, and consultation is already under way to achieve this.

There are currently no physical activity recommendations in England that focus on the pre-school age group. It is becoming increasingly clear that activity is particularly important in this group to promote development and that many pre-school children spend too much time engaged in sedentary activities. This evidence is currently being considered to inform a United Kingdom-wide recommendation for physical activity in the early years. In addition, an expert group is considering the evidence for the development of specific recommendations on limiting time spent being sedentary, to sit alongside recommendations on physical activity.

The case for fitness monitoring

Globally, the physical fitness of children of comparable ages is declining by 4.3% per decade. The figure is 7–9% in England. This decline is independent of increasing childhood obesity. Fitness decreases during childhood, possibly due to decreasing emphasis on physical education in older age groups. Comprehensive fitness testing in Texas showed that about 30% of eight year olds were 'fit', but the figure was down to 10% by 17 years. Having a normal body mass index (BMI) but being unfit confers greater health risks than being 'fat and fit'. This makes the trend of declining child fitness particularly alarming. It highlights the need for greater awareness of inactivity so that it sits alongside childhood obesity as a national priority.

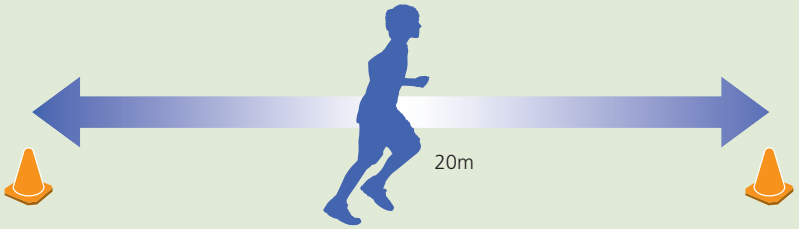
The Department of Health's *Let's Get Moving* pathway in primary care aims to identify inactive 16–74 year olds through a structured primary care questionnaire, and help these individuals become more active. The Change4Life campaign endeavours to get the population more active (see **Box 1**).

The National Child Measurement Programme annually records weight and height. There is no equivalent standardised measurement strategy for fitness in children. A number of objective measures of child fitness exist but in England these have primarily been used as research tools (see **Box 2**).

Standardised fitness assessments for children have been successfully introduced

Box 2: The 20 metre shuttle run, or 'beep test'

This common test of cardiorespiratory or 'aerobic' fitness involves an individual running between two cones 20 metres apart. They must get to the opposite cone before a 'beep'. The beeps sound with increasing frequency as the test proceeds, requiring the individual to run faster to keep up. The number of completed runs in a specified time has been shown to closely predict a child's heart and lung fitness.



Box 3: Lessons from California

In 2003, physical fitness testing (PFT) became mandatory for 10–15 year olds in California. Each year, over 1.3 million students are assessed in six fitness areas.

A score in the 'healthy fitness zone' represents a level of fitness thought to provide some protection against potential health risks. Over three years, up to an 8.2% improvement has been seen in the number of students achieving scores in the 'healthy fitness zone' across all six areas.

In 2007, a similar mandatory test was introduced in Texas for children aged 8–17 years.

in some areas of the United States (see **Box 3**). The introduction of a standardised school-based fitness assessment in England may have multiple benefits that extend beyond the benefits for the individual (see **Box 4**). The latest government strategy, *Be Active, Be Healthy,* has emphasised the importance of measuring physical activity in order to accurately monitor trends and the effect of interventions. By objectively measuring fitness, trends could be accurately quantified each year. By analysing data by region, school and age group, structured interventions could be appropriately targeted and educational curricula could be modified. Each individual child could also assess their fitness and monitor changes over time.

Extensive piloting would be required to determine the feasibility and scope of such an assessment. In addition, evidence must be gathered to assess whether the true strength of child fitness testing lies in surveillance, screening, health promotion, or all of these. Crucially, by formalising such an assessment, awareness of physical fitness as an area of health importance would increase throughout the population. This may provide a stimulus for the cultural change that is so desperately needed.

Box 4: The benefits of improving physical fitness in children

- Lowering the lifetime risk of six diseases.
- Building a lifelong habit of participation in physical activity.
- Higher educational attainment.
- Maintaining a healthy weight.
- Improving social and mental well-being.

Over many decades, the importance of physical activity has repeatedly been emphasised, most recently within *Be Active, Be Healthy*. Government action in these areas has been strong but further targeted interventions and a population-wide cultural shift will be required for us to become a truly active nation.

The health and wider benefits of physical activity are substantial. If a medication existed that decreased the risks of chronic disease to a comparable extent, it would undoubtedly become one of the most widely prescribed drugs within the NHS. As a population, we can harness all of these benefits by taking simple and inexpensive steps to become more active. The scourge of inactivity has been ignored for too long. This is the time for action.

Actions recommended

- New recommendations on the minimum physical activity requirements should be built immediately into public health programmes.
- Particular emphasis should be placed on the pre-school age group and on strength and balance activities for older adults.
- Recommendations on minimum physical activity requirements should be consistent across the United Kingdom.
- Further research should be undertaken to establish the most effective interventions to increase physical activity within specific age groups.
- Comprehensive physical fitness testing should be piloted in secondary schools.
- The pilot must include both standard tests of cardiorespiratory fitness and multi-stage fitness assessments.

Winter kills

England's annual winter death toll averages over 30,000 people. This death rate is far higher than that in comparable countries. With better preparation for cold weather, thousands of lives could be saved each year.

Key points

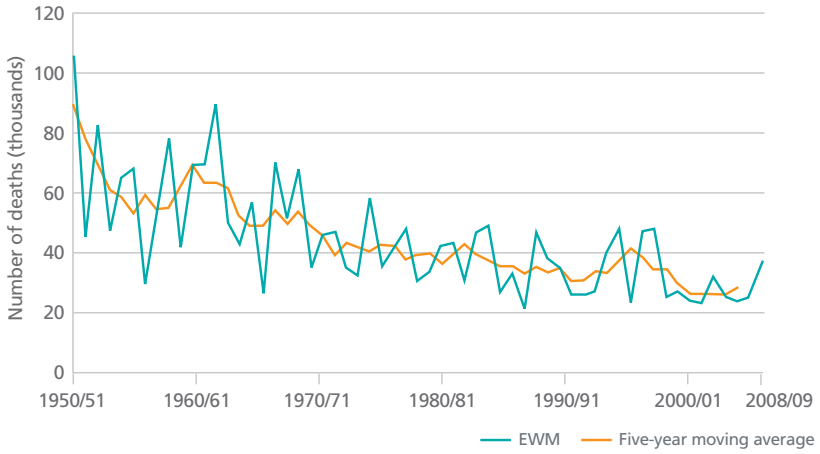
- Mortality in England rises 18% during the winter months, whereas other, colder, countries have smaller increases.
- Every 1 degree Celsius decrease in average winter temperature results in 8,000 additional winter deaths in England.
- Finland has 45% fewer winter deaths than the United Kingdom.
- Most winter deaths occur due to increased cardiac death, strokes and respiratory problems.
- People with underlying cardiovascular or respiratory disease and the elderly – especially women – are at greatest risk.
- Every £1 spent keeping homes warm can save the NHS 42 pence in health costs.
- Around two-fifths of eligible households do not claim their pension credit.
- Illnesses occur in a predictable pattern following cold weather, enabling local and national advance planning.

Winter can be fun for families. Children look forward to playing in the snow. Forecasters wonder whether each year's Christmas will be white. Sadly, for thousands of families, winter brings illness and death. On average, over 30,000 additional people will die in England each winter because of cold weather. Cold weather is implicated in one in twenty deaths. Some of these extra deaths are due to falls or road collisions. The vast majority are due to heart attacks, chest infections and strokes. Many are preventable.

Winter excess deaths

Cold weather is widely believed to jeopardise health. People associate it with influenza and colds. Winter bed crises affect some parts of the National Health Service. Cold weather and illnesses have been linked since ancient times. Hippocrates noted that winter brought 'pleurisy, pneumonia, coryza, hoarseness, cough, pains of the chest, pains of the ribs and loins, headache, vertigo, and apoplexy [stroke]'. Medical journals have been reporting excess winter mortality for 150 years.

Figure 1: Excess winter mortality (EWM) by year and five-year moving average, England and Wales

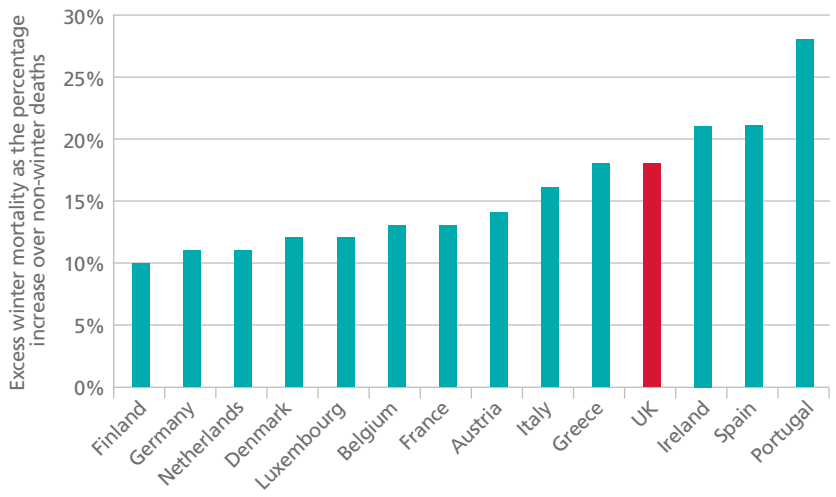


Source: Office for National Statistics

Modern evidence confirms this. From December to March each year there is a persistent pattern of increased deaths (excess winter mortality) compared with the summer months. Some winters are worse than others. Although the number varies from year to year, around a fifth more people die each year over the winter months than during the summer. Some years are particularly bad. Over the winter of 2008/09, there were 36,700 more deaths than in the previous summer. In the winter of 1999/2000, this number was over 45,000. The latest figures are not yet available, but this winter has been marked by severe weather. With improvements in living standards and general population health, the extent of excess winter mortality has gradually fallen over the last half century (see **Figure 1**). It is still too high.

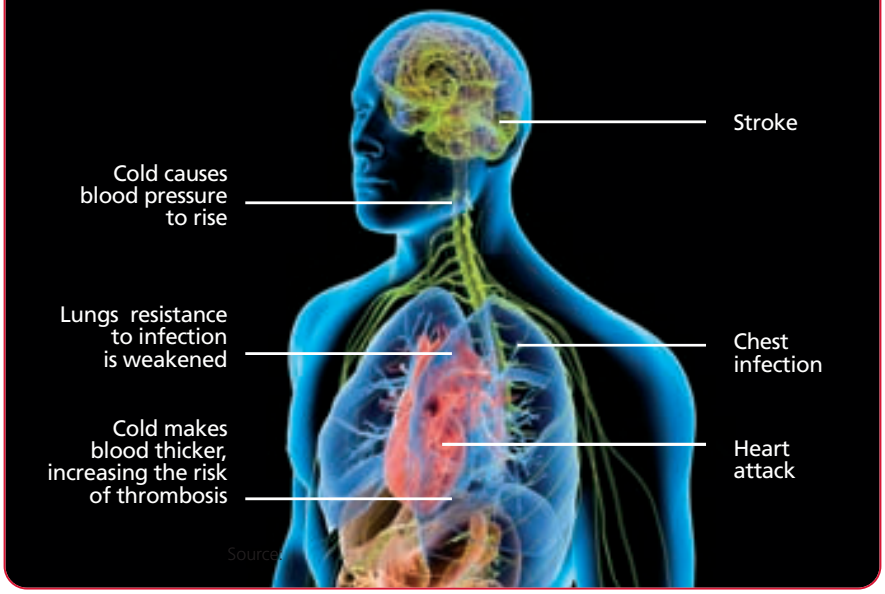
The United Kingdom overall does not compare well with other European countries. Finland – a much colder country – has a winter excess death rate close to half that of the United Kingdom. Other northern European countries, such as Denmark, Germany, the Netherlands and Belgium, all perform better than England (see **Figure 2**). This demonstrates the 'paradox of excess winter mortality'. The countries with the greatest excess winter mortality – Spain and Portugal – are also the ones with the mildest winters. The population in colder countries is protected from the effects of cold weather by strong cultural norms of well-heated homes and warm outdoor clothing. The lack of these norms in southern Europe can cost lives when it turns colder.

Figure 2: Excess winter mortality by country



Source: Healy JD. Excess winter mortality in Europe: a cross country analysis identifying key risk factors. *Journal of Epidemiology and Community Health* 2003; 57(10): 784–9

Box 1: Health impacts of cold weather



England is insufficiently prepared for cold weather. Staying warm saves lives. By failing to protect vulnerable people from the cold, tens of thousands of lives are endangered every winter.

The effects of cold

Extreme cold can kill directly through hypothermia. Chilled to an extreme, the body's organs simply cease to operate, and the heart stops beating. More commonly, exposure to cold causes thickening of the blood, increasing the risk of coronary thrombosis and stroke. Cold weather produces a rise in blood pressure and causes the coronary blood vessels around the heart to spasm. Together, these factors can prove a lethal mix (see **Box 1**). Diseases of the circulation – including heart attack and stroke – account for around 40% of excess winter deaths.

Around one-third of excess winter deaths are due to respiratory illness. In cold weather, people spend more time indoors in close proximity to one another. This helps infection spread. Inhaling cold air affects the lung airways, causing them to narrow and produce phlegm. This worsens chronic lung disease and asthma. Exposure to the cold suppresses the immune system and cold air diminishes the lungs' capacity to fight off infection, leading to an increased risk of bronchitis and pneumonia. Those living with underlying heart, circulatory or lung disease are at the highest risk.

The effect of cold weather is so stark that it can be measured directly (see **Box 2**). Once the temperature falls below 18 degrees Celsius, every further degree drop in outdoor temperature results in a 1.4% increase in mortality in this country, amounting to a further 8,000 excess

Box 2: The effect of temperature on health

Indoor temperature	Effect
21° Celsius	Recommended living room temperature
18° Celsius	Minimum temperature with no health risk, though may feel cold
Under 16° Celsius	Resistance to respiratory diseases may be diminished
9–12° Celsius	Increased blood pressure and risk of cardiovascular disease
5° Celsius	High risk of hypothermia

Source: Department of Health, 2009

deaths. This effect is three times greater in extreme cold.

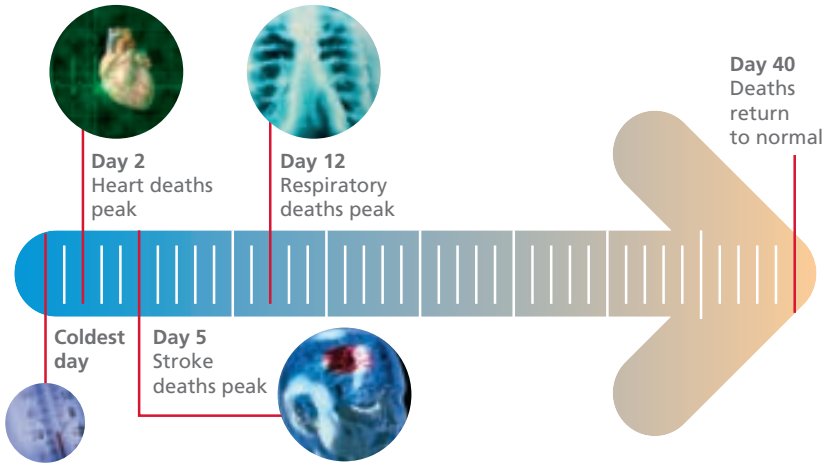
Not everyone is affected equally. Older people, particularly women, are the most at risk. The majority of excess winter deaths are in people aged over 75 years. In part this may be due to these being the people most likely to have underlying conditions making them vulnerable. People living in poorly heated housing live in greater danger. Old, badly insulated properties offer significantly less protection against the risks of the cold than more modern, warmer dwellings. Heating matters. Not having central heating is strongly correlated to a greater risk of death.

The effects of cold weather are predictable. Cold weather deaths from heart disease increase almost immediately, reaching their highest just two days after the coldest weather. The steepest rise for stroke takes place later, at five days. It takes another week for deaths from respiratory illnesses to peak. Indeed, after a cold spell, it takes over a month for death levels to return to normal (see **Box 3**).

Weather forecasts can be linked to health predictions. This allows preventive health measures to be targeted to vulnerable groups at the right time. A study by the Met Office has shown that general practices using a weather and health forecasting service were able to reduce hospital admissions from one type of chronic lung disease 17% more than other practices. There are clear benefits in communicating directly with people when they are at increased risk of becoming unwell – given the right information at the right time, individuals are better able to self-manage their health. Using statistical estimates to predict the health consequences of cold weather allows hospitals to prepare for surges in need. However, these methods are not used routinely. More could be done to ensure that relevant health services are on a coordinated alert to cope with these inevitable rises.

Death is the most extreme consequence of exposure to cold. It is not the only problem. Increased illness due to cold conditions puts a strain on local general practices, hospitals and other health services. Lost work due to illness is a particular burden for small businesses and the self-employed. Cold weather may trigger asthma in young people. This, and other illnesses, can result in children having to stay away from school.

Box 3: Cold weather death sequence



Source: Adapted from Donaldson GC, Keatinge WR. Early increases in ischaemic heart disease mortality dissociated from and later changes associated with respiratory mortality after cold weather in south east England. *Journal of Epidemiology and Community Health* 1997; 51(6): 643–8

The cost of staying warm

In 2007, 2.8 million households in England experienced fuel poverty. Fuel poverty is defined as having to spend 10% or more of household income on heating the home. Fuel prices have risen over recent years. Between 2003 and 2007, the number of households in fuel poverty more than doubled (see **Figure 3**).

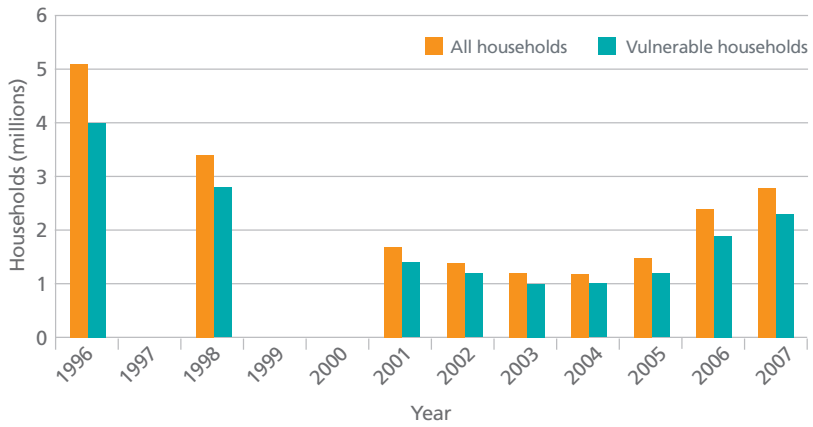
Households containing vulnerable people (the elderly, children and those with a disability or long-term illness) have been disproportionately affected by these price rises. Half of all fuel-poor households include at least one person aged over 60 years. A quarter have an occupant over 75 years old. These are the people most at risk from cold weather.

Prepayment meters are the most expensive way of paying for gas and electricity. They are disproportionately found in the homes of people on low incomes. A quarter of those using these meters are on annual incomes of less than £10,000. Over 30% of people living with a long-term illness or disability have prepayment meters. Most do not realise that they pay extra for their energy.

Persistent cold, together with the financial worry of being able (or unable) to afford adequate heating, can cause depression. People in fuel poverty are 2.5 times more likely to report high or moderate stress than those able to afford their heating.

The financial and emotional costs to the families of those made ill through exposure to cold is great. There are wider considerations too. The annual cost to the NHS of treating winter-related disease due to cold private housing is £859 million. This does not include additional spending by social services, or economic losses through missed work. The total costs to the NHS and the country are unknown. A recent study showed that investing £1 in keeping homes warm saved the NHS 42 pence in health costs. The idea of the NHS contributing to reducing winter injury and death in this way is not new. In the winter of 2009/10, NHS County Durham and Darlington contributed £500,000 of its budget towards the gritting of roads, paths and pavements in priority areas.

Figure 3: Fuel poverty in England



Source: Department of Energy and Climate Change, 2009

Helping people stay warm

Interventions to tackle fuel poverty work. The relief from cold and debt can reduce depression by half and visits to general practitioners by a quarter. In one study, warmer housing led to 38% fewer days off work and reduced the incidence of asthma in children. Missed school days fell by 50%, resulting in improved childhood educational achievement.

A number of government schemes aim to mitigate against fuel poverty. These include boiler replacement programmes, home insulation and draught-proofing subsidies, as well as cold weather payments to boost household budgets when the weather is at its coldest. New homes must be built to ever higher standards of fuel efficiency and insulation.

Many of those most at risk are not benefiting from these policies. Two-fifths of pensioner households who could claim pension credit do not. Each year, between £6 billion and £10 billion of benefits remain unclaimed, and the percentage of unclaimed entitlements is rising. A scheme called Warm Front includes a benefit entitlement check to ensure that vulnerable people are receiving the help they need. Following assessment, the average yearly household income increases by around £1,600. For people at risk, this can be the difference between life and death.

Simple measures can also help. Blocking draughts around windows and doors can save heat and lives. A preference for fresh air – for example, sleeping with the windows open – can undo any benefit from good daytime heating.

Outdoor protection

Keeping warm indoors is a critical part of staying healthy in the winter. Keeping warm outdoors is also essential and perhaps harder to achieve. Fully heated housing does not alone protect the elderly from winter mortality.

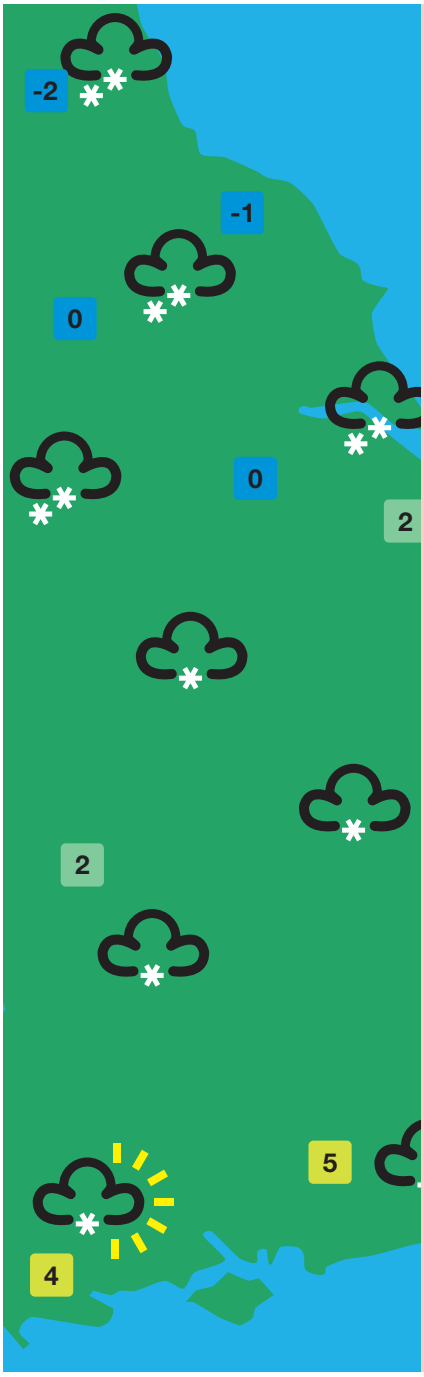
Every parent knows it is important to wrap up their children in the cold. Physical activity generates heat which protects against the harmful effects of cold weather. Older people may move more slowly, producing less heat. Not only does this make them more vulnerable when walking outdoors in the cold, it also means that their total time exposed to the cold is longer.

Research confirms that there is a striking benefit from wearing hats, anoraks and gloves in cold weather. The low excess winter mortality in Siberia has been linked to local habits of dressing warmly when outdoors in the cold. In warmer countries, like England, many people brave freezing weather without a hat or gloves. Yet it is often seen as patronising to run public information campaigns to remind people of the importance to health (or even survival) of good, warm clothing.

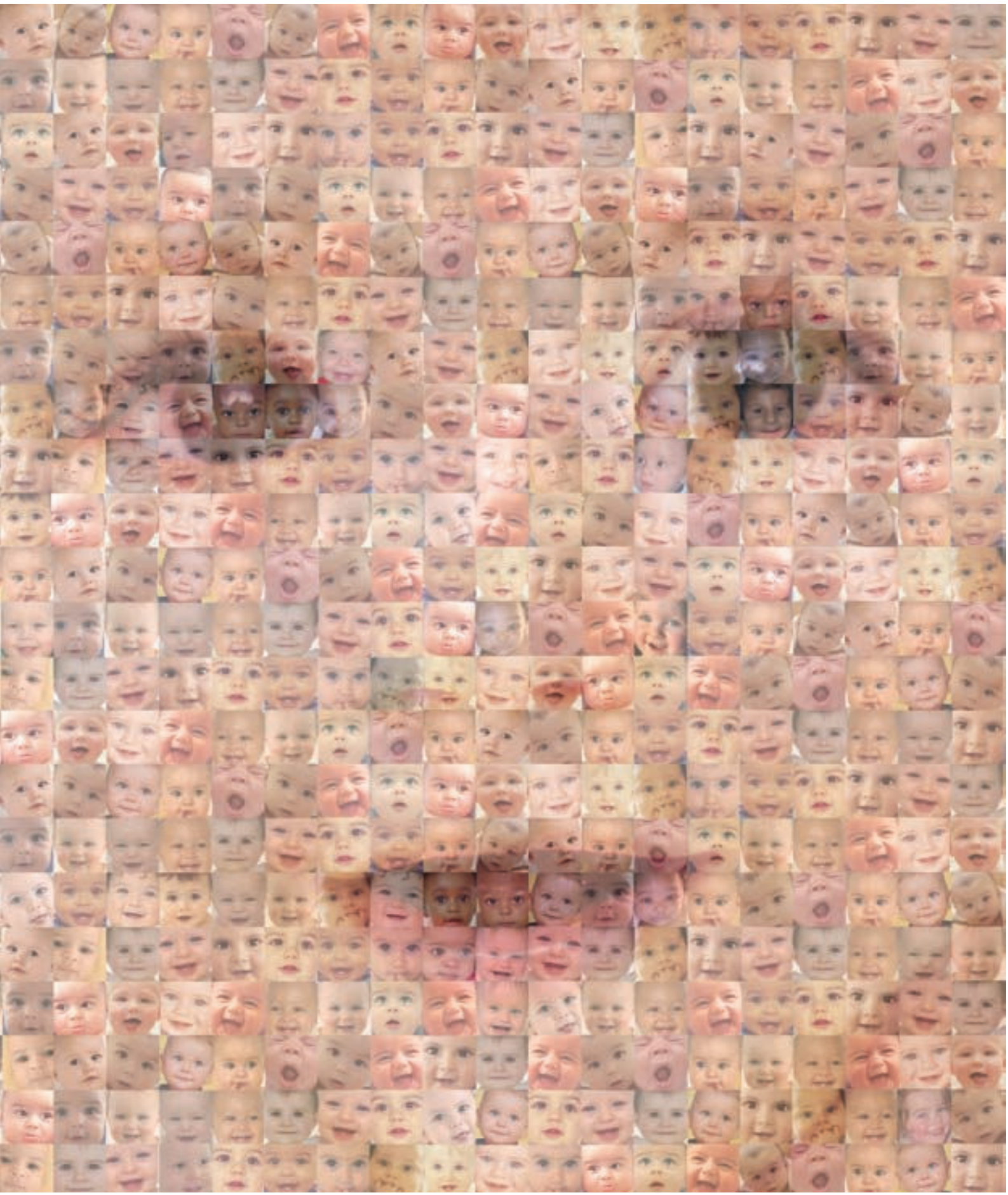
One of the most effective ways of staying warm is to wear multiple loose layers. Modern fabrics have replaced woolly garments as the best protection against cold, wind and rain. Clothing made from new materials is often more expensive and is not designed with older people in mind. Well designed winter wear can protect vulnerable people from the death threat of cold weather, but those who need it most often cannot afford it.

Death by cold weather is not inevitable. The success of countries such as Finland shows this. Much more could be done to save the lives of tens of thousands of vulnerable people each year and match the performance of the best worldwide.

Actions recommended



- A national cold weather plan should be developed to prevent and deal with the health consequences of cold weather.
- Healthcare providers should identify people vulnerable to harm from cold weather and refer them for appropriate help.
- During periods of cold weather, supermarkets and local shops should be encouraged to offer free home deliveries of groceries to vulnerable people.
- Warm clothing technology appropriate for older people should be developed and promoted.
- Further research should be conducted into the risk factors for winter mortality and how it might be prevented.

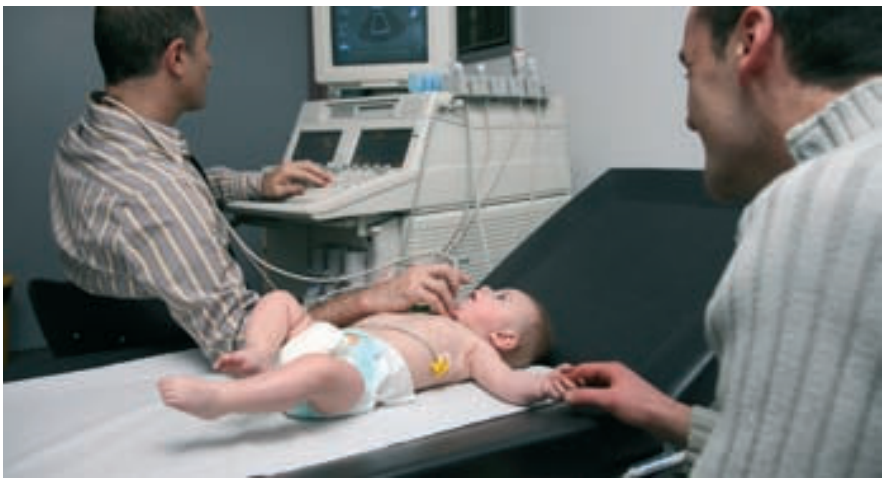


Rare is common

Rare diseases take many different forms and most doctors will see very few in a lifetime of practice. Taken together, though, people with rare diseases share many problems, including difficulty in getting a diagnosis and accessing the right services and support for themselves and their families.

Key points

- A disease is rare when it affects fewer than five in every 10,000 people. There are more than 6,000 rare diseases, so in fact one person in every 17 has a rare disease – around 3 million people in England.
- As a consequence, rare diseases are an important cause of illness and death – not just in England but across the world.
- Rare diseases can affect any system in the body. They are usually chronic and difficult to manage, and – because they are rare – coordinated efforts are needed to provide effective and accessible care.
- Around four in every ten people with a rare disease report difficulty in getting a correct diagnosis.
- Many people with rare diseases do not have access to specialist services, causing delay in diagnosis, slow treatment and isolation for affected individuals and their families.
- More and more children with rare diseases are surviving into adulthood because of improved treatments and services, but their transition to adult services is often unsatisfactory as expert services for adults with rare diseases are lacking.



One in 17 people in England (approximately 3 million people) have a rare disease. By definition, individual rare diseases affect fewer than five in 10,000 people. However, there are more than 6,000 different rare diseases. These diseases are rare individually but become relatively common when they are considered collectively as a category of illness. Rare diseases affect over 30 million Europeans and over 25 million North Americans.

The majority of affected people are children since these conditions tend to be present from birth, start in childhood and may be life-limiting. The British Paediatric Surveillance Unit, established more than 20 years ago, provides a simple and effective way of studying rare childhood disorders across the country. It allows the frequency of very rare diseases to be estimated reliably and the experiences of children and families in the period immediately before and after diagnosis to be better understood (see **Box 1**).

Rare diseases can affect all body systems (see **Figure 1**). As the number of people affected with specific diseases in any single area or region of the country is small, specialist services may be needed regionally or supra-regionally rather than locally.

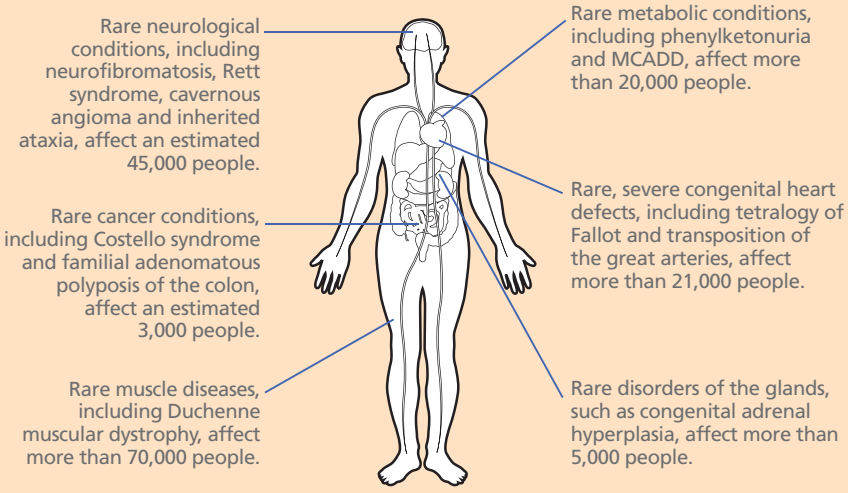
Different but similar

Despite their diversity, rare diseases share some common features. They are severe, usually chronic, life-threatening and may get worse over time. Symptoms or signs usually start in childhood. Most are incurable and often there is no effective treatment. Affected individuals and their families need support as they often face an uncertain future with a lack of therapeutic hope. The quality of life of the affected person and their family may be compromised.

These characteristics pose important practical challenges when delivering the range of services needed by people with rare disease. It can be difficult to make a timely diagnosis and information about the disease may be hard to access. There may be a delay in referral or lack of access to specialised services, and care is usually needed from an interdisciplinary specialist team. There can be poor coordination and communication within and across care sectors, and poor social or educational support. There can also be a lack of integrated family, social care, educational and employment support.

Some aspects of this challenge were summarised by one person with an inherited ataxia, a condition that leads to problems with coordination of body movements: *'The problem is that I need treatment from several specialists – dermatologists, spinal surgeons and neurologists – and it can be hard to get them to work together.'*

Figure 1: Some examples of the body systems affected by rare diseases*



* Figures are for numbers of people affected in the United Kingdom.

Box 1: Katy's story

Ten-year-old Katy and her family had no idea that she had MCADD (medium chain acyl CoA dehydrogenase deficiency) until she collapsed during a school holiday and her internal organs began to fail. She needed intensive care and her parents were told to expect the worst. She was eventually diagnosed with MCADD and given treatment that allowed her to recover.

MCADD is a very rare condition caused by the lack of an enzyme that converts fat to energy. It affects about one child in every 10,000 in the United Kingdom. Katy was fortunate not to die during her acute illness. She should be able to avoid such episodes in the future by following simple dietary advice and going to her local hospital for emergency treatment if she can't eat or becomes unwell.

Information about children with MCADD in the United Kingdom was collected through the British Paediatric Surveillance Unit and a test for MCADD is now offered as part of the national newborn screening programme in England.

Improving services for people with rare diseases and their families

A diagnosis of a rare disease has a huge impact, not just on the individual but also on their family. There are over 1 million carers of people with rare diseases in England. Parents of such children often have no alternative but to become full-time carers. Advice about benefits and other forms of support are vital to avoid social isolation and poverty.

The Genetic Interest Group is a UK alliance of 138 charities supporting children, families and individuals affected by genetic disorders. It has developed a 'family route map' which identifies seven areas for improvement for people with rare diseases: information; communication; diagnosis, treatment and surveillance; empowering patients, families and carers; educating healthcare professionals; and ethical, legal and social issues. In 2008, the Genetic Interest Group joined others to create Rare Disease UK. This alliance is working with government, pharmaceutical companies, academics and clinicians to develop a rare disease strategy and to raise public awareness of rare diseases.

Groups such as the Genetic Interest Group play a key role in reducing the sense of isolation for individuals with rare diseases and their families. They provide access to information, give practical and emotional support, advocate for better services, promote research funding and encourage patients to participate in treatment trials. Many patient groups for rare diseases provide better sources of information to sufferers and their families than healthcare professionals.

Diagnosing rare diseases

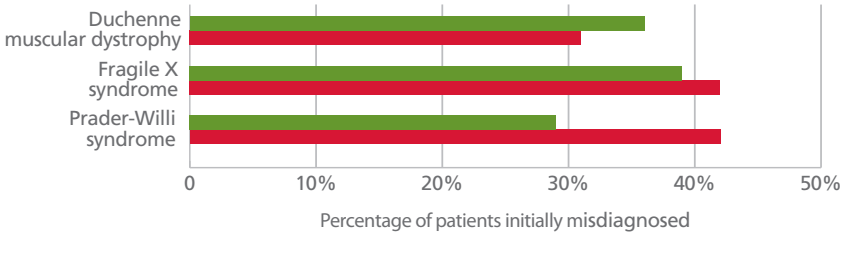
Training and knowledge about rare diseases are variable amongst healthcare professionals. Awareness may be higher amongst local general practitioners in an area where a specialist centre happens to be based.

Individuals with rare diseases may complain of signs and symptoms that have other, more common, causes or which do not always make sense clinically to a doctor or nurse who has never encountered the disease. Many people with rare diseases wait a long time, seeing many different doctors, before their condition is eventually correctly diagnosed. These delays add to the isolation and difficult emotions experienced by affected people and their families when they do finally receive the correct diagnosis (see **Box 2**).

General practitioners diagnose and care for the vast majority of ill people. They play a crucial role in assessing different symptoms and signs and deciding whether specialist care is needed. It is easy to see why rare causes of common or non-specific symptoms may be overlooked. A European study into rare diseases has reported that over one-third of people with a rare disease are initially misdiagnosed in the United Kingdom (see **Figure 2**).

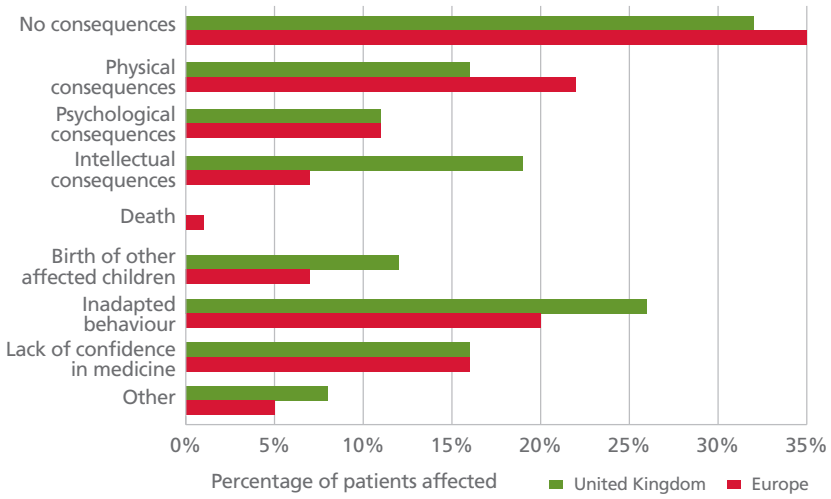
The study surveyed 6,000 patients with rare diseases throughout Europe and found that 25% experienced a delay of five to 30 years from first symptoms to the correct diagnosis being made. Overall, 40% of patients with rare diseases were

Figure 2: Rare diseases may initially be misdiagnosed



Source: European Organisation for Rare Diseases (Eurordis), 2005

Figure 3: The consequences of delaying the treatment of rare diseases are serious



Source: European Organisation for Rare Diseases (Eurordis), 2005

Box 2: Christopher's story

Christopher was born early and had frequent infections and sickness as a young child. His parents, a health visitor and a general practitioner, were not worried as he was growing well and was already a head taller than other toddlers. However, when Christopher was three years old, his mother noticed that he had developed acne and pubic hairs and that his behaviour had changed. He grew even taller and more muscular and his mother insisted on seeing a specialist.

Christopher was diagnosed with precocious puberty and congenital adrenal hyperplasia. His mother said it hit the family very hard. 'We felt incredibly alone and very guilty for what Christopher must have been feeling. The emotions of puberty are hard to cope with during teenage years, never mind when you are of pre-school age.'

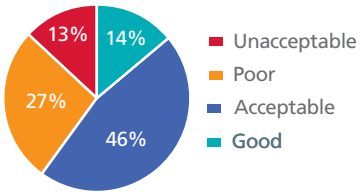
Christopher will be on medication for the rest of his life. As his bone age is advanced, he will go from being a tall child to a short adult. Yet he lives a normal family life, is popular at school, can do the same as any child of his age and can expect to lead a normal adult life.

initially diagnosed incorrectly. This led to unnecessary medical interventions: 16% had surgery, 33% did not receive appropriate medical treatment and 10% received psychological treatment because their symptoms were interpreted as 'psychosomatic'.

A delay in diagnosis may also mean a delay in commencing potentially life-enhancing or life-extending treatments with potentially serious consequences (see **Figure 3**).

A range of studies on breaking bad news has shown that how a diagnosis is communicated to an affected person or their family is vitally important. If badly handled, it may have long-term effects on how much a patient trusts the services provided. This is particularly true for individuals with rare diseases as it may affect their adherence to treatment in the longer term. In a recent European study, over a third of those receiving a diagnosis of a rare disease in the United Kingdom reported an unacceptable or poor experience when being told their diagnosis (see **Figure 4**).

Figure 4: Acceptability of communicating diagnosis of rare disease



Source: European Organisation for Rare Diseases (Eurordis), 2005

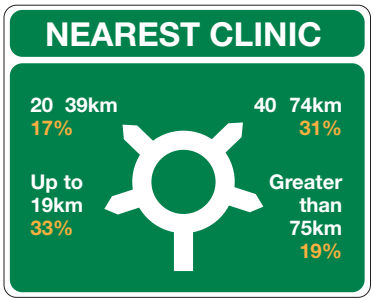
Access to services for people with rare diseases

Once a rare disease is diagnosed, it is important that all necessary services are integrated and respect patient and carer expertise. Many groups of rare diseases can be looked after by a single specialist (for example, congenital heart defects or inherited metabolic disorders) but for some several different specialists need to work together. Care pathways for individual rare diseases help identify to health services, affected people and their families what should be expected and how the services should work together.

The distances travelled to access expert specialist care can be large. Half the families taking part in a country-wide study of MCADD screening had to travel 40km (25 miles) or more to their nearest regional specialist metabolic centres (see **Figure 5**). For this condition, once all the diagnostic tests are completed, most subsequent care can be provided locally on a shared care basis. Unfortunately, this is not always possible for all rare diseases.

Whilst there have been significant improvements in diagnosing and treating children with rare diseases, the same is not true for adults. With earlier diagnosis and

Figure 5: Distances travelled by families attending for diagnostic confirmation of MCADD



Source: UK Collaborative Study of Newborn Screening for MCADD and the MRC Centre of Epidemiology for Child Health at the Institute of Child Health, University College London

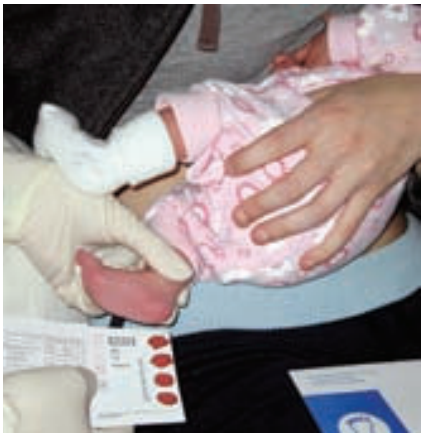
more effective treatments, people with rare diseases now live longer. The transition into adult services is often difficult. Children leave a paediatrician they have known all their lives and may not locate an adult service with experience of their condition. This lack of continuity of care can cause distress and sub-optimal care.

People with rare diseases are estimated to cost the NHS over £1 million annually in each English health region. There are potential efficiencies in treatment if repetition of tests is avoided every time the patient sees another consultant. People may present to an accident and emergency department because they lack information and support. The paediatric passport system ('open access') allows children to fast-track to the correct department. The same system does not exist for adults with rare diseases.

Screening for rare diseases

Achieving an early, timely diagnosis is very important. Affected people and their families often do not get their concerns heard and the disease recognised and diagnosed. People with rare diseases or their family members may be referred to a clinical geneticist for diagnosis and genetic counselling. Not all rare diseases are genetic. Currently, referral to a clinical geneticist may happen only relatively late in the patient journey.

For some rare diseases (for example, severe congenital heart defects, MCADD, phenylketonuria) early identification can prevent irreversible damage or death. This is why newborns are tested shortly after birth for these very rare conditions. The vast majority of newborns do not have rare diseases, so any screening must discriminate reliably between affected and unaffected babies. The benefit for pre-symptomatic diagnosis of affected babies must be clear before a screening programme is introduced. As new diagnostic tests and treatments are constantly being developed, the need for screening for rare diseases is reviewed regularly through the UK National Screening Committee.



Research into rare diseases

There have been major advances in identifying the genes implicated in many rare diseases. While this can help with diagnosis and also shed light on the underlying cellular mechanisms involved in causing rare diseases, at present genetic testing does not always translate into hoped-for treatments. The prospects for preventing most rare diseases remain limited.

Rare diseases are sometimes called 'orphan diseases' because pharmaceutical companies are reluctant to invest in new treatments. It is simply not cost-effective to

"The rarer a condition is, the more important it is that a screening programme does no harm to all the children tested. Screening tests must reliably distinguish those likely to have the disease from those unlikely to have it. Effective treatments and specialist services must be readily available so that all those suspected of having a rare disease can obtain a definite diagnosis and, if needed, treatment as soon as possible."

Professor Carol Dezateux, Institute of Child Health, University College London

develop and market products for the small numbers of patients affected by each rare disease. Even where research is carried out, producing evidence about new treatments can be challenging. Alliances between networks of specialists and patient groups can often be the best way of getting such research under way. In this country, there is a strong tradition of public involvement in research as well as organised specialist clinical networks capable of contributing to disease registers and multi-centre studies. The Medical Children's Research Network was established to facilitate research trials and studies to prevent, diagnose and treat children's diseases. Despite this, there is relatively little research into rare diseases. The amount of research funding for rare diseases collectively is relatively small compared with other conditions (see Table 1). Increasingly, international collaborations are being developed to overcome this problem.

Next steps

Rare diseases have come of age. In 2009 and again in 2010, a national Rare Disease Day was held to raise public and political awareness of these diseases. It is vital that rare diseases are recognised more widely and that this is reflected in the provision of integrated diagnostic and treatment services as well more research and, above all, help for affected people and their families to live fulfilled lives.

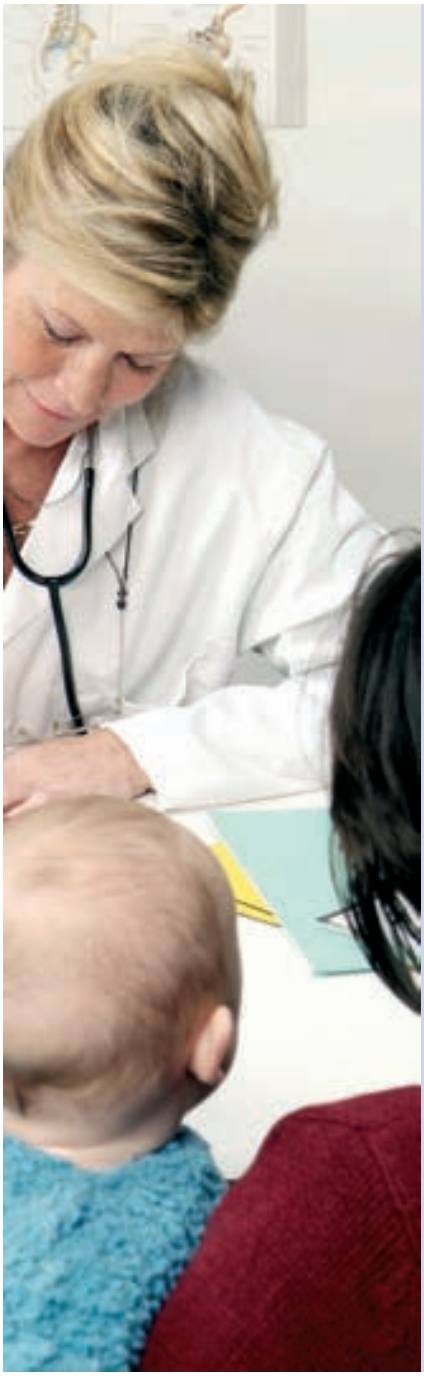
Many healthcare professionals provide excellent services to individuals with rare diseases and their families. However, this is not the norm. Many patients in England, particularly adults with rare diseases, struggle to access specialist services. National coordination of the management of rare diseases is needed to ensure that excellence becomes standard, no matter where a patient lives.

Table 1: Funding for research, and numbers affected, for various conditions in the United Kingdom

Disease	Number of affected individuals	Research funding (2008/09)	Approximate spend per person affected
Cancer	2,000,000	£370,087,680	£185
Heart disease	2,600,000	£75,200,599	£29
Alzheimer's dementia	420,000	£5,221,278	£12
Diabetes	2,600,000	£7,073,613	£3
Rare diseases	3,500,000	£3,595,880	£1

Source: Research funding estimates from the Association of Medical Research Charities; affected individuals from Cancer Research UK, British Heart Foundation, Alzheimer's Society, Diabetes UK and Rare Disease UK

Actions recommended



- Strengthen the network of reference centres for rare diseases to enable better coordination of specialist services, including the transition from paediatric to adult services.
- Ensure that adequate numbers of specialists are trained so that future service needs can be met.
- Appoint a National Clinical Director for rare diseases to oversee the development of clear standards and pathways for the treatment and surveillance of rare diseases, with national registers to support service planning and delivery as well as research.
- Strengthen research, including translational research with economic incentives, to develop and market medicines for the 'orphan diseases'.
- Raise public and professional awareness of this neglected group of diseases.
- Support international collaborative efforts to share information and resources for rare diseases.


grandad
Me

Grandparenting for health

Grandparents and grandchildren have a special relationship and most have frequent contact. Grandparents could be a great asset to a child's health and development. They are usually overlooked in discussions about building healthy childhoods.

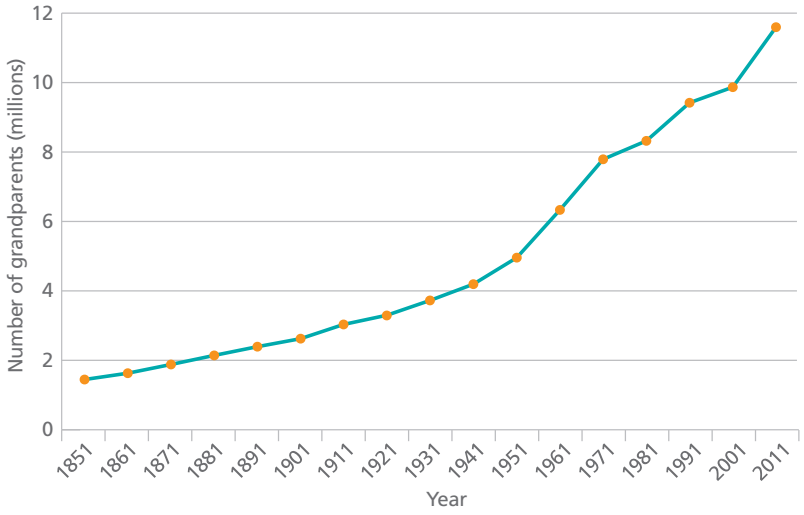
Key points

- There are over 11 million grandparents in England, more than ever before.
- Many grandparents are actively involved with their grandchildren while they are growing up.
- Changes in society mean that parents are increasingly looking to grandparents to become more involved in childcare.
- Studies of the activities that grandparents and grandchildren undertake together show that only a minority are health-orientated.
- Grandchildren often find the relationship with their grandparents supportive at times of adolescent turbulence, when health risk-taking is greatest.
- There is a significant opportunity to equip grandparents to improve the health of their grandchildren and their own health in tandem.

Over the last 50 years, the number of grandparents has doubled. There are now over 11 million grandparents in England. Today's grandparents are healthier, more active, and increasingly involved with their grandchildren. The relationship between grandparents and grandchildren is special. It is also different from many of the other important childhood relationships. Grandparents are a major influence on children, and there is great potential to build on the positive relationship between grandparents and grandchildren to improve health.

Life expectancy has now risen to 79 years. In 1901, less than 5% of the population were over the age of 65 years. Today that has tripled to around 17%. An ageing population has created more grandparents than ever before (see **Figure 1**). It is now common for children, even in their teenage years, to have three or four grandparents still living. Over three-quarters of the population belong to a three-generation family. Nearly one in five is a member of a four-generation family. Within each family, parents now tend to have fewer children. As a result each grandparent has fewer grandchildren. Grandparents may therefore devote more time and attention to each grandchild.

Figure 1: The estimated number of grandparents in England has increased over time



Source: Murphy M, London School of Economics, 2010, personal communication

Box 1: Key research findings: young children and grandparents

- Young children engage in a wide range of activities with grandparents and in doing so learn a variety of different skills.
- The child is treated as an equal partner when learning with their grandparent.
- Children's pattern of learning when engaged with grandparents is different, based on 'learning by doing'.
- Children with an involved grandmother are significantly less likely to attend accident and emergency departments with minor problems.

Sources: Kenner et al, 2005; Fergusson et al, 1998; Grandparents Plus, 2009 (full references cited at the end of this Report)

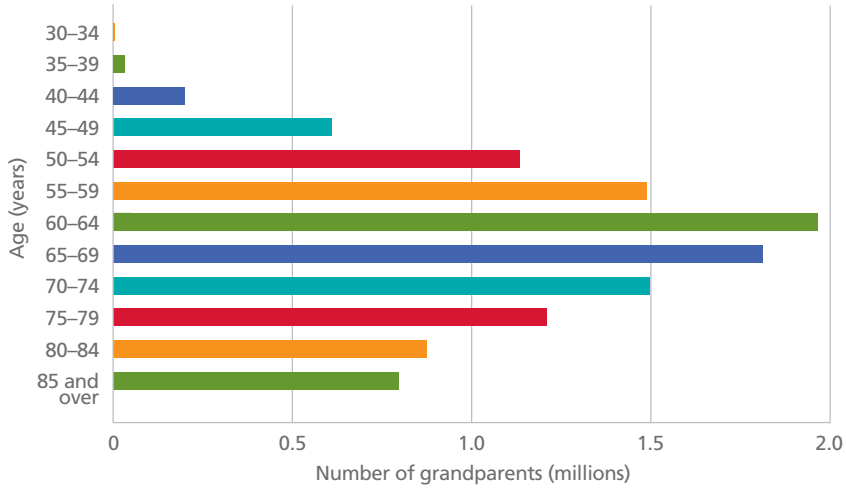
Grandparents increasingly enjoy good health for many years and nearly one in two grandparents are under the age of 65 years (see **Figure 2**). The majority care deeply about their grandchildren, and value their relationship with them. They have a growing and active role in supporting parents in bringing up children. The growing popularity of organisations like Grandparents Plus, Proud Grandparents and the Grandparents' Association reflects the growing recognition of the importance of grandparents.

Grandparents: closely involved with grandchildren

Many modern grandparents are very involved with their grandchildren. They have more spare time than parents. They also have a strong desire to spend time with their grandchildren. Just over 60% of grandparents see their grandchildren at least once a week, and nearly 80% see them once a month. Significantly, many grandparents live close to their grandchildren. Seven out of 10 live within 10 miles, while four out of 10 are within a 15-minute journey of their grandchildren. Face-to-face contact is not the only means of keeping in touch. Many grandparents use the internet or the telephone to keep in contact with their grandchildren. Close relationships are more likely to continue into adolescence if grandparents and grandchildren spend time together when the grandchildren are younger.

Where practical, when parents are looking for childcare, they often turn to their own parents first. Grandparents are now the single biggest source of childcare after the parents themselves. Mothers increasingly return to part- or full-time work after having children. In 1971, just under 60% of women were economically active, compared with 75% today. A long-hours working culture makes English parents some of the most 'time poor' in Europe. Whilst flexible working is more common, finding childcare arrangements for evening

Figure 2: The estimated number of grandparents by age in England



Source: Murphy M, London School of Economics, 2010, personal communication

or weekend working slots is difficult. Grandparents often fill the gaps at less convenient times or at short notice. It is often grandparents who step in to care for an unwell child at short notice, or provide care for disabled children when it may be hard to find suitable alternative arrangements.

Around one in three families are now relying on grandparents to provide childcare. Some groups are more likely to ask their parents for help, such as mothers in lower-earning occupations, unmarried couples and single mothers. Around half of single mothers rely on grandparents for childcare. One study found that grandparents provide 40% of childcare when parents are working, and 70% of childcare at other times. The total value of childcare contributed by grandparents has been calculated at £3.9 billion.

Nearly 170,000 grandparents act as the primary carer for their grandchildren, taking the place of parents. Grandparents who take over the direct care of their grandchildren may be more likely to experience poor physical health and depression compared with other people of a similar age. It is important to support these grandparents in this challenging but important role. However, for most grandparents, close involvement with their grandchildren improves their quality of life.

Parents are more likely to separate today. This creates new families with 'step-grandparents' and 'step-grandchildren'. Around one in every five grandparents has step-grandchildren. Two in every five grandparents have grandchildren in non-intact families.

Grandparents are an important source of advice to parents. One in three parents would go to their own parents first for advice about health matters, rather than consult a doctor, the internet or the media. Advice from grandmothers may help reduce unnecessary visits to a doctor. Grandchildren with close grandmothers are significantly less likely to go to an accident and emergency department with minor complaints that do not require medical treatment. Support from grandparents can also take other forms – financial, or providing help with shopping or preparing meals. One in every three grandparents in their seventies provide financial support for their grandchildren.

Grandparents and grandchildren: a special relationship

Grandparents and grandchildren are frequently in contact. Statistics fail to capture the importance and richness of this special relationship. Time and again, researchers are surprised by its importance to both grandchildren and grandparents. Traditional research methods (involving interviewing adults) have not always helped in understanding the relationship between young children and their grandparents. When researchers interviewed children, they found, for some children, that grandparents were a major

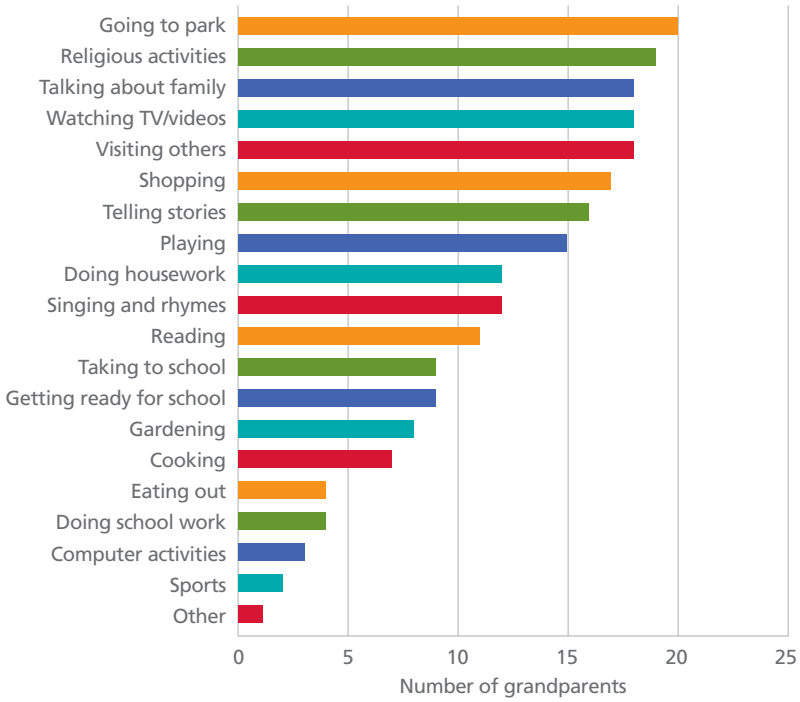
influence on their learning. This was particularly true for learning a language or learning about their culture. Observing grandparents and grandchildren interacting, researchers saw a very different relationship compared with that between parents and children: there were more activities focused on fun and enjoyment. The relationship was more equal, and because of this was characterised by mutual or shared learning.

Box 2: Key research findings: adolescents and grandparents

- The majority of grandchildren think that their grandparents are an important part of their lives.
- Grandchildren want their grandparents to be actively involved in their lives.
- Young people are better adjusted and have fewer problems when their grandparents are involved in their lives.
- Young people whose grandparents take an active interest in their education have fewer emotional and behavioural difficulties.
- Grandchildren adjust better to major life events (such as parental separation) when they have a close grandparent.
- During adolescence, many teenagers begin to take greater responsibility for caring for their grandparents.
- Grandparents are often perceived as less strict than parents.
- Grandchildren sometimes find it easier to confide in their grandparents than in their parents.

Sources: Buchanan and Flouri, 2008; Hill, 2006; Dench and Ogg, 2002; Buchanan and Griggs, 2009 (full references cited at the end of this Report)

Figure 3: The activities that grandparents do with young grandchildren



Source: Kenner C, Jessel J and Gregory E. *Intergenerational Learning between Children and Grandparents in East London: End of award report*. Swindon: Economic and Social Research Council; 2005

Children learnt by exploration and sometimes looked to teach their grandparents. This was particularly true for using modern technology, for example computers. Grandparents engaged in a wide range of activities – taking children for walks, reading books, cooking or going to the cinema (see **Figure 3**). Grandparents chose activities on the basis of enjoyment. Many of these activities help children's general and social development. However, research has shown that only a minority of activities focused on children's health, so there are real opportunities for improvement in this area. Grandparents may sometimes have a better opportunity than parents or teachers to influence their grandchildren's behaviour, building on the strength of their relationship. Sport and exercise are often perceived as hard work and boring. When children enjoy exercise with their grandparents, they can appreciate the positives. Similarly, other shared activities, such as cooking, can have an emphasis on health. Recent concerns that grandparents' cooking may lead to children becoming overweight show the importance of using such opportunities to develop healthy behaviours. It will be important to equip grandparents with the right tools to support healthy eating.

In adolescence, most people think that peer relationships are dominant. However, researchers from Oxford University found that grandparents remain a strong and important influence on England's teenagers. More than half of all adolescents described at least one of their grandparents as important in their life. More than a third reported that one of their grandparents was the most important person in their life after their parents or siblings. Nearly all young people reported regular contact with at least one grandparent. Surprisingly, contact was often initiated by the children themselves, for example visiting grandparents on the

way home from school. Teenagers valued the opportunity to seek advice from grandparents and confide in them about problems. Grandparents provided emotional support and advice at times of difficulty. One in four teenagers said that they talked to their grandparents about problems they could not discuss with their parents. Many sought advice about future careers and other major life decisions. Nearly eight out of ten adolescents reported that they usually respected what their closest grandparent said.

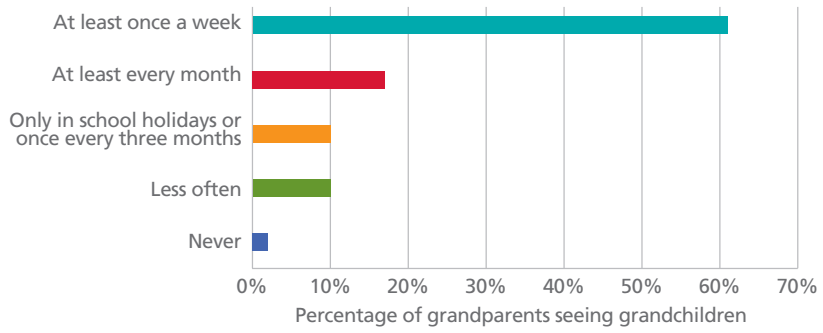
The research found that a strong grandchild–grandparent relationship was beneficial. Adolescents reported better emotional health and were better adjusted socially if their closest grandparent was involved in their life. This was particularly true for adolescents with either a single parent or separated parents. Talking about problems during an emotionally difficult period helps individuals deal better with problems. For teenagers, not being able to talk to and confide in somebody can cause emotional and behavioural problems, such as illicit drug use, unsafe sex or heavy alcohol consumption. It appears that a close relationship with a grandparent helps teenagers deal with problems and may reduce the impact of high-risk health behaviours.

This may be particularly important when parents are splitting up. Parents are often important in promoting and validating links with grandparents, but those links may be lost when parents separate. At present, grandparents enjoy no special privilege or consideration, and are easily forgotten in agreements about children made during divorce proceedings. Grandparents and grandchildren see it as their 'right' to have a relationship, and this relationship can provide an emotional buffer for children during this difficult time.

The importance of this relationship is often overlooked by outsiders. Many studies in a variety of countries have shown that the grandchild–grandparent relationship remains important during adolescence. More needs to be understood about this relationship. What do grandchildren choose to confide to their grandparents? How and when can grandparents influence their grandchildren? What is the impact of grandparents on specific health behaviours?

The relationship between adolescent grandchildren and their grandparents is often two-way. Grandchildren provide grandparents with help and support, for example with shopping or gardening, that continue throughout the grandparent's life. Often this is not prompted by parents. The relevance of grandparents varies from family to family, with different cultures placing a different emphasis on the relationship. Levels of respect are particularly high amongst Pakistani and

Figure 4: The frequency of contact between grandparents and grandchildren



Source: Office for National Statistics

Chinese families, and lowest amongst white families. Judaism also places great importance on wider family networks, including grandparents. Families of Asian origin are much more likely to have grandparents living at home. Society risks undervaluing grandparents.

Grandparents and health

Childhood is a vital time for health. Personality develops, together with many attitudes and behaviours that persist through life. Eating and exercise habits are established. Older children may start experimenting with illicit drugs, alcohol or tobacco. Consumption patterns established in these early years have a huge impact on long-term patterns of use, and on longer-term health. In my 2007 Annual Report, I focused on many of the problems that affect teenagers. The teenage years are a period in which experimentation and risk-taking are part of the rite of passage into adult life. This can pose a threat to health in the short term, but there is also the concern that behaviours, once established, may persist and into adult life and become a hazard to long-term health. Children also begin to learn about their emotions and how to form relationships, which is important for their long-term psychological well-being. For some children, for example those with chronic illnesses such as diabetes, childhood can be particularly difficult.

Grandparents are already an important influence on children. This may be as a source of advice and influence on parents. It can be through taking care of children, thereby supporting parents. It may be by taking children for regular exercise, or teaching children to cook. It can even be by simply setting a good example about taking medications regularly or seeing a doctor or dentist when there are problems. Importantly, many grandparents are able to offer a loving, sympathetic and supportive ear at times of emotional difficulty during the teenage years. These examples show how grandparents can improve the health of grandchildren. However, the huge potential of grandparents is largely untapped. The importance of grandparents needs to be recognised and there is also a need to understand more about their relationship with grandchildren, and to develop tools to help grandparents improve the health of their grandchildren.

Numerous policy documents, initiatives and projects emphasise the role of parents, teachers and peers in building a healthy childhood and sustaining healthy behaviour into adult life. Few, if any, see a role for grandparents. Parents, teachers and the media are considered the main health educators of children. Interventions to improve children's health are specifically designed for parents and teachers. Some of these interventions might be suitable for grandparents, while others could be designed specifically for them.

When policy documents concerning children's health are developed, the role of grandparents should form part of the thinking. Developing the role of grandparents as educators and mentors of their grandchildren's health behaviour could add an important new dimension. It would build on a relationship that is mutually valued and non-confrontational and where real influence is exercised. At the moment, any focus on health within the relationship is a by-product of recreational activities. Exploring ways to equip grandparents with the tools, skills and knowledge to lay the foundation in childhood for a healthy future could provide a solution to a problem that has proved intractable.

Box 3: Grandparenting in numbers

- There are over 11 million grandparents in England.
- 1 in 14 grandparents are under the age of 50 years.
- Nearly 1 in 2 grandparents are under the age of 65 years.
- Almost 61% of grandparents see their grandchildren weekly.
- 7 out of 10 grandparents live within 10 miles of their grandchildren.
- The value of care provided by grandparents is £3.9 billion.
- Nearly 170,000 grandparents are assuming the primary carer role.
- 92% of grandparents find their grandchildren very rewarding.
- The average 10 year old has 3 grandparents living, compared with 1950 when they had 2.

Sources: Office for National Statistics, 2004; Age Concern, 2004; Grandparents Plus, 2009; Dench and Ogg, 2002; Murphy M, London School of Economics, 2010 (full references cited at the end of this Report)

Actions recommended

- The important contribution of grandparents to children's health and well-being should be recognised and valued.
- Research into how grandparents can improve children's health should be conducted.
- The census should routinely count the number of grandparents in the country.
- Evidence-based tools and advice should be produced for grandparents to promote the health of their grandchildren.
- Policy initiatives aimed at improving children's health should consider the potential role and impact of grandparents.
- The importance of the grandparent–grandchild relationship for a child's emotional well-being should be recognised when parents divorce.
- Grandparents who take on full caring responsibilities need to be supported in this role.
- Children should be encouraged to maintain their relationships with their grandparents and support them throughout life.


AMBULANCE
AMBULANCE

Climate change and health

Climate change and health are inextricably linked. Global health is fundamentally threatened by climate change. Conversely, there is an opportunity to actively improve health by taking steps that also help to slow climate change.

Key points

- Climate change is already harming health, robbing the world's people of an estimated 5.5 million healthy years of life every year.
- Climate change damages global health through a myriad of means. It fundamentally threatens the requirements for good health – food, shelter, clean water, clean air and civil order.
- The health impact of climate change is unjustly distributed. The impact is over 500 times greater in Africa than in England.
- A series of win-win actions can both slow climate change and substantially improve England's health now. These include walking and cycling for a greater proportion of journeys.
- As it has the greatest carbon footprint of any public sector organisation in Europe, the NHS has a responsibility to be a leader in reducing greenhouse gas emissions. It can enhance its efficiency and service whilst doing so.
- Climate change spells global health disaster. Action needs to be rapid and bold.

People speak of climate change affecting the planet. They speak of melting ice-caps, of rising sea levels, and of warmer summers. Climate change will damage the planet's inhabitants, not just the planet itself. We face an immense human cost.

The health impact of climate change is already here. It is growing, and it is unpredictable. The World Health Organization estimates that climate change is already responsible for the loss of 5.5 million years of healthy life annually. So, in health terms, climate change is not just some future threat: it is a present and worsening reality. It brings increasing temperatures, with a myriad of adverse health impacts. It also brings an increase in the climate's variability. The consequences are not easy to predict. The 2003 summer heat wave in western Europe was not foreseen; it caused 70,000 deaths. On current projections, these increased temperatures could be the norm by the middle of this century. Similarly, it was not predicted that Hurricane Katrina would cause such devastation in 2005. In 70 years' time, tropical cyclones, the most intense form of hurricane, are projected to be four times as common as they are now. In the 1990s, weather-related natural disasters caused 600,000 deaths worldwide (see **Table 1**). It is difficult to predict how many times this figure will multiply in the years to come.

Table 1: Extreme weather events already affect millions and kill many thousands worldwide. Further climate change will increase this substantially

1990s		
Extreme weather events	People affected	People killed
2,078	1,851 million	601,000

Source: World Health Organization

On a global scale, the increasing temperature threatens health in a number of ways. Infectious diseases are of particular concern. Global warming is opening up far greater swathes of the earth's surface to disease-carrying mosquitoes, which cannot survive in cooler climes. It is estimated that, by 2080, 300 million more people will be affected by malaria every year unless evasive action is taken. At the same time, 6 billion people around the world will be at risk of dengue fever.

Higher temperatures and more erratic rainfall will reduce the availability of clean water in poorer countries. This risks turning back the clock on recent advances in sanitation, and impeding future efforts. Dirty water carries diarrhoeal diseases such as cholera, which already kill 2.2 million people every year worldwide. Dirty water harbours trachoma, an infection that is a leading cause of avoidable blindness. Promising developments have been made to reduce the great suffering that these simple infections cause in the world, but climate change threatens to reverse such advances with ease.

Small changes in temperature significantly affect air quality. Heat causes levels of pollen and other allergens to rise, causing diseases such as asthma. Heat affects the concentration of ozone and other pollutants at the surface of the earth, and higher concentrations cause illness and death from respiratory and cardiovascular disease. A rise in temperature of one degree Celsius increases air pollution enough to cause an additional 20,000 deaths globally in a year.

Climate variability causes great problems, bringing both flooding and drought. Floods cause drownings and injuries. They allow water-borne infectious diseases to spread and also encourage insects and rodents. Floods can be very disruptive to

"Climate change is a health issue affecting billions of people, not just an environmental issue about polar bears and deforestation."

Professor Anthony Costello
Director, University College London Institute for Global Health

normal life by damaging the infrastructure, including healthcare services. They can also cause significant psychological and psychiatric problems for those whose lives are affected.

Threatening the fundamentals of human health

Climate determines human health at its most fundamental level. Clean water, clean air, adequate shelter, food and civil order are basic requirements for health. All of these are disrupted by climate change. The combination of heat and erratic rainfall brings drought. This is a disaster for crops, and therefore also for human nutrition. Malnutrition already causes 3.5 million deaths annually. Some people die from pure starvation; others die from simple infections, their bodies weakened by a lack of food. We risk millions more starving every year.

Climate change threatens to displace populations around the world, as people will be forced to leave flooded homes. Predicted sea rises will expose over 100 million more people to coastal flooding by 2080. Drought will also displace many. By 2090, if climate change is unchecked, extreme droughts are projected to occur twice as frequently as they do at present, and last six times as long. The total area of land in extreme drought will increase between 10- and 30-fold. Displacement causes conflict and disrupts normal living, including education and health services. The displaced often move to temporary living conditions that lack basic sanitation facilities. The perfect storm of food, water and energy shortages worldwide is likely to lead to unpredictable human migration on a scale that ultimately risks the most severe health hazard we know: civil disorder.

The health impact in England

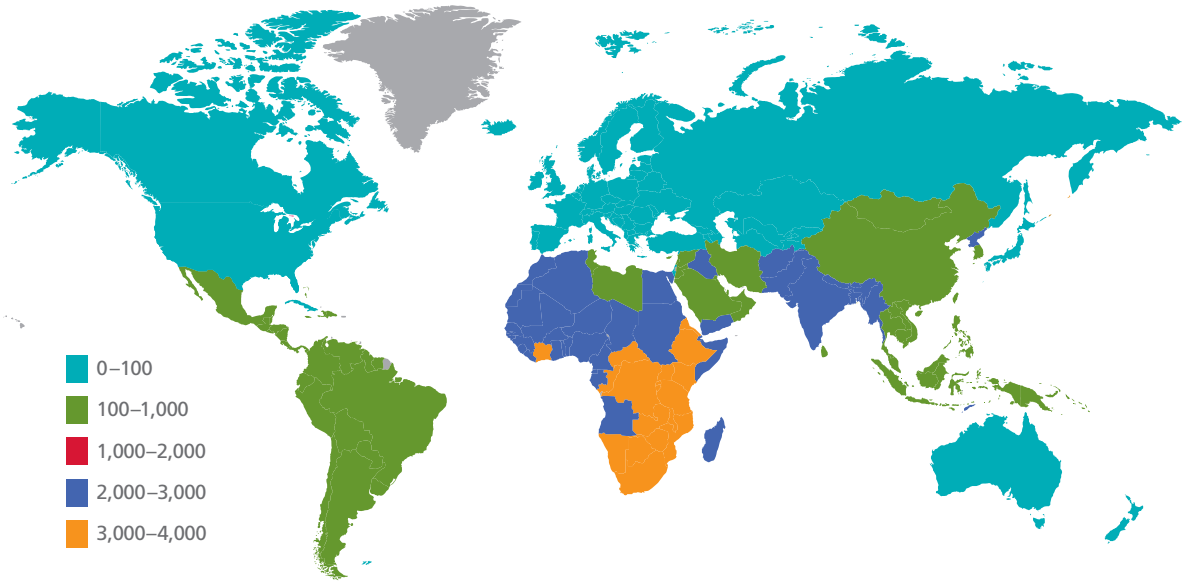
Climate change will affect England in similar ways to the rest of the world, although the magnitude of the impact will be less than elsewhere. The rising temperature will expose us to new infectious diseases. The population of England currently considers tick-borne encephalitis and other dangerous insect-borne diseases distant, even exotic. We risk coming to know them first-hand. Skin cancer, which already kills 1,900 people every year, will become more common. Extremes of climate, such as flooding and heat waves, will occur more frequently. The magnitude of the impact in England is as difficult to predict as it is globally. So far, the direct impact of climate change in England is small compared with other parts of the world.

England will suffer in other ways. Many predict that mass migration will occur because of climate change. People from areas that become inhospitable will need to migrate elsewhere. England is likely to share in the challenge of housing people within our borders. This is likely to strain essential public services, including the NHS.

The global health impact: an unjust distribution

Climate change is disproportionately affecting parts of the world that can least afford to be affected. We live in a world of great health inequality. A baby born in the United Kingdom has a life expectancy of 79 years. A baby born in Mozambique or Sierra Leone can expect to live for just 47 years. Climate change is threatening to

Figure 1: The health impact of climate change is over 500 times worse in southern Africa than in the United Kingdom



Years of healthy life lost due to climate change annually per million population (figures for 2000)

Source: World Health Organization

widen this gulf. This effect is here already: World Health Organization calculations for the year 2000 show that the adverse health impact of climate change was over 500 times greater for the countries of southern Africa than it was for much of the developed world (see **Figure 1**).

There is a great irony in this. The average person in many African countries is responsible for less than one-fortieth of the carbon dioxide emissions for which the average UK citizen is responsible. Those who are the least responsible for creating climate change are the most affected by it.

Taking responsibility for a global problem

The unjust distribution of climate change's impact presents a clear moral imperative. Few would think it right that the lifestyle of the world's richer countries should disrupt the planet so significantly that we severely damage the health of the world's poorest people. In 2007, I produced a draft strategy for consultation, *Health is Global*. This is now a definitive UK Government strategy. It recognises that we live in an interconnected and interdependent world. It is no longer realistic to consider one country's health in isolation. Infectious diseases do not respect international borders; displaced people need somewhere to go. The health damage caused by climate change is truly an issue for the whole world.

England has both a duty and an opportunity to lead. We were the first country to undergo industrial revolution and enter the high-carbon world. We consequently have one of the highest cumulative per capita records in the world. We are already a leading country in the transition to low carbon, being the first to enact legally binding carbon reduction targets.

Averting disaster whilst improving health

There are some substantial and fortuitous overlaps between actions that can help slow climate change and actions that would be desirable even without climate change, because they help to improve health (see **Table 2**). Where such synergies exist, making changes to the way in which we live offers an opportunity to simultaneously help slow climate change and positively improve our country's health in a sustainable way. Actions in two areas are particularly important: diet and exercise.

Worldwide, food production is responsible for at least 10% of greenhouse gas emissions. Meat farming is responsible for the substantial majority (80%) of these emissions. These come from deforestation and from the processes of slaughter and transport. They also come from the animals themselves. Cows, sheep and other ruminant animals produce significant amounts of methane, a potent greenhouse gas, as they digest their food.

Table 2: Win-win actions can both slow climate change and improve health now: some important policy choices

Action	Positive effect on climate change	Positive benefit for health
Less motorised transport use, more 'active transport' (walking, cycling).	Reduction in greenhouse gas emissions from vehicle production and fuel use.	More people achieving recommended exercise levels. Less obesity, heart disease and stroke. Greater mental well-being.
Less use of fossil fuels for energy generation.	Alternative energy sources generating fewer greenhouse gas emissions.	Alternative energy sources generating less air pollution, reducing illnesses and deaths from heart and lung disease.
Fewer animal products in the diet.	Reduction in the substantial greenhouse gas emissions produced by livestock farming.	Less saturated fat in the diet. Less obesity, heart disease and diabetes.
Improvements to household ventilation and insulation.	Enhanced energy efficiency.	Insulation reduces cold-related illness and death. Ventilation provides cleaner air, cutting respiratory diseases including lung cancer.

The agricultural industry can play an important role in meeting the emission reduction targets set by government. It can alter some of its production and transport processes and improve efficiency. We could also consider producing – and therefore eating – fewer animal products.

Reducing our consumption of animal products can also have a positive health impact. Meat, butter, cream and cheese can play a part in a healthy balanced diet. In excess they can cause health problems. Their high level of saturated fat finds its way into our diet in biscuits, cakes and pastries, as well as in meat. Some animal products can be highly calorific. They can contribute to obesity, diabetes and heart disease.

A recent study examined the health impact of reducing the United Kingdom's consumption of animal products by 30% by 2030. This reduction would cut greenhouse gases substantially. There would also be health benefits. It would reduce heart disease by 15% – a substantial reduction – and it would prevent 18,000 premature deaths every year. Taking both deaths and disease-related ill health into account, a 30% reduction in animal product consumption would save the equivalent of 175,000 healthy years of life every year.

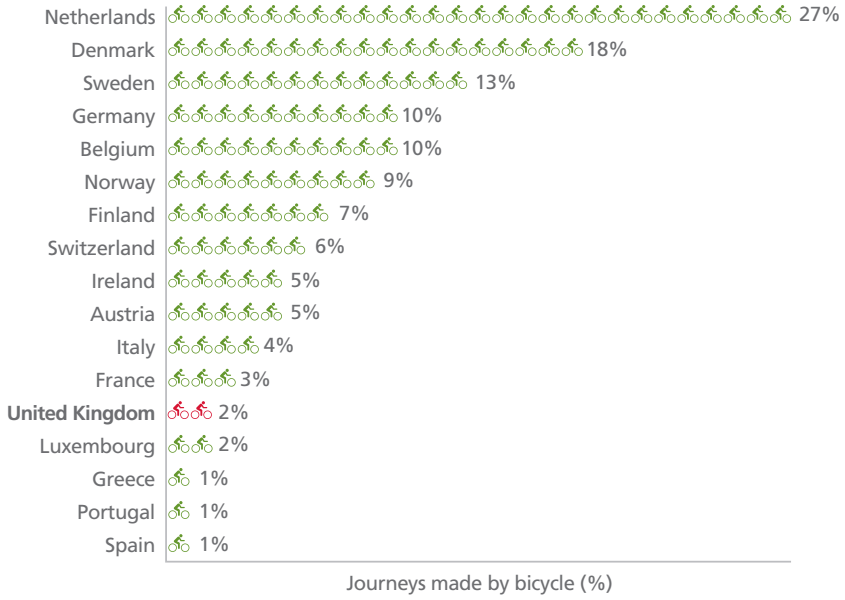
Our diet is warming the planet. It is also damaging our health. Changing our diet is difficult, but doing so would both help slow climate change and bring significant health benefits. These are contentious matters but they need to be openly debated and options weighed up.

The second area in which there is opportunity for a double benefit is transport, particularly in towns and cities. Road traffic is responsible for almost 20% of greenhouse gas emissions worldwide. Decreasing these emissions is key to slowing climate change. There need to be two major strands to this effort: motor vehicles need to produce fewer emissions, and we also need to use motor vehicles less. Both strands have important health benefits, particularly the latter.

Alternatives to driving increase physical activity. Our sedentary culture is causing major health problems. My 2002 Annual Report highlighted the dangers of the obesity 'time bomb'. I reported estimates that obesity reduces life expectancy by nine years, causes 9,000 premature deaths every year in England, and costs the economy at least £2.5 billion a year.

The time bomb continues to tick. One-quarter of the adult population is now obese and over half of the adult population is overweight or obese. Being overweight causes diabetes, heart disease, stroke, cancer, and psychological and social problems. Increasing physical activity is vital

Figure 2: Cycling is rare in the United Kingdom compared with many other countries in Europe



Source: European Conference of Ministers of Transport, 2004

to reducing obesity and these health risks. As highlighted in an earlier chapter of this report, regular physical activity offers the additional benefits of enhanced general well-being and a lower risk of depression and dementia.

Crises often compete for attention and their solutions often conflict with one another. This is not the case here. Currently, road transport contributes heavily to the climate change crisis, and low levels of physical activity have created a public health crisis. The two crises share a solution: a fundamental change to transport, especially urban transport, is needed in England. The United Kingdom has one of the lowest rates of cycling in Europe (see **Figure 2**). For a far larger proportion of journeys than is currently the case, cycling and walking need to be more feasible and appealing options than driving. Most streets in most cities in England are currently designed around cars. This situation cannot continue.

A number of European cities offer an alternative vision. In Amsterdam and Copenhagen, for example, many streets are designed with cyclists and pedestrians very much in mind (see **Box 1**). The people of these cities drive substantially less. They walk and cycle substantially more. Recently published work considers how London could look in 2030 if its transport patterns changed to mirror these cities. The findings are striking. Carbon dioxide emissions would be reduced by nearly 40%, making a substantial contribution to tackling climate change. The health benefits would be impressive: there would be significant reductions in heart disease, stroke, diabetes, depression and dementia. In London alone, over 55,000 healthy years of life could be saved every year. Travel by bicycle or on foot needs to become the safe, viable, attractive option for a far greater proportion of journeys.

Altering lifestyle habits is difficult, but the rewards for taking these steps are clear and significant. Lifestyle changes can make a substantial contribution to slowing climate change and can significantly reduce the disease and death that are associated with a sedentary lifestyle – a lifestyle to which the current absolute dominance of motorised transport contributes.

A number of other interventions can simultaneously tackle climate change and improve health. Switching to low-carbon electricity generation can help reduce air pollution. This can reduce the number of adults who die or suffer from lung diseases, including cancer, and the number of children who suffer from asthma. Improvements in household insulation and heating mechanisms, if properly designed, can improve energy efficiency and hence reduce emissions. Such improvements can also reduce the number of deaths from winter cold and improve indoor air quality.

All of these synergies are fortuitous and interesting. More than that, they have a very practical value. England needs to take many steps to play its part in slowing climate change. Many of these steps cost money and require difficult choices and changes. The existence of simultaneous

Box 1: Cycling reduces carbon emissions and improves health. Roads need to be designed to make it appealing and safe

Amsterdam: Wide, segregated cycle lanes are common

London: Cyclists usually share the road with other traffic

health benefits offers an additional motivator. These benefits offer a valuable means to help justify the costs and to offset them. Delaying action to avert dangerous climate change will make the ultimate solution more difficult, more expensive, and less likely to succeed. It is vital to seize these current opportunities now.

The role of the National Health Service

The NHS is responsible for more greenhouse gas emissions than any other public sector organisation in Europe. NHS organisations – hospitals, general practices and ambulance services – produce many emissions directly. NHS suppliers release even more emissions, in manufacturing and transporting the equipment and supplies that the NHS uses (see **Figure 3**).

The NHS makes an extremely significant contribution to road travel in this country. It has 50,000 vehicles on the road. Its vehicles ferry patients to appointments. Its doctors travel between hospital sites. Its suppliers deliver goods. People drive to see their general practitioner, to their hospital clinics, and to visit their family and friends in hospital. In total, one in every 20 road journeys in the UK is related to the NHS.

It is vital that the NHS makes substantial emissions cuts. The NHS is so large that such cuts can play a significant part in reducing emissions for the country as a whole. Importantly, the NHS can also be a role model. A number of actions that can help the NHS address climate change have additional benefits that will help it become a modern, safe, affordable and high-quality organisation. Again, these overlaps are fortuitous. Actions include more coordinated care closer to home, better use of specialist care, better use of information and communications technology, and less travelling by staff and patients. My 2004 Annual Report highlighted the public sector's food purchasing power, and the potential to enhance health through this. Serving healthier, seasonal food in hospitals could also reduce the greenhouse gas emissions associated with the transport of non-seasonal foods and the production of animal products. If the NHS can grasp these opportunities, it can enhance its performance whilst also becoming a leading public sector exemplar in the transition to a low-carbon economy.

Figure 3: More than half of emissions associated with the NHS are created in the production and transport of its supplies

Source: NHS Sustainable Development Unit, 2009

The NHS needs to be brave. The necessary reductions will not be made by tinkering. Questions about where and how health services are delivered need to be re-examined in a fundamental way. Communications technology could allow many more consultations to occur remotely, diminishing the need for travel. Disposable equipment is now the norm; this has an infection control benefit but an environmental cost. Novel solutions need to be sought. In some cases, risks and benefits will need to be re-weighed, but there are many implementable solutions that have dual benefits. Energy efficiency savings can cut financial costs as well as emissions, and the money saved can be invested elsewhere in the health service. Remote consultations can also be much more convenient and waste less time and energy. Reducing travel can make roads and communities safer as well as decreasing air pollution. Healthier, seasonal food in hospitals can benefit regional economies as well as being more nutritious and tastier for patients. More personalised knowledge online can promote better self-care and support carers in the community. There are hundreds of fortuitous synergies. Each one needs to be grasped.

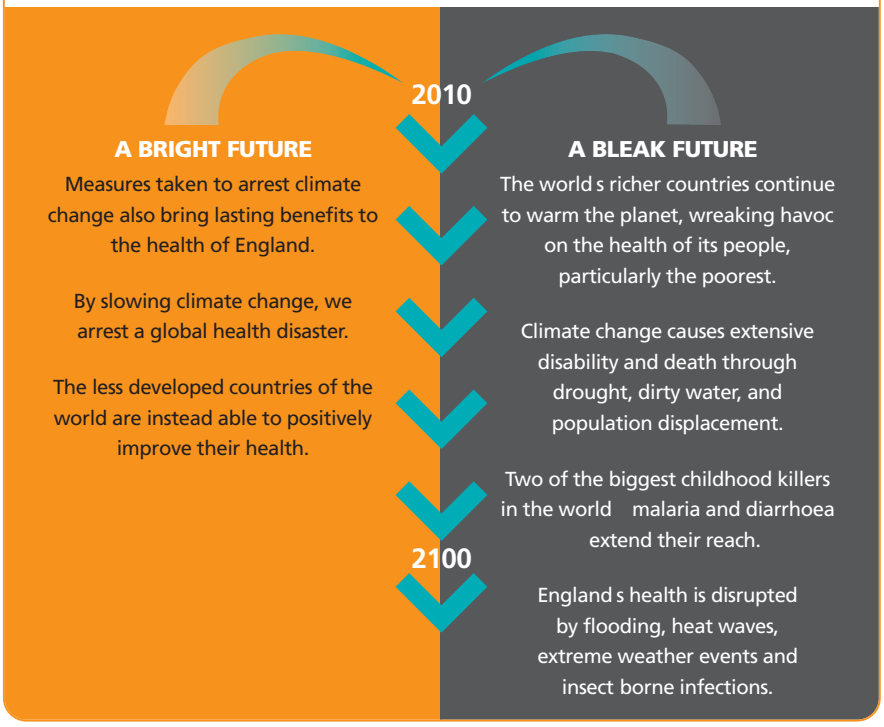
The NHS Sustainable Development Unit is leading this important work, but all organisations in the NHS need to recognise the enormity of the issue. They also need to recognise the considerable opportunity that they can benefit from – now and in the future – if they take action. The NHS deals well with emergencies that present an immediate threat to human life. It must prove itself equally capable of dealing with climate change – a slow-burning yet immense threat to human health.

Choosing the future

Climate change is a public health emergency on a global scale. A problem that is everybody's is too easily treated as a problem that is nobody's. Instead, the threat of dangerous climate change should stimulate us to address multiple challenges to our health. It should make us focus on exploiting the opportunities for synergistic benefits. The population of England needs to make substantial changes to its collective lifestyle. Many of these changes will not only help avert damage to the earth and to human health worldwide, they will also actively improve our own population's health.

We are faced with a choice between two very different futures: one is bleak; one is bright (see **Box 2**). In one we fail to meet the challenge. We substantially damage the health of the world's people, particularly the poorest. In the other, we are bold. We take the necessary major steps. Not only do we arrest this global health disaster, we also make significant improvements to England's health in the process.

Box 2: Through our actions now, we are choosing between two very different futures



Actions recommended

- The synergies between improving health and slowing climate change should be championed by the Government and health leaders to drive bold lifestyle changes.
- National targets should be set to double travel on foot in England's towns and cities, and to increase travel by bicycle eight-fold; transport policy and road design should support the achievement of such gains.
- The health impacts of climate change should feature prominently in undergraduate and postgraduate health professional education curricula.
- The NHS in England should make its facilities readily accessible by public transport, and should make services increasingly available remotely, using modern technology, to reduce travel.
- The NHS in England should use its buying power and other means to drive rapid transition to a low-carbon economy; the aim should be to reduce its carbon footprint by 10% from its 2007 level by 2015.

The Regions


North East
North West
Yorkshire and the Humber
East Midlands
West Midlands
East of England
London
South East
South West

NORTH EAST

A good death for every citizen

In 2007, the North East consulted on a regional public health strategy, *Better Health, Fairer Health*. The consultation confirmed support for one interesting theme: the right to a good death. Whilst there was already work taking place on palliative care, little was being done on the culture and attitude towards death – specifically death as a public health issue.

The North East has now developed the United Kingdom's first charter for 'a good death'. The charter will guide planning and provision for a wide range of services, including health and social care, to support end of life care.

The process for developing this regional charter has stressed the need to 'normalise' death, to tailor services and support around people's wishes, and to build capacity and understanding amongst individuals, communities and organisations in order to create a compassionate approach to the end of life. The charter is about living with dying and ensuring that people have the opportunity to fulfil their potential in whatever time they have left.

NHS North East has worked with around 70 partners from a range of health, social care, voluntary and community organisations, as well as patients and carers, to produce the charter, which sets out rights and entitlements for people who are dying, their families and carers.

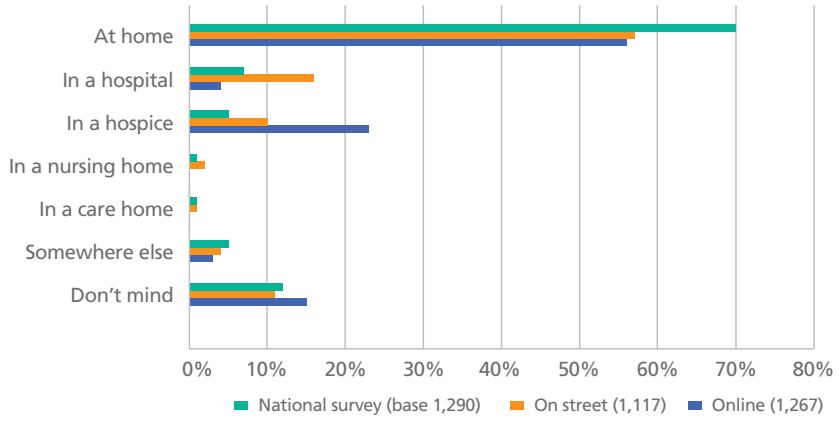
A three-month consultation was held from October to December 2009. Over 2,500 people in the North East shared their views and opinions on the charter and the wider subject of death and dying. The consultation included raising awareness amongst NHS staff, patient representatives, social care providers, employers, carers' organisations and community groups. Consultation and communications activity featured a dedicated website with an online questionnaire, on-street research, focus groups, telephone interviews, YouTube postings, media coverage and photo opportunities.

Feedback from the consultation will shape the final content of the charter and ensure that it is responsive to public views. It will help NHS North East and partners to plan and deliver end of life care. Early findings confirm that the majority of people (57%) would like to die at home. Of those, over one-third (38%) would prefer to do so even if they did not have sufficient support from family, friends or social and medical professionals.

Plans are under way to pilot implementation of the charter in part of the region and to evaluate the pilot. The plans include establishing a unit to work with the new professor in end of life care at Teesside University through March 2011, to raise community and social awareness of death, dying and bereavement, and to build capacity for NHS and social care staff across a range of settings.

The lessons from the pilot will be crucial in ensuring that the charter approach is embedded and implemented throughout the North East. This will help to build a society where death is accepted as a normal part of life, where individuals recognise their responsibility to be compassionate to those who are dying and to their loved ones, and where the policies and practice of all organisations are sympathetic to the needs of dying people.

Figure 1: Survey results showing where respondents felt would be the best place to die, 2008/09



Source: National figures from a survey by the National Council for Palliative Care, 2009; on-street and online survey from the North East consultation, October–December 2009

NORTH WEST

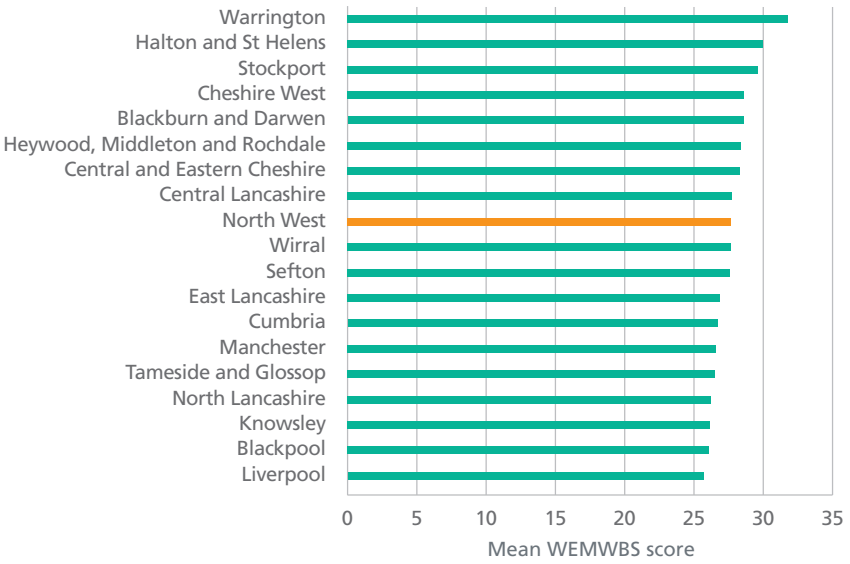
A better understanding of mental well-being

There is increasing evidence that positive mental well-being leads to a more flourishing and fulfilling life at home, school, work and in the community. There are two main elements of mental well-being: feeling good and functioning well. This does not require individuals to feel good all the time: the experience of painful emotions and the ability to manage them are essential for long-term well-being. The Government Office for Science's Foresight report found that action to improve mental well-being could have high economic and social returns.

The North West Regional Wellbeing Survey was undertaken in 2009 to establish a meaningful baseline for mental health and well-being. A total of 18,500 face-to-face interviews were conducted in 19 primary care trust areas. Interviewers used a questionnaire that incorporated the Warwick-Edinburgh Mental Well-being Scale (WEMWBS), which focuses on positive aspects of mental health. Additional questions sought to measure a wide range of determinants of mental well-being, for example feelings, relationships, health, life events and lifestyle.

The survey found stark differences in mental well-being across the North West (see **Figure 1**). Those who were aged 40–54 years, white and living in disadvantaged circumstances have much lower levels of well-being. It found that 20.4% of the population have relatively high levels of mental well-being, and these were observed to have strong associations with work, education, relationships, health, managing on an income, life satisfaction and lifestyle. Within local areas, the proportion of people with relatively high well-being ranged from 60.2% to 5.7%, and the proportion of people with relatively low well-being ranged from 30.3% to 5.0%.

Figure 1: Levels of well-being varied throughout the region

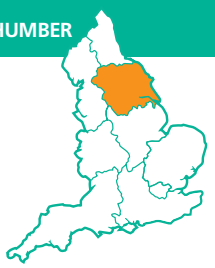


Source: Deacon L, Carlin H, Spalding J et al. *North West Mental Wellbeing Survey 2009: Summary*. Liverpool: North West Public Health Observatory; 2009

Improving an individual's positive sense of self and their ability to change is essential in getting them to adopt healthy behaviours. Programmes aiming to tackle health-damaging behaviours cannot be delivered in isolation from improving well-being, therefore action to promote well-being must be used alongside other behaviour change programmes. Likewise, physical health and mental well-being should be addressed jointly in prevention and care pathways. Other significant findings of the survey included the importance of supporting people's ability to build and manage relationships, and of people being part of a local community and influencing decisions.

Whilst Liverpool has the lowest mean score, the city is geared up to tackling this issue through its recently launched public mental health strategy and the designation of 2010 as the Year of Health and Well-being (www.2010healthandwellbeing.org.uk). This is a high-profile, multi-agency campaign to engage partners and people in doing more to improve their health and well-being, driven by city leaders and health and well-being ambassadors. Individuals, groups and organisations are being asked to pledge to take action to improve their health and well-being, in particular through the five 'ways to well-being': to connect with others; to be active; to give; to take notice; and to keep learning. Events and activities are planned throughout the year to support people with their pledges.

YORKSHIRE & THE HUMBER



The challenge of financial inclusion

The link between inequalities in income and inequalities in health was recently highlighted by Sir Michael Marmot's Health Inequalities Strategic Review Team and in books such as Richard Wilkinson and Kate Pickett's *The Spirit Level*, which captured the attention of many media commentators and social policy researchers in 2009.

In England, the life expectancy gap between those living in areas with the top 5% and bottom 5% of income is around seven years, and the difference in disability-free life expectancy is around 17 years.

Across Yorkshire and the Humber, partners in local authorities, the voluntary sector, primary care trusts and central government are working hard to promote financial inclusion and to eliminate the 'poverty premium' that sees people on low incomes pay more for essential goods and services. The City of Leeds has been carrying out a number of actions to address this, including investing in credit unions so that people have an affordable alternative to doorstep lenders, and setting up cross-organisation collaboration to make sure that there is easy access to debt advice, benefits and welfare rights services.

Economically, this makes sense. Leeds City Council commissioned the University of Salford to carry out an evaluation of its financial inclusion activities. This showed that:

- over 50,000 people were helped to take greater control of their lives
- the activities put more money directly into people's pockets – £26 million of additional disposable income
- every £1 spent by beneficiaries generated an extra 25p in the regional economy
- every £1 invested in financial inclusion generated £8.40 for the regional economy.

Where people were helped directly to increase their incomes, they spent the extra money mainly on food, paying bills, their children and saving. As well as feeling better off, a substantial number of people also reported that their health improved: they made fewer visits to the doctor and needed fewer prescriptions.

Whilst there is a rich tradition of work to raise income and reduce debt, this is an area that is often characterised by a patchwork approach to services and support. The challenge is to make the approach more systematic.

This costs money. It requires substantial investment up front and over time, but the work in Leeds is providing strong evidence of the scale of the potential returns on this kind of investment.

Doing nothing costs money too. In 2004/05, Leeds received £8.4 million to invest in regeneration through the Neighbourhood Renewal Fund. Whilst this funding was going into communities, between £3 million and £9.5 million was leaching straight out in 'excess' interest paid by residents in those very communities.

With support from the Department of Health and the Department for Work and Pensions, Leeds City Council is leading work to promote the case for investment in financial advice and support, and is developing a framework of principles to guide service commissioners.

EAST MIDLANDS

Protecting children from smoke in the home

Since the successful implementation of current smoke-free legislation in 2007, exposure to second-hand smoke has been reduced in all public areas and workplaces. Current legislation does not offer protection to the families of smokers in private dwellings and vehicles.

Children exposed to second-hand smoke are at an increased risk of developing asthma, chest infections, glue ear and meningitis. They are also at an increased risk of hospital admission within one year of birth and of sudden infant death syndrome. And they are around three times more likely to become smokers themselves.

In the East Midlands, it is estimated that just over 200,000 children under 16 years (25%) live in households where smoking is allowed. To reduce this number, individual primary care trusts have established 'Smoke-free Homes' schemes in all eight tobacco control alliance areas: Nottingham City, Nottinghamshire, Derby City, Derbyshire, Leicester City, Leicestershire, Northamptonshire and Lincolnshire.

These schemes are in various stages of development, but in all the aim is to encourage residents to make a commitment either to have a smoke-free house at all times or to restrict smoking in the house, especially if children live there.

Families can refer themselves directly to the scheme in response to advertising campaigns, or they can be referred by agencies such as the fire service or the NHS, or by health visitors or schools (see **Figure 1**).

The widest-reaching scheme in the East Midlands is in Lincolnshire and is managed and coordinated by the Smoke-free Lincolnshire Alliance. Started in 2004, with funding from local and regional partners, the Lincolnshire scheme has grown dramatically, with over 13,000 homes signed up. As of December 2009, 14,000 children (slightly more than 10%) in Lincolnshire who are aged 0 to 16 years are protected from the effects of second-hand smoke in the home.

Figure 1: Origin of referrals to the Lincolnshire scheme, May 2004 to December 2009

Referral origin	Number
PHOENIX (the local NHS Stop Smoking Service, including the pregnancy stop smoking service)	3,975
Smoke-free Homes – direct referrals	5,816
Children's centres	1,377
NHS	721
Events	609
Schools	173
Unknown	140
Other	452

Source: Smoke-free Lincolnshire Alliance

The Lincolnshire scheme focuses on targeting the areas of highest deprivation. Smoke-free Homes referrals are plotted on maps to monitor whether the target areas are being reached.

The Smoke-free Homes scheme in Nottingham City is the subject of a University of Nottingham six-year research project (February 2009 to February 2015). The research aims to assess the effectiveness and cost-effectiveness of the use of nicotine replacement therapy (NRT) in helping parents make their homes smoke-free, thereby reducing their children's second-hand smoke exposure. It also aims to define the optimum model for implementing this intervention effectively within Nottingham City, and to test the intervention in a single-centre randomised controlled trial.

Heart attacks and ethnicity

The relationship between deprivation and coronary heart disease is well known. The same applies to particular patient groups, including those from minority ethnic backgrounds. South Asian and African-Caribbean groups have higher rates of conditions, such as diabetes, that are risk factors for premature heart disease.

Approximately 12% of the region's population of 5.4 million are from a minority ethnic community. The region has lower life expectancy than the national average and higher levels of mortality from coronary heart disease.

Hospital admissions for patients with heart attack, chest pain and cardiac arrest were examined for the period April 2008 to March 2009. Deprivation was calculated using the areas where patients lived and was aggregated to the relevant national Indices of Multiple Deprivation (IMD) quintiles. IMD quintiles categorise households into five groups, ranging from the most deprived to the most affluent neighbourhoods. Ethnicity data were derived from the hospital admission information. Because of the small numbers involved, ethnicity groupings were limited to White, South Asian, African-Caribbean and Other.

There was a total of 35,620 admissions due to heart attacks across the whole of the West Midlands; 62% were males, and 1,026 patients had died.

Heart attacks amongst the White British population peak at the age range of 60–69 years. Admissions for South Asian and African-Caribbean groups appear to occur at a younger age, at 50–59 years and 40–49 years respectively. Preliminary information on these patients suggests that older patients are far more likely to have other pre-existing conditions and illness compared with younger patients. This is common across all ethnic groups.

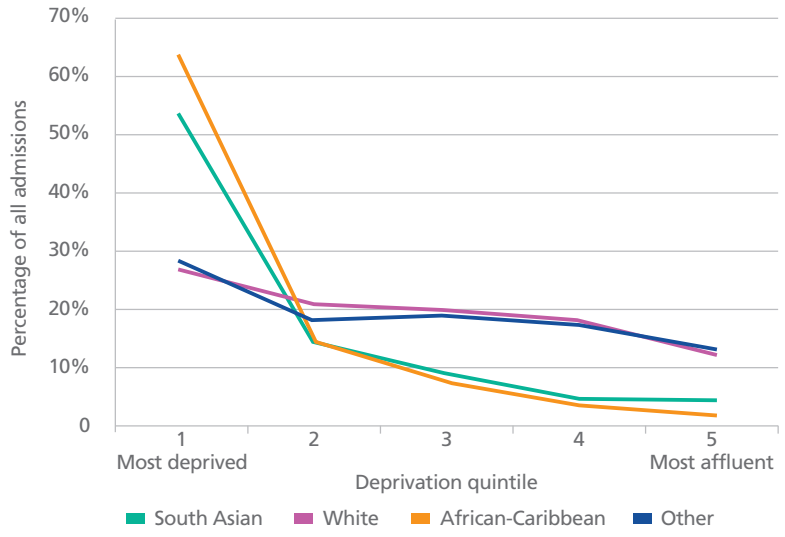
Whilst the distribution of admissions for the White population is relatively even across the deprivation quintiles, over half (53.3%) of South Asians and almost two-thirds (63.1%) of African-Caribbeans admitted following heart attacks are from the 20% most deprived communities (see **Figure 1**). This may in part be due to South Asian and African-Caribbean populations being generally less affluent. However, the finding does suggest that deprivation is the main reason for the differences in coronary heart disease between different ethnic groups.

Access rates for cardiac surgery are lower for patients from the most deprived communities. Levels of access for patients of South Asian and African-Caribbean origin are lower than those for White patients.

Further work needs to be undertaken to clarify:

- the differences within ethnic groups, particularly to establish the relative importance of deprivation, ethnicity, age and other pre-existing conditions
- how prevention and early identification of risk factors can be better targeted to address these differences, in particular in relation to diabetes mellitus, impaired glucose tolerance, hypertension and other cardiovascular risk factors
- the extent of the variation in differential access to treatment (rehabilitation and/or surgical intervention) with respect to deprivation and ethnicity.

Figure 1: Death and discharges for heart attacks and chest pain by deprivation and ethnicity



Source: Hospital Episode Statistics, West Midlands CBSA

EAST OF ENGLAND

Prioritising VTE prevention to save lives

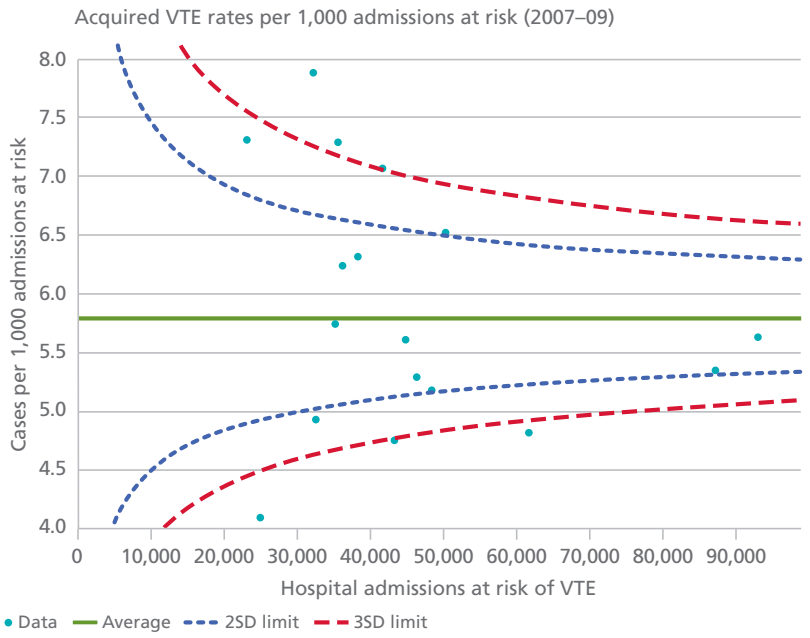
Venous thromboembolic disease (VTE), including pulmonary embolism and deep vein thrombosis, is thought to be responsible for up to 10% of all deaths in hospitalised patients. It could account for up to 2,500 deaths a year in the East of England. Many cases are not detected, so prevention is key to saving lives.

VTE prevention has been the subject of a Health Select Committee report, an independent report by a working group set up by the Chief Medical Officer, and a National Institute for Health and Clinical Excellence guideline. There are relatively cheap and effective preventive approaches using mechanical prophylaxis and anticoagulation, yet the Health Select Committee report suggested that around 40% of at-risk surgical patients and 60% of at-risk medical patients may not be receiving adequate preventive treatment.

To calculate the potential for preventing VTE, an extract of Hospital Episode Statistics data for 2007–09 was analysed and the Department of Health's risk assessment model applied. The headline results are set out below:

- There are 2,235 admissions for VTE each year in the East of England and 385,000 admissions of high-risk patients.
- On average, 5.8 (range: 4.2 to 7.8) per 1,000 of these at-risk patients are diagnosed with VTE in hospital or within eight weeks following admission. This is in line with recent epidemiological studies, but varies considerably by hospital (see **Figure 1**).
- Based on the Health Select Committee's estimates that 40% of at-risk patients receive appropriate prophylaxis and that prophylaxis reduces the risk in high-risk patients by half, VTE occurs in the East of England at a rate of 7.25 per 1,000 high-risk patients not receiving prophylaxis, and at 3.63 per 1,000 high-risk patients receiving prophylaxis.
- If the rate of prophylaxis were increased to 80% of high-risk patients, up to 560 VTEs would be prevented in this group each year.

Figure 1: Variation in acquired VTE rates in East of England NHS trusts



Source: Analysis of Hospital Episode Statistics, 2007–09

Systematic prevention of VTE is a key priority for the East of England Clinical Programme Board on Patient Safety. To reduce the number of hospital-associated VTEs in high-risk patients, the Board has set an ambitious programme of work to identify good practice. This includes the pilot of an innovative 'nurse led, doctor completes' scheme, in which the nurse assesses and initiates, and the doctor completes prophylaxis. After initial success at the pilot site, the scheme is being rolled out to other hospitals in the region.

Other approaches include developing training programmes for VTE champions across the region, and working with Patient Safety Champions from the National Patient Safety Agency to ensure patient and public involvement and the provision of good patient information. The inclusion of quality measures for VTE in financial contracts with primary care trusts will ensure a system-wide approach to the VTE project and will provide a further impetus to changes in practice.

Fire in hospitals: learning from experience

Whilst the utmost care is taken to ensure that NHS sites are safe and resilient, they are vulnerable to the same disruptive challenges that face any large and complex building. In 2008/09, there were a number of significant fires within NHS facilities in London, which required the evacuation of part or the whole of a building.

Moving large numbers of sick patients under pressure creates complicated and demanding problems. The need to balance the health, safety and well-being of the patients against the risk of the fire is delicate. In one of the events, two patients were undergoing complex surgery in theatre; they required rapid stabilisation, closure and removal, all in smoke-filled corridors.

Management of these events provided a substantial catalogue of experiences and lessons for NHS managers and emergency planners. For instance, two sites found that not all beds would fit through exits, whilst the need to track patients as they left the affected building for transfer to other facilities was found to be an area that would benefit from improvement.

The NHS London Head of Emergency Preparedness ensured that each of the events was thoroughly debriefed. The experiences were gathered within one report, *Review of five London hospital fires and their management*, providing an evidence-based platform to enhance all NHS preparedness. The five events included in the report occurred at very different healthcare facilities – a specialist cancer hospital, a major central London teaching hospital, a paediatric tertiary referral centre, a medium-secure mental health hospital and a large district general hospital.

An initial, unstructured interview with the key managers responsible for leading the response was conducted soon after each fire. A more structured data collection tool was developed and a subsequent semi-structured interview undertaken using a modified version of the Schultz benchmarking tool for hospital evacuation. The original Schultz tool was used to review the impact on healthcare facilities affected by the 1994 Northridge earthquake in California.

The report included an overview of each hospital and a description of the event, and outlined the issues of concern and the lessons identified. To provide an easy checklist for planners and managers, the 38 lessons were categorised under seven headings:

- Planning
- Command and control
- Communication
- Staff
- Media
- Post-event
- Training and exercising.

In October 2009, the final report was launched at the United Nations/World Health Organization International Day for Disaster Reduction event in London. It was also circulated to all NHS organisations in London and to English strategic health authorities, and placed on the NHS London and World Health Organization websites.

Many NHS London organisations have mapped the checklist against their current plans, and have updated those plans where deficiencies were identified. Other organisations have used the report to run internal exercises so that managers are more confident with the decision-making processes and procedures involved in an evacuation.

The report has provided an evidence base for both United Kingdom and international healthcare managers. It supports the Department of Health's development of evacuation and shelter guidance and the World Health Organization's safer hospitals strategy.

NHS London will incorporate the lessons identified into the 2010 round of emergency preparedness performance management. This annual assurance process reviews how NHS organisations' arrangements for responding to a variety of threats compare with national guidance. NHS organisations in London will be required to provide evidence that they have integrated the lessons from the review into their planning.

SOUTH EAST

Landmark decision to fluoridate Southampton's water

Water fluoridation has been used to reduce dental decay and improve dental health inequalities for many decades in many countries. Efficacy of water fluoridation is supported by recent systematic reviews of the scientific evidence and endorsed by responsible bodies. Assurance on safety comes from systematic reviews of clinical studies, toxicological reviews, and surveillance of the health of millions of people worldwide who drink fluoridated water.

The Water Act 2003 obliges water companies to adjust fluoride levels if requested to do so by strategic health authorities (SHAs) in England. The SHA must have consulted and ascertained local opinion beforehand. Poor and unequal dental health in Southampton children led the primary care trust to ask South Central Strategic Health Authority to consult on a suitable water fluoridation scheme after conducting independent reviews of feasibility and affordability.

This was the first proposal for a new water fluoridation scheme in the United Kingdom for 20 years and attracted worldwide attention, including from anti-fluoridation groups. An extensive public engagement programme was undertaken. SHA staff spent many hours at public events discussing the issues with residents. Widespread leaflet distribution was followed by three high-profile 'Question Time' events to allow informed public debate of the issues with experts. Coverage in the local press was extensive and mostly well balanced. The primary care trust actively supported the proposal.

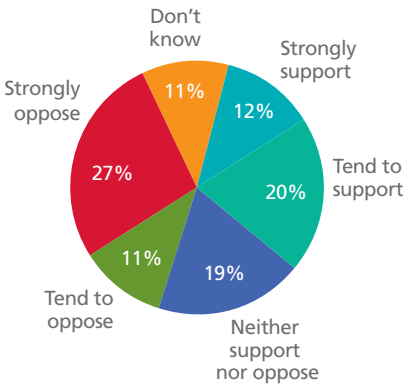
The consultation received over 10,200 responses, some of which were duplicates: 52% of respondents thought that fluoridation may help improve dental health, but 72% of responses were opposed to the proposal. Common arguments against fluoridation were that:

- it is a form of mass medication
- it is against human rights
- there is insufficient evidence regarding the effects
- there are potential adverse health effects and other impacts
- alternative methods are available.

An independent telephone survey of 2,000 randomly selected residents stratified by age, gender, work status and ethnicity showed a more balanced picture (see **Figure 1**), with no clear majority for or against.

Regulations require SHA boards to weigh all the arguments presented, having regard to the extent of support for the proposal and the cogency of the arguments advanced, and to decide whether the health arguments in favour of the proposal outweigh all arguments against it.
In February 2009, the strategic health authority board decided unanimously to request Southern Water to fluoridate the Southampton water supply.

Figure 1: Level of support for fluoridation in a random telephone sample of residents



Source: ICM survey commissioned by South Central Strategic Health Authority

Local reaction has been mixed. Many who opposed the scheme feel that their views were not taken into account. The SHA always made it clear that its decision would not be based on numbers of responses alone but on the cogency of the arguments given.

The Nuffield Council on Bioethics has emphasised the need for responsible authorities to be guided by the evidence of potential benefits and avoidance of harm. Its report on the ethical issues of public health stated: 'Stewardship is not exercised simply by following the public vote, especially where issues involve complex scientific evidence.' The report concluded that the assessment of technical evidence is not well suited to a public consultation. A recent report to the Department of Health also supports action by state authorities to protect the health of disadvantaged groups and children, even at the expense of individual choice, if necessary.

In June 2009, judicial review proceedings were issued against the strategic health authority in relation to its decision. The judge has given permission for the claimant (a resident of Southampton) to proceed with a challenge on the interpretation of government policy but has refused permission to proceed on the grounds of the consultation and decision-making process, stating that the process had been 'unimpeachable'.

Increasing active travel by schoolchildren

Active travel to school improves levels of physical activity and reduces carbon emissions. Active travel can help set good exercise habits in early years, and help combat the epidemic of childhood and adult obesity.

The South West is the largest and most rural region in England. It has the lowest percentage of people living in urban settlements of any English region (67%, compared with 82% for England as a whole). It has a relatively poor transport infrastructure. The region has some of the least accessible bus services in England, with 82% of people living within a 13-minute walk of an hourly service compared with 90% in England as a whole.

Levels of active travel to school depend on the distance children live from school, the transport options available, school/local authority travel planning, and a variety of socio-economic factors that may influence student and parental choice regarding travel modes.

The School Census collects a variety of information about each pupil attending school on 'census day', including how that pupil has travelled to school. Nine local authority areas in the South West region (Bristol, South Gloucestershire, Dorset, Poole, Bournemouth, Devon, Plymouth, Torbay and Somerset) commissioned the School Travel Health Check (www.viewfinder.infomapper.com/dorset/resources?id=951175). This innovative sustainable development initiative aims to provide robust data that will allow schools, planners and individuals to develop more sustainable school travel options.

The 2008/09 data show wide variations across participating local authorities, schools and types of school in levels of active transport. A considerable proportion of children (46%) attend a school other than their nearest. This varies slightly depending on the type of school. The highest levels are in Bournemouth, where 68% of pupils do not attend their nearest school, whilst the lowest levels (35%) are in Devon.

The percentage of pupils who live within walking distance of their school (defined as within 0.8 kilometres for primary schools and 2.0 kilometres for secondary schools and colleges) is 53%, ranging from 42% in Dorset to 64% in South Gloucestershire.

Overall, 16% of those who live within walking distance travel to school by car, depending on school type. There are 25 primary schools and one secondary school where more than 60% of pupils who live within walking distance currently travel to school by car. When pupils who live within walking distance of the school are in the minority, they are more likely to travel by car.

An analysis of travel to school by all pupils shows that 48% walk, 3% cycle, 26% travel by car or van, 3% share a car, 15% travel by bus, 1% travel by taxi and less than 1% travel by train. This varies by local authority and type of school.

Levels of walking to school are higher in Bristol and South Gloucestershire, and lower in Dorset. This is not completely explained by rurality, as areas such as Bournemouth and Poole (both urban areas) have comparatively low percentages of children who walk. Levels of walking also vary between school type, and they decrease as pupils move from primary school to secondary school and sixth form. The low level of walking at special schools is because of longer travel distances (only 5% of pupils live within walking distance) and is possibly also due to pupils' disabilities.

Active travel to school is an important source of physical activity for young people. It could be increased further. These statistics provide a useful baseline against which to measure progress, and should be used in conjunction with a qualitative assessment of local authority and school travel policies. The allocation of school places could also result in fewer active travel trips, as many areas have high numbers of pupils not attending their closest school, which is likely to mean fewer opportunities for active travel.

The South West region is planning for considerable population growth over the next two decades, and intends to build a large number of urban extensions. It is essential that these developments facilitate and encourage active travel.

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Leeds CITY COUNCIL

Originator: Steven Courtney
Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board: Scrutiny Board (Health)

Date: 25 June 2010

Subject: Kirkstall Joint Service Centre – Scrutiny Board Statement and initial response.

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

1.0 Purpose of Report

1.1 The purpose of this report is to provide the Scrutiny Board (Health) with details of the recommendations from the recent City and Regional Partnerships Scrutiny Board inquiry into the proposal for a new Joint Service Centre at Kirkstall and the associated response.

2.0 Background

2.2 This is attached to this report.

2.1 At the meeting of Scrutiny Board (City and Regional Partnerships) on 10 September 2009 reference was made to the fact that the proposal for a new Joint Service Centre at Kirkstall had stalled. The Board were advised that three Joint Service Centres at Chapeltown, Harehills and Kirkstall had been proposed via the Leeds Improvement Finance Trust (LIFT) in which the Council is a strategic partner with NHS Leeds (formerly Leeds Primary Care Trust) and they recognised that the provision of Joint Service Centres was an important strand of the Council's Strategic Plan contributing towards tackling the City's health and social inequalities agenda.

2.2 The Board, in conjunction with the Chair of the Health Scrutiny Board decided to investigate this matter, however it was agreed not to undertake a full scrutiny inquiry, but rather to investigate the matter and publish a Statement and recommendations on their findings.

3.0 Issues to consider

3.1 In line with the requirements of the Council's Constitution, the Scrutiny Board Statement and response to the identified recommendations is scheduled to be considered by the Executive Board at its meeting on 22 June 2010. As such, the Executive Board report (which includes a copy of the Scrutiny Board statement) is attached for information.

3.2 The outcome of the deliberations of Executive Board will be presented at the meeting of Scrutiny Board (Health).

3.3 In addition, at the Council meeting in May 2010, the former Scrutiny Board (City and Regional Partnerships) was not reconstituted. As such, given the background to attached Scrutiny Board statement, it seems appropriate that Scrutiny Board (Health) takes on the role of the former Scrutiny Board (City and Regional Partnerships) as it relates to the statement on Kirkstall Joint Service Centre.

4.0 Recommendations

4.1 Members are requested to:

4.1.1 Note the content of this report and associated appendices;
4.1.2 Take on the role of the former Scrutiny Board (City and Regional Partnerships) as it relates to the statement on Kirkstall Joint Service Centre; and,
4.1.3 Agree to formally monitor progress against the recommendations (as identified in the Scrutiny Board statement).

4.2 Members are also asked to identify any further and/or additional scrutiny activity that the Scrutiny Board (Health) may feel is warranted.

5.0 Background Papers

- The Council's Constitution

Agenda Item 14

Originator: James Rogers

Tel: 2243579

Report of the Assistant Chief Executive (Planning, Policy and Improvement)

Executive Board

Date: 22 June 2010

Subject: Final Statement and Recommendations of the City and Regional Partnerships Scrutiny Board's Statement on the Kirkstall Joint Service Centre

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

Eligible for Call In ☐ Not Eligible for Call In (Details contained in the report) ☐

EXECUTIVE SUMMARY

This report provides the Executive Board with details of the recommendations from the recent City and Regional Partnerships Scrutiny Board inquiry into the proposal for a new Joint Service Centre at Kirkstall and the reasons why it had stalled. The report outlines details of the statement and recommendations and asks the Board to approve the proposed response.

1.0 Purpose Of This Report

1.1 This report provides the Executive Board with details of the recommendations from the recent City and Regional Partnerships Scrutiny Board inquiry into the proposal for a new Joint Service Centre at Kirkstall and the reasons why it had stalled. The report outlines details of the statement and recommendations and asks the Board to approve the proposed response.

2.0 Background Information

2.1 At the meeting of Scrutiny Board (City and Regional Partnerships) on 10th September 2009 reference was made to the fact that the proposal for a new Joint Service Centre at Kirkstall had stalled. The Board were advised that three Joint Service Centres at Chapeltown, Harehills and Kirkstall had been proposed via the Leeds Improvement Finance Trust (LIFT) in which the Council is a strategic partner with NHS Leeds (formerly Leeds Primary Care Trust) and they recognised that the

provision of Joint Service Centres was an important strand of the Council's Strategic Plan contributing towards tackling the City's health and social inequalities agenda.

2.2 The Board, in conjunction with the Chair of the Health Scrutiny Board decided to investigate this matter, however they agreed not to undertake a full scrutiny inquiry, but rather to investigate the matter and publish a Statement and recommendations on their findings. This is attached to this report.

3.0 Main Issues

3.1 Below, each of the Scrutiny Board's five recommendations are listed along with the proposed response. In preparing the response, views have also been sought from the NHS Leeds.

3.2 Recommendation One:

That NHS Leeds be asked to review their governance process in line with the Department of Health Code of Practice 2003 in order to ensure that

(i) the public is advised of all matters to be considered at NHS Leeds Board meetings whether to be held in public or in private session and
(ii) that all appropriate reports are made available at the time the agenda is released.

NHS Leeds has reviewed and revised its processes to ensure that prior notice is given for all items to be discussed at its Board meetings. This recommendation has therefore already been implemented.

3.3 Recommendation Two:

That the "Lessons Learned" report on the Joint Service Centre project be endorsed including the recommendations for improvement as set out in appendix 1 of this Statement.

A Lessons Learned Workshop was held in February 2010 and attended by all key partners who are fully committed to implementing the recommendations made.

3.4 Recommendation Three:

That the Public Private Partnerships Unit and NHS Leeds and other stakeholders submit a joint report to this Scrutiny Board before 31st December 2010 on the progress in implementing the recommendations for improvement detailed in appendix 1 of this Statement.

This recommendation is supported and a report will be prepared.

3.5 Recommendation Four:

That this Statement be submitted to Scrutiny Board (Health) for information at its meeting in April 2010.

The Scrutiny Board (Health) meeting was cancelled in April, however it is now intended to include the statement on the June 2010 agenda.

3.6 Recommendation Five:

That NHS Leeds be asked to submit a paper to this Board and Kirkstall ward members on the improvements they intend to make to the existing Health centre before September 2010.

NHS Leeds is in the process of finalising its options appraisal for the refurbishment of the existing Kirkstall Health Centre. NHS Leeds will therefore be in a position to report back to the Scrutiny Committee before September 2010 with regard to the details of planned service improvements to that property.

4.0 Other Issues

4.1 Following the withdrawal of NHS Leeds from the Kirkstall scheme, the Council wrote to the Communities and Local Government Department (CLG) to ask for additional time to explore other options which would meet the criteria to access the remaining joint service centre PFI credits . The CLG responded by offering a final deadline of 30th June 2010. Regretably, it has not been possible to develop a scheme which would meet the criteria for accessing the remaining credits.

5.0 Implications For Council Policy And Governance

5.1 There are no specific implications for Council Policy and Governance.

6.0 Legal And Resource Implications

6.1 There are no specific legal or resource implications.

7.0 Conclusions

7.1 The City and Regional Partnerships Scrutiny Board's investigation into the issues why the proposals for the Kirkstall Joint Service Centre had stalled have identified some important learning for both the Council and the NHS. The recommendations it makes and the "lessons learned" seminar held jointly with PPPU, the PCT, LIFT Company, Council Officers and other Stakeholders has resulted in some clear actions to be taken. Subsequently NHS Leeds have advised that consideration would be given to improvements to the existing Health Centre at Kirkstall. Despite this latter activity by NHS Leeds, it has not been possible to arrive at a scheme which officers feel would meet the criteria for accessing the joint service centre credits.

8.0 Recommendations

8.1 Executive Board are recommended to:

Approve the proposed responses to the Scrutiny Board's recommendations.

Background Papers

Correspondence with NHS Leeds re Kirkstall JSC .

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Scrutiny Board (City & Regional Partnerships)

Statement on Kirkstall Joint Service Centre

April 2010

Introduction and Scope

Introduction

1. At our meeting on 10th September 2009 reference was made to the fact that the proposal for a new Joint Service Centre at Kirkstall had stalled.

2. We were advised that three Joint Service Centres at Chapeltown, Harehills and Kirkstall had been procured via the Leeds Improvement Finance Trust (LIFT) in which the Council is a strategic partner with NHS Leeds (formerly Leeds Primary Care Trust).

3. We recognised that the provision of Joint Service Centres was an important strand of the Council's Strategic Plan - contributing towards tackling the health and social inequalities prevalent in the city, through "narrowing the gap"

4. We agreed to raise this matter with the Chair of the Scrutiny Board (Health) to ascertain if this Board could undertake scrutiny of this issue if Scrutiny Board (Health) had no plans to do so.

5. We were subsequently advised that Scrutiny Board (Health) had no spare capacity to scrutinise this issue in detail during the current municipal year.

6. We decided to investigate this matter and determined not to undertake a full scrutiny inquiry but to investigate the matter and publish a Statement and recommendations on our findings.

7. We agreed to keep the Scrutiny Board (Health) informed of our findings.

Scope of the Statement

8. We agreed to examine the following areas:

- Progress made with regard to the provision of Joint Service Centres at Chapeltown, Harehills and Kirkstall.
- Identify the reasons for any delay in the provision of the three Joint Service Centres.
- Identify the process and rules that apply to the funding of these centres and the consequences of any delay.
- Role and responsibilities of the Council and NHS Leeds for delivery of this project.

Conclusions and Recommendations

9. We received a report from the Deputy Chief Executive of the Council on the Joint Service Centres which was considered by the Executive Board on 14th October 2009. This report ` described the progress and budget implications associated with the delivery of the Joint Service Centres at Chapeltown and Harehills.

10. It was clear from the report that the two Joint Service Centres at Chapeltown and Harehills were progressing well and that the current programme anticipated a completion date of the 18th October 2010 and 28th June 2010 respectively.

11. We noted with concern that the Deputy Chief Executive's report stated that further option appraisals were currently being undertaken by NHS Leeds, with regard to the proposed Kirkstall Joint Service Centre.

12. On 22nd October 2009 NHS Leeds submitted to the Scrutiny Board the following statement:

"NHS Leeds Board signed up to Kirkstall Joint Service Centre in April 2009. NHS Leeds is committed to delivering Children's and Adolescent Mental Health Services (CAMHS) from this centre. The council believe that this would not meet the criteria for PFI credits and have asked NHS Leeds to consider alternatives.

Some proposals have been produced but these require consideration for clinical suitability and service needs.

Following this, a paper will be presented to the NHS Leeds Board in November.

We will continue to work closely with council colleagues and, following the NHS Leeds Board meeting in November, will ensure that the Scrutiny Board (Health) and the City and Regional Partnerships Scrutiny Board are kept informed."

13. We received a briefing paper from NHS Leeds' Acting Director of Finance updating us on the reasons why NHS Leeds Board (at its meeting on 19th November 2009) was unlikely to continue to support a Joint Service Centre for Kirkstall.

14. The briefing paper stated that this joint project was proposed in 2003. Since that time there had been a number of major changes in the factors which would influence a decision as to whether NHS Leeds could continue to participate in this project not least being a PCT merger and the changing economic environment.

15. We noted that the NHS Leeds view that the service needs under pinning and the project had changed over the period. A recent review by NHS Leeds had concluded that there was no need for additional or significant improvements in premises for GPs in Kirkstall. In addition, plans for a wide ranging minor surgery services in the community had also been revised by the NHS Leeds.

16. We acknowledged that a review by NHS Leeds Provider Arm service in 2008/09 had identified that there was a need to improve the configuration of services for Child and Adolescent Mental Health Services (CAMHS) and that the lack of consolidated premises

Conclusions and Recommendations

for this service was a significant drawback in this respect.

17. The review also concluded that there was no other need for service development or expansions in any other services that the NHS Leeds provides in Kirkstall and that there was sufficient capacity within NHS Leeds to accommodate all foreseen service developments. As a consequence in July 2009 NHS Leeds approved a preferred option for the Joint Service Centre at Kirkstall whereby the CAMHS service would be relocated from the Cringlebar and Bramley sites into the new Joint Service Centre.

18. We were advised that the Council had subsequently informed NHS Leeds that it considered this would not meet the requirements for a Joint Service Centre, as the CAMHS service would require a separate entrance and users of the service would be unlikely to make use of the range of other services in the Joint Service Centre, such as advice, benefits and library services. The Council requested NHS Leeds to give further thought to their other options.

19. We were informed that NHS Leeds Board on 19th November 2009 had considered a report of the Acting Executive Director of Finance, NHS Leeds and had decided not to proceed with a Joint Service Centre for Kirkstall. We were provided with a copy of the report which had been considered by NHS Leeds Board.

20. We were concerned that the agenda for NHS Leeds Board on 19th November 2010 had no item indicating that this project was to be considered at this meeting. The matter was dealt with in private session without the public present and consequently there was no public discussion or debate on this issue. We regard this to be contrary to the 2003 Department of Health Code of Practice on Openness in the NHS.

Recommendation 1

That NHS Leeds be asked to review their governance process in line with the Department of Health Code of Practice 2003 in order to ensure that

(i) the public is advised of all matters to be considered at NHS Leeds Board meetings whether to be held in public or in private session and

(ii) that all appropriate reports are made available at the time the agenda is released.

20. We expressed grave concern that at the 11th hour there had been a change of heart on the part of NHS Leeds. The City Council had been working on this joint project in good faith with the PCT since 2003. Even as late as October 2008, NHS Leeds had been consulting widely with local residents on the proposal, raising peoples expectations and aspirations for the area. This last minute change of heart and policy was a bitter disappointment for local residents and Ward Members, who were hoping that this project would help to kick-start the re-generation of this part of Kirkstall,

Conclusions and Recommendations

21. We made reference to the level of resources the Council had effectively wasted in pursuing this joint proposal.

22. We were subsequently advised by the Public Private Partnerships Unit (PPPU) that the estimated cost of work carried out by them in respect of the Kirkstall Joint Service Centre was between £114,588 and £135,991 plus the cost of financial advisors and technical support . This estimate excluded any client costs from Environment and Neighbourhoods or Customer Services departments.

23. We requested a " lessons learned" report on this project as a consequence of NHS Leeds deciding to withdraw from this project.

24. We were informed that PPPU was to hold a "lessons learned" seminar on 4th February 2010[1] with the PCT, LIFT Company, Council Team and other Stakeholders in order to prepare a report for consideration by our Board.

25. We considered this "lessons learned" report at our Board meeting in March 2010 and believed it to be a comprehensive and thorough review of the issues involved. This report and the actions to be taken had been agreed with NHS Leeds and other stakeholders.

26. We took the view that implementation of the actions proposed would help to safeguard the Council's position and provide greater clarity as to the commitments and responsibilities of all stakeholders at the Pre Procurement and Procurement Stages for joint projects of this kind.

Recommendation 2

That the "Lessons Learned" report on the Joint Service Centre project be endorsed including the recommendations for improvement as set out in appendix 1 of this Statement.

Recommendation 3

That the Public Private Partnerships Unit and NHS Leeds and other stakeholders submit a joint report to this Scrutiny Board before 31st December 2010 on the progress in implementing the recommendations for improvement detailed in appendix 1 of this Statement.

Recommendation 4

That this Statement be submitted to Scrutiny Board (Health) for information at its meeting in April 2010.

27. We were advised by the Acting Director of Finance, NHS Leeds that consideration would be given to making improvements to the existing Health Centre in Kirkstall.

Recommendation 5

That NHS Leeds be asked to submit a paper to this Board and Kirkstall ward members on the improvements they intend to make to the existing Health centre before September 2010.

[1] *as part of the project appraisal undertaken on PPPU projects*

APPENDIX 1

KEY LESSONS LEARNT SUMMARY

What Could Have Been Improved and How?

Outlined below is a summary of the key lessons learnt.

Category	What Could Have Been Improved	Recommendation for Improvement
Affordability and Best Value	It was noted that often projects have funding streams attached which changes the focus from options appraisal and value for money to securing funding for projects. E.g. the incentives to retain PFI credits.	Options appraisals should clearly evaluate all procurement options available, including a do nothing option. As the PCT did not have PFI available to them for JSC, partners funding of revenue needs to be properly considered.
Affordability and Best Value	The PCT did not have a suitable tool for appraising service and funding priorities. Consequently they had difficulty assessing the value for money of the programme. Affordability should not be confused with Value for Money. Consequently when the Kirkstall scheme was reviewed in 2009 the previous justification for the PCT element of the project did not stand up to scrutiny. Differences in sources of funding (the Council were granted PFI credits) may have led to a divergence in prioritisation of the programme between the Council and PCT.	That a cost benefit analysis / options appraisal tool is developed jointly by the Council and PCT. Leeds City Council has an existing options appraisal methodology and the corporate project management methodology "Delivering Successful Change" may also provide a basis for developing this. A shared methodology should ensure a shared and consistent understanding of service needs and project benefits is developed at the outset of any future project developed in partnership. Affordability should not be confused with Value for Money.

Category	What Could Have Been Improved	Recommendation for Improvement
Guidance and Documentation	The Department for Health business case guidance changed during the procurement.	Guidance can be followed and changes can be taken account of relatively easily. However, it is not Government Guidance that is important; it is ensuring you have a business case that is robust and agreed within your service.
Leadership and Managing the Process	Project Management arrangements at the PCT were not properly embedded in governance processes. Consequently as corporate priorities changed and as major restructuring of the organisation was undertaken the links between the JSC programme and PCT strategy and management were not consistent or effective. It was therefore difficult to manage decision making and to ensure the project was progressed in line with PCT corporate priorities and managerial support.	That work is undertaken with partner organisations to ensure that a formal governance structure with clear roles and responsibilities is set up at the very beginning of the project including communication strategy and reporting processes.
	Communication of formal decisions between the PCT and LCC could have been improved.	As above.
	Stage 1 of the procurement was fast tracked through the Strategic Health Authority approval process, which resulted in disproportionate levels of work and decision making being deferred to stage 2.	Ensure that a realistic programme is agreed and planned in sufficient detail.
	The PCT lacked sufficient estates experience to inform the JSC programme.	That a shared review of available skills and experience is undertaken with partner organisations and experience is lacking in certain areas consideration is given to sharing resources and / or accessing external advice.

Category	What Could Have Been Improved	Recommendation for Improvement
Project Principles	The PCT did not have a sufficiently clear vision for the JSC programme with objectives set which aligned corporate and service strategies and that in the case of the Kirkstall centre they felt the emphasis for development was placed on the building rather than the services required.	That work is undertaken with partner organisations to ensure that a cost benefit analysis is produced to inform the options appraisal and Outline Business Case. The reason to go ahead with the project needs to be addressed at the start of the project and the questions: "is it right?" and "is it viable?" need to be addressed at the start. Also, "what do you need?" not "what do you want?".
Risk Management	None	N/A
Stakeholder Management and Communication	The timing of PCT stakeholder consultation could have been improved. Buy in from stakeholders in decision making positions was lacking, leading to decisions not being made at the right times. Stakeholder management with regards the Kirkstall highways issues could have been improved, although development of the ultimate workable solution was felt to have been successful.	That work is undertaken with partner organisations to ensure that a communications strategy is clearly developed.
Technical and Statutory Issues	None	N/A
Understanding the Market	None	N/A

What Went Well and Why?

Outlined below is a summary of the key lessons learnt.

Category	What Went Well	Recommendation
Affordability and Best Value	Of the 3 centres planned the 2 that were delivered were within the budget set. The service mix, however, changed significantly as a result of the changing requirements of LCC and the PCT.	Ensure that a cost benefit analysis is produced to inform the options appraisal and Outline Business Case. Affordability should not be confused with Value for Money.
Guidance and Documentation	None	N/A
Leadership and Managing the Process	Harehills and Chapeltown have been successfully delivered in the context of major organisational and service change.	Consider the lessons learned from Chapeltown and Harehills (subject of a separate report) for other projects / programmes.
	The project team worked well together (including the SHA and advisors), which was illustrated by the fact that Commercial and Financial Close was achieved in relative short timescales bearing in mind the additional scrutiny required of the PCT and SHA.	Spend time building the team. That work is undertaken with partner organisations to ensure that a formal governance structure with clear roles and responsibilities is set up at the very beginning of the project including communication strategy and reporting processes.
	The design competition for Kirkstall worked very well and delivered a well developed, flexible reference scheme in a short time period.	Consider different models to develop schemes on a project by project basis.
Project Principles	None	N/A

Category	What Went Well	Recommendation
Risk Management	The City Council risk management process that was adopted later in the programme by the Council, PCT and Liftco worked well.	Ensure that a robust risk management process is in place and followed.
Stakeholder Management and Communication	Stakeholder management was good with regards to who was consulted.	That work is undertaken with partner organisations to ensure that a communications strategy is clearly developed.
Technical and Statutory Issues	None	N/A
Understanding the Market	The JSC programme would not have been delivered without the involvement of Liftco. In a competitive process it is likely that bidders would have walked away due to the delay and uncertainty. Tranche 3 (Chapeltown and Harehills) was sustained because tranches 1 and 2 had given Liftco an ongoing delivery role working in partnership with the PCT and Council.	That the advantages of partnership working need to be taken account of / considered at the options appraisal stage. They also need to be communicated to stakeholders.
	Over the course of the project the Liftco process developed a challenge role that broke down barriers between organisations and encouraged dialogue.	

NEXT STEPS

	Action	Action Owner
1.	Present the Lessons Learned Report to the Joint Service Centres Project Board and the Strategic Partnering Board for information.	D Grooby
2.	Present the Lessons Learned Report to Scrutiny Board.	D Outram
3.	Feedback the Lessons Learned Report to the PCT.	V Pejhan-Sykes
4.	Present the Lessons Learned Report to the Public Private Partnerships Unit management team for information.	D Grooby
5.	Dissemination to the project team.	D Grooby
6.	Dissemination to PPPU Governance function who will then: • Be responsible for developing, maintaining and communicating a PPPU wide Lessons Learned Log and act as a central repository for valuable PPPU lessons learned information. • Share lessons learned with other Project Teams, Project Boards and the Strategic Investment Board.	D Grooby
7.	The Council and PCT to consider the joint development of a cost benefit analysis / options appraisal tool.	D Outram & V Pejhan-Sykes

Evidence

Monitoring arrangements

Standard arrangements for monitoring the outcome of the Board's recommendations will apply.

The decision-makers to whom the recommendations are addressed will be asked to submit a formal response to the recommendations, including an action plan and timetable, normally within two months.

Following this the Scrutiny Board will determine any further detailed monitoring, over and above the standard quarterly monitoring of all scrutiny recommendations.

Reports and Publications Submitted

- Report of the Deputy Chief Executive dated 14th October 2009
- Statement by NHS Leeds dated 22nd October 2009
- Briefing Paper by NHS Leeds for the Scrutiny Board on 5th November 2009
- Report of the Acting Director of Finance NHS Leeds to NHS Leeds Board on 19th November 2009
- Media Statement by NHS Leeds dated 19th November 2009
- Reports of the Head of Scrutiny and Member Development to meetings on 5th November and 9th December 2009 and 4th March and 16th April 2010

Evidence

Witnesses Heard

- Mr David Outram, Chief Officer, Public Private Partnerships Unit, Leeds City Council
- Ms Visseh Pejhan-Sykes, Acting Director of Finance, NHS Leeds
- Mr Andy Taylor, Chair of the Plan Review Board
- Mr David Grooby, Executive Project Manager PPPU

Dates of Scrutiny

10th September 2009

5th November 2009

9th December 2009

4th March 2010

16th April 2010

Scrutiny Board (City & Regional Partnerships) **Statement on Kirkstall Joint Service Centre**

Date April 2010
Report author: Richard Mills

www.scrutiny.unit@leeds.gov.uk

Leeds CITY COUNCIL

Originator: Steven Courtney
Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board: Scrutiny Board (Health)

Date: 25 June 2010

Subject: Determining the Work Programme 2010/11

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

1.0 Purpose of Report

1.1 The purpose of this report is to help the Scrutiny Board determine its priorities and work programme for 2010/11.

2.0 Introduction

2.1 Through a number of the previous agenda items, the Scrutiny Board has been provided with a range of information and inputs from key stakeholders that should help identify the Board's priorities and develop its work programme for 2009/10.

Health Scrutiny Protocol

2.2 In order to successfully deliver the Scrutiny Board's work programme, the relationship between the Board and the NHS bodies across the City is key. To help maintain this relationship it is essential that guidance exists to help provide a common understanding on how Health Scrutiny should operate locally and provide a framework for the scope and style of Scrutiny in the City. Such guidance will help to ensure that scrutiny remains a positive and challenging process for all parties concerned.

2.3 In this regard, shortly after the health scrutiny duty became a requirement, a protocol was developed and agreed by the appropriate Scrutiny Board in April 2003. In 2009, the Scrutiny Board (Health) agreed a revised protocol – reflecting a number of national and local developments. The protocol is attached at Appendix 1 for information.

2.4 While the fundamentals for health scrutiny currently remain unchanged, as part of its report on Renal Services in Leeds, the previous Scrutiny Board (Health)

recommended a review of the protocol to ensure it was fit for purpose. This review is currently being undertaken and will be reported to the Board in due course – seeking endorsement of any proposed changes.

Changes and/or development of local health services

2.5 Current legislation places a duty local NHS bodies to make arrangements to involve and consult patients and the public in planning service provision, the development of proposals for changes, and decisions about changes to the operation of services.

2.6 The requirement to consult on service changes and/or developments, includes a duty to consult the Scrutiny Board (Health) where the NHS body is considering any proposals relating to substantial changes and/or development of local health services.

2.7 In recent years, to help the Scrutiny Board maintain a focus on changes and/or developments of local health services, while maintaining the Board's capacity to undertaken detailed inquiries, the Scrutiny Board has established a Working Group to:

- Consider, at an early stage, proposals for service changes and/or developments of local health services, including:
  - Whether or not the relevant Trust's plans for patient and public engagement and involvement seem satisfactory[1]; and,
  - Whether the proposal is in the interests of the local health service.
- Consider the significance of any proposed service changes and/or developments, alongside the associated levels of patient and public engagement and involvement.
- Maintain on overview and on-going involvement in current service change proposals and associated patient and public engagement and involvement activity, including details of any stakeholder feedback and how this is being used to shape the proposals.
- Refer any matters of significant concern to the Scrutiny Board (Health) for detailed and specific consideration.

2.8 Within these arrangements it has always been recognised that the statutory duty to consider substantial changes and/ or development of local health services remains the direct responsibility of the Scrutiny Board (Health) and not the Working Group.

2.9 As such, and in line with practice from previous years, revised draft terms of reference for the Working Group is attached at Appendix 2 for the Board's consideration.

2.10 In previous years, categories used to identify the significance of any proposed service changes and/or developments have been summarized as follows:

- **Category 4** – substantial variation (e.g. introduction of a new service)
- **Category 3** – significant change (e.g. changing provider of existing services)
- **Category 2** – minor change (e.g. change of location within same hospital site)

[1] This early engagement with Scrutiny will help the Working Group to discuss and agree the proposed degree of variation, prior to the commencement of any patient and public engagement and involvement activity.

- **Category 1** – ongoing improvement (e.g. proposals to extend or reduce opening hours)

2.11 However, recent experience has shown that the terms used to describe category 4 and 3 service changes and/ or developments (i.e. substantial and significant) can sometimes be used interchangeably, leading to confusion and misunderstanding. As such, the proposed draft terms of reference have been amended to make a clear distinction and reclassifying category 4 service changes and/or developments as 'major'.

2.12 Subject to any identified and agreed amendments, the Board is asked to consider establishing a Working Group (with appropriate membership) in line with the attached draft terms of reference.

Work Programme

2.13 Having considered the range of written information presented at the meeting, and discussed relevant issues with those present, the Board is now asked to consider and identify matters to be included in its draft work programme.

2.14 A preliminary outline work programme is attached at Appendix 3, which identifies some issues suggested for inclusion in the Board's work programme, alongside a number of unscheduled issues predominately identified by the previous Scrutiny Board (Health). Members are asked to consider these issues when formulating matters to be included in its draft work programme.

2.15 In addition, Members are also asked to consider and determine how any specific proposed inquiry meets the criteria approved from time to time by the Scrutiny Advisor Group (Appendix 4).

3.0 Recommendations

3.1 Members are requested to:

3.1.1 Note the contents of this report, including the protocol between the Scrutiny Board (Health) and NHS bodies in Leeds (updated June 2009);

3.1.2 Establish a Health Service Developments Working Group (with appropriate membership) in line with the attached draft terms of reference (subject to any identified and agreed amendments);

3.1.3 Determine the Board's priorities and identify matters to be included in its draft work programme for 2010/11.

4.0 Background Papers

- Council's Constitution

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LEEDS
CITY COUNCIL

Scrutiny Board (Health)

Protocol between the Scrutiny Board (Health) and NHS Bodies in Leeds

Updated: June 2009

Purpose

The purpose of this protocol is to provide guidance and a common understanding on how Health Scrutiny will operate in Leeds and provide a framework for the scope and style of Scrutiny in the City. In so doing the aim for all parties is to help ensure that Scrutiny remains a positive and challenging process.

Background

The overview and scrutiny function was established through the Local Government Act 2000, which introduced new models of governance and decision-making arrangements for local authorities in England and Wales. In these arrangements, the overall role of the overview and scrutiny function is to hold the Executive Board to account for its decisions and to contribute to evidence-based policy development in the Council.

The Health and Social Care Act 2001 first introduced the concept of Local Authority scrutiny of health and required:

- NHS bodies to consult health local authorities about proposed substantial variations to or substantial developments of health services within their areas; and,
- those local authorities with social services responsibilities to establish an Overview and Scrutiny Committee to respond to consultations by local NHS bodies on proposed substantial variations to or developments of services.

Building on the powers to promote community well-being contained in the Local Government Act 2000, the Health and Social Care Act 2001 provides explicit powers for local authorities to scrutinise health services within their areas as part of their wider role in reducing health inequalities. Currently, the Health Scrutiny Board has been designated to act as Leeds City Council's Overview and Scrutiny Committee responsible for undertaking the health scrutiny role

To assist with the planning and development of effective overview and scrutiny of health and health services, the Department of Health published its guidance *'Overview and Scrutiny of Health – guidance'* in July 2003. This guidance is available from the Department of Health's website. It should be noted that the Department of Health is currently undertaking a review of its guidance to reflect identified good practice and developments and changes to the legislation.

Scrutiny Boards (general)

The overall role and function of scrutiny is to hold decision-makers to account and secure improvements in local practice for local people via a contribution to policy development and review. As such, Scrutiny Boards do not have decision-making powers.

Scrutiny Boards will comprise of Elected Members selected to represent the political balance of the local authority. These Members will be the only members of the Board with voting rights and will be selected to serve for a period of 12 months. The membership of the Board will seek to avoid conflicts of interest and where potential for this exists interests of those Members will be declared and subject to the Council's procedures on these matters[1].

[1] Leeds City Council Constitution - Scrutiny Board Procedure Rules Section 2

Scrutiny Boards may seek nominations from other representative groups to act as co-opted members of the Board. These nominations may be for the duration of a municipal year and/or on an inquiry by inquiry basis, as set out in the Scrutiny Board Procedure Rules, Leeds City Council Constitution.

Support arrangements

The Scrutiny Support Unit is the primary source of support for, and co-ordination of, the work of the Council's Scrutiny Boards. In summary, the role of the Scrutiny Support Unit is to:

- Provide a research and intelligence function to individual Scrutiny Boards (each of which has been allocated a different area of specialism)
- Manage programmes of Inquiries for each of the Scrutiny Boards
- Manage the presentation of witnesses, research and reports to Scrutiny Boards and/or carrying out research and reports "in house" as appropriate
- Assist Scrutiny Boards to prepare reports of their Inquiries and steering recommendations through the Council's decision making arrangements
- Lead the continuing development of the Overview and Scrutiny function

HEALTH SCRUTINY IN LEEDS

Overview

Scope

Health scrutiny in Leeds covers all aspects of health and health related services provided to the population of Leeds; this includes the planning, provision and operation of services[2] commissioned and provided by NHS bodies and the local authority in Leeds. The primary aims of the health scrutiny function are to identify whether:

- health services reflect the views and aspirations of local communities;
- all sections of local communities have equal access to services;
- all sections of local communities have an equal chance of a successful outcome from services; and,
- any proposals for substantial service changes are reasonable.

NHS Trusts

The Scrutiny Board will not manage the performance of NHS Trusts in the City, or provide another form of inspection. Such functions will be undertaken by other external bodies such as, the Commission for Quality Care, the Strategic Health Authority, the National Institute for Clinical Excellence and the Commission for Health Improvement. However, it should be recognised that performance data will often usefully inform Scrutiny inquiries and support the work of the Scrutiny Board in considering the delivery of the objectives of the Local Area Agreement (LAA).

Health Scrutiny will be distinctive in being undertaken by lay, elected representatives and focussed on improving health and well being across Leeds.

[2] This includes all internally and externally provided services that contribute to the overall health and well-being of the residents and working population of Leeds

Local Involvement Network

The Local Government and Public Involvement in Health Act 2007 gave a duty to all 150 local authorities in England with social services responsibilities, to enable the formation of a Local Involvement Network (LINk).

LINks will act as the successor to local Patient and Public Involvement Forums (PPIF) but with an extended remit covering social care, and have been established to give communities a stronger voice in how their health and social care services are delivered.

Regulations that established the health scrutiny function[3] state that Scrutiny Boards should take account of all relevant information available. Under provisions in the Local Government and Public Involvement in Health Act 2007, this now includes information identified and provided by the LINk. As such, the relationship between the LINk and the Council's Scrutiny Boards will be key.

An important power of the LINk is the ability to refer relevant matters to the appropriate Scrutiny Board[4]. In turn, this places responsibility on the appropriate Scrutiny Board to acknowledge any such referrals and keep the LINk informed about the progress of any agreed actions. The process for dealing with such referrals is set out in a separate guidance note[5].

A separate guidance note is currently being produced that will set out a common understanding for how the Health Scrutiny Board will work with Leeds LINk. This will provide a framework for the scope and style of this relationship. In broad terms, the Health Scrutiny Board will not seek to duplicate the advocacy role of the LINk and, wherever possible, will seek to avoid any unnecessary duplication within its work programme.

Work programme

Although some matters may arise at short notice the Health Scrutiny Board will publish a forward work programme. The work programme will be considered and, where necessary, revised on a monthly basis. It will subsequently be widely circulate to all key stakeholders.

Where the production of a specific report is requested and/or necessary for a particular Scrutiny Board meeting, then sufficient notice will be given for the preparation of that documentation.

Information to be supplied to the Board

The work of the Health Scrutiny Board will involve a combination of maintaining an overview of local health issues, including developing awareness of what health bodies are doing, and undertaking in-depth inquiries.

To support the work of the Scrutiny Board, it is likely that members of the Board will require a range of information from NHS bodies, including:

- minutes and reports from Trust Board meetings open to the Public;

[3] The Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations, 2002, HMSO

[4] As set out in the Local Government and Public Involvement in Health Act 2007 and the Local Involvement Networks Regulations 2008

[5] Scrutiny Guidance Note: Requests for Scrutiny, Including Councillor Call for Action (CCfA), Local Crime and Disorder Matters, and Health and Social Care Matters.

- advance notification of proposals for substantial development or reconfiguration[6] of local services;
- notification of current and/or planned service monitoring and review activity within Trusts across the City;
- information of sufficient detail to enable the Board to discharge its scrutiny role and function.

Where confidential information has been requested by the Health Scrutiny Board in connection with their inquiries it is incumbent upon NHS bodies to take all reasonable steps to anonymise this information. Where this is not possible the public must be excluded from the meeting whilst the Scrutiny Board considers the confidential information provided.

NHS Officers

It is acknowledged that NHS officers are responsible to a range of bodies. These include NHS Trust Boards, the Strategic Health Authority, the Department of Health and the emerging local involvement network (LINk).

As an integral and essential method for publicly holding local NHS bodies to account, representatives of NHS bodies will answer questions openly and honestly and provide all information that will assist the Scrutiny Board in its consideration of specific matters, including scrutiny inquiries.

The Director of Public Health (DPH)

The DPH role is one of advocacy and leadership that integrates the three domains of health protection, health improvement and health and social care quality. The DPH has responsibility for producing an independent Annual Report on the health of the local population and is charged with working with primary care and local communities to develop their public health capacity and capability.

To assist the Health Scrutiny Board discharge its role and function, the Directors of Public Health is likely to be a key source of information and is likely to be requested to assist the Scrutiny Board in matters under investigation – both in general terms and where the Scrutiny Board is undertaking a particular inquiry. In cases relating to specific inquires, this input will usually be outlined in Terms of Reference for an inquiry. In all cases, notification of any input will be given well in advance.

Attending Scrutiny Board Meetings

Prior to Scrutiny Board meetings

Prior to Board meeting, the Chair receives a briefing from the Scrutiny Support Unit on items to appear on the forthcoming agenda. On occasion NHS officers may be requested to attend this or a separate session to enable the Chair of the Scrutiny Board to be briefed ahead of the Scrutiny meeting.

Scrutiny Board meetings

Scrutiny Board meetings are usually held monthly in a committee room in the Civic Hall. However, from time to time meetings will be arranged at different venues – often dictated by the nature of the inquiries taking place.

Where attendance at a Scrutiny Board meeting is required, a reasonable notice period will be provided for NHS bodies to respond. This period will be at least 15 working days notice of the meeting at which attendance is being requested. Where

[6] Further guidance on the definition of Substantial is provided within this protocol

attendance will require the production of a report then sufficient notice will be given for the preparation of that documentation.

Where the Health Scrutiny Board requests a response from a local NHS body to whom it has made a report or recommendation, that body will respond to the Board in writing within 28 days of the request.

For all Scrutiny Board meetings the Scrutiny Support Unit will endeavour to give approximate times for when items are likely to be discussed. However, as items may over run, there may be a short waiting time.

Conduct at Scrutiny Board meetings

A separate Member/Officer protocol [7] has been agreed by the City Council. This will be used as the basis for the conduct of Scrutiny Board Members in their dealings with officers from NHS bodies.

Conduct of Scrutiny Board Inquiries

The role of Terms of Reference

The majority of Scrutiny Inquiries have agreed terms of reference. These identify the subject areas members of the Board wish to pursue and are used to inform departments of the Council and NHS bodies of the emphasis of a particular inquiry.

Officers in the Scrutiny Support Unit will liaise with relevant officers of the Council and NHS bodies during the preparation of Terms of Reference to ensure that the focus of the inquiry is relevant and the timing of it appropriate.

Draft Terms of Reference are usually presented to the Scrutiny Board via a written report. This will provide a basis for discussion between officers and the Scrutiny Board. The Scrutiny Support Unit will advise on the particular information required.

Gathering Evidence

The evidence to be gathered will be outlined in the Inquiry's Terms of Reference. This material may be considered at full Scrutiny Board meetings, which are open to the public, and/or by a small working group of Scrutiny Board, tasked with undertaking a specific evidence gathering task. In the latter case Board Members will report their findings to an appropriate full meeting of the Health Scrutiny Board.

The Scrutiny Support Unit will endeavour to give guidance on what will be asked and sometimes possible question areas will be passed on to allow some time for preparation before the meeting. However, Members may follow a related line of discussion and ask other questions on the day.

Preparation of Reports

At the conclusion of an inquiry, where considered appropriate, the Scrutiny Board will produce a preliminary report. This will be drafted by the Scrutiny Support Unit in conjunction with the Scrutiny Board Chair and agreed by the Board. This report will provide a summary of the evidence submitted, along with the Scrutiny Board's conclusions and recommendations. Where the Health Scrutiny Board is considering making recommendations to the Council and/or an NHS body, it will invite advice from a relevant Chief Officer prior to finalising its report and recommendations.

[7] Leeds City Council Constitution - Section 5

Publication of Report Findings

Once it has completed an inquiry, the Health Scrutiny Board may make reports and recommendations to the Board of the NHS bodies scrutinised and/or relevant decision-makers with the City Council. Any reports made will also be copied to:

- All witnesses/ organisation that supplied information to the Scrutiny Board during the inquiry
- The appropriate member(s) of the Council's Executive Board
- Leeds Director of Public Health
- Local MPs and MEPs
- The Strategic Health Authority (Yorkshire and the Humber)
- Leeds Local Involvement Network (LINk)
- Local voluntary organisations and/ or other organisations that have expressed an interest in the issues dealt with in the report.
- A copy of the report should also be placed in local libraries, on local authority and Strategic Health Authority websites and made available to other local networks so as to be widely available to members of the public.

Response to Reports

Where the Health Scrutiny Board has sent a report to an NHS body, the NHS body concerned will be required to send its response to the Board within 28 days. The reply should set out the general views of the NHS body on the recommendations, alongside any proposed action or reasons for inaction in response to each specific recommendation made. The NHS response should also be copied to:

- All witnesses/ organisation that supplied information to the Scrutiny Board during the inquiry
- The appropriate member(s) of the Council's Executive Board
- Leeds Director of Public Health
- Local MPs and MEPs
- The Strategic Health Authority (Yorkshire and the Humber)
- Leeds Local Involvement Network (LINk)
- Local voluntary organisations and/ or other organisations that have expressed an interest in the issues dealt with in the report.
- A copy of the report should also be placed in local libraries, on local authority and Strategic Health Authority websites and made available to other local networks so as to be widely available to members of the public.

Consultation with the Scrutiny Board (Health) by NHS Bodies in Leeds

The Health and Social Care Act (2001), subsequently reinforced by the NHS Act 2006 and the Local Government and Public Involvement in Health Act (2007), places a duty local on NHS Trusts, Primary Care Trusts and Strategic Health Authorities to make arrangements to involve and consult patients and the public in planning service provision, in the development of proposals for changes, and in decisions about changes to the operation of services.

The requirement to consult on service changes and/or developments, includes a duty to consult the Health Scrutiny Board where the NHS Body has under consideration any proposal for:

- a substantial development of the health service; or,
- a substantial variation in the provision of such a service in the local authority area.

However, levels of service variation and/or development are not defined in legislation and it is widely acknowledged that the term 'substantial variation or development of health services' is subjective, with proposals often open to interpretation. To assist all parties concerned, the following locally developed definitions and examples of service change/ development have been agreed:

- **Category 1** – ongoing improvement (e.g. proposals to extend or reduce opening hours)
- **Category 2** – minor change (e.g. change of location within same hospital site)
- **Category 3** – significant change (e.g. changing provider of existing services)
- **Category 4** – substantial variation (e.g. introduction of a new service)

In seeking to determine whether a development or variation is substantial, the NHS body concerned and the Health Scrutiny Board will have regard to issues such as (but not limited to):

- the number of people likely to be affected,
- whether changes in the accessibility of services will result; and,
- whether changes in the deployment of the workforce will be necessary.

In addition, any substantial variations or developments of local health care services need to be in the best interests of the local health service and the people it serves, and any consultation with stakeholders needs to be adequate prior to any final decision being made. Where the Health Scrutiny Board has concerns regarding any agreed substantial service changes / developments, there is provision within current legislation for the Health Scrutiny Board to refer matters to the Secretary of State for Health.

Any such referral must be relating to a substantial service change and/or development and should be seen as an action of last resort. The Health Scrutiny Board can refer matters to the Secretary of State for Health where the Scrutiny Board:

- Is concerned that consultation on substantial variations/ developments has been inadequate; and/or,
- Considers that any proposal is not in the interests of the local health service.

SCRUTINY BOARD (HEALTH)
HEALTH SERVICE DEVELOPMENTS WORKING GROUP

TERMS OF REFERENCE

1.0 Background

1.1 The Health and Social Care Act (2001), subsequently reinforced and amended by the NHS Act (2006) and the Local Government and Public Involvement in Health Act (2007), places a duty local on NHS Trusts, Primary Care Trusts and Strategic Health Authorities to make arrangements to involve and consult patients and the public in:

- Planning service provision;
- The development of proposals for changes; and,
- Decisions about changes to the operation of services.

1.2 The requirement to consult on service changes and/or developments, also includes a duty to consult the Health Scrutiny Board where the NHS Body has under consideration any proposal for:

- a major development of the health service; or,
- a major variation in the provision of such a service in the local authorities area.

2.0 Scope

2.1 The levels of service variation and/or development are not defined in legislation and it is widely acknowledged that the term 'major variation or development of health services' is subjective, with proposals often open to interpretation.

2.2 To assist Health Overview and Scrutiny Committees, and to help achieve some degree of consistency, the Centre for Public Scrutiny (CfPS) published a scrutiny guide, *Major Variations and Developments of Health Services*[1]. Based on this guidance, and through discussions between NHS Leeds and the Health Scrutiny Board, the following locally developed definitions and examples of service change/ development have been agreed and are summarised in Table 1 (below).

Table 1: Summary of levels of change

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

[1] Published in December 2005 and available from the publications section of the CfPS website: http://www.cfps.org.uk/

2.3 The definitions of reconfiguration proposals and stages of engagement/consultation are detailed in Annex 1.

2.4 The overall purpose of the Working Group is to provide an environment that allow local NHS bodies to have an on-going dialogue with Scrutiny, regarding changes and development of local health services. Therefore, the role of the working group can be summarised as follows:

- Considering, at an early stage, any future proposals for service changes and/or developments of local health services, including:
  - Whether or not the relevant Trust's plans for patient and public engagement and involvement seem satisfactory[2]; and,
  - Whether the proposal is in the interests of the local health service.
- Maintaining on overview and on-going involvement in current service change proposals and associated patient and public engagement and involvement activity, including details of any stakeholder feedback and how this is being used to shape the proposals.
- Reviewing the implementation of any agreed service change and/or development, including any subsequent service user feedback.
- Referring any matters of significant concern to the Health Scrutiny Board, for consideration.

2.5 It should be recognised that the statutory duty to consider major changes remains the responsibility of the Health Scrutiny Board itself. As such, any major changes and/or variations identified will automatically be referred to the Health Scrutiny Board for consideration.

2.6 Where a major change and/or development is identified, the view of the Working Group on the relevant Trust's plans for patient and public engagement and involvement, and on whether the proposal is in the interests of the local health service will usefully inform the deliberation of the Health Scrutiny Board when considering such matters.

3.0 Frequency of meetings

3.1 It is initially proposed that the Working Group will meet on a regular bi-monthly basis, as follows:

- July
- September
- November
- January
- March
- May

3.2 However, due to the nature of the work and the potential timing of proposed service changes and/or developments, it is recognised that the Working Group will adopt a flexible approach and may choose to meet outside this timetable.

[2] This early engagement with Scrutiny will allow the Working Group to discuss and agree the proposed degree of variation, prior to the commencement of any patient and public engagement and involvement activity

3.3 It should also be recognised that the purpose of meeting on a bi-monthly basis is not only to ensure the early engagement of members of the Scrutiny Board (Health) with regard to emerging service changes and/or developments, but to ensure the continued involvement in relation to previously identified matters.

4.0 Membership

4.1 The membership of the Health Proposals Working Group for the duration of the current municipal year (2009/10) is as follows:

- *To be confirmed (TBC)*

5.0 Key stakeholders

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

- NHS Leeds
- Leeds Teaching Hospitals NHS Trust (LTHP)
- Leeds Partnerships NHS Foundation Trust (LPFT)
- Director of Adult Social Services (or nominee)
- Director of Public Health (or nominee)

6.0 Monitoring arrangements

6.1 The Scrutiny Board (Health) will be kept fully appraised of the activity of the Working Group and regular updates, including reports and minutes from the Working Group, will be provided.

June 2010

Definitions of reconfiguration proposals and stages of engagement/consultation

Definition & examples of potential proposals	Stages of involvement, engagement, consultation			
	Informal Involvement	Engagement		Formal consultation
Major variation or development Major service reconfiguration – changing how/where and when large scale services are delivered. Examples: urgent care, community health centre services, introduction of a new service, arms length/move to CFT				**Category 4** Formal consultation required (minimum twelve weeks) **(RED)**
Significant variation or development Change in demand for specific services or modernisation of service. Examples: changing provider of existing services, pathway redesign when the service could be needed by wide range of people			**Category 3** Formal mechanisms established to ensure that patients/service users/ carers and the public are engaged in planning and decision making **(ORANGE)**	
Minor change Need for modernisation of service. Examples: Review of Health Visiting and District Nursing (Moving Forward Project), patient diaries		**Category 2** More formalised structures in place to ensure that patients/ service users/ carers and patient groups views on the issue and potential solutions are sought **(YELLOW)**		
Ongoing development Proposals made as a result of routine patient/service user feedback. Examples: proposal to extend or reduce opening hours	**Category 1** Informal discussions with individual patients/ service users/ carers and patient groups on potential need for changes to services and solutions **(GREEN)**			

OSC involved

OSC may be involved

Information & evidence base

Information & evidence base

Information & evidence base

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

APPENDIX 3

Scrutiny Board (Health)
Work Programme 2010 /11

Item	Description	Notes	Type of item
Meeting date – June 2010			
Co-opted Members	To receive and consider a report of the Head of Scrutiny and Member Development on Co-opted Members.		B
Constitutional Changes	To receive and consider a report of the Head of Scrutiny and Member Development on proposed changes to the Council's Constitution in relation to Scrutiny.		B
Input into the Work Programme 2009/10 - Sources of Work and Establishing the Board's Priorities	To receive and consider various inputs to inform the development of the Scrutiny Board's work programme for 2010/11.		B
Kirkstall Joint Service Centre – Scrutiny Board statement	To receive and consider the statement of the former Scrutiny Board (City and Regional Partnerships).		B
Determining the Work Programme 2009/10	To identify the Scrutiny Board's priorities and determine its work programme for 2010/11.		B

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

APPENDIX 3

Scrutiny Board (Health)
Work Programme 2010 /11

Item	Description	Notes	Type of item
Meeting date – July 2010			
Input into the Work Programme 2009/10	To receive and consider the input from NHS Leeds to inform the development of the Scrutiny Board's work programme for 2010/11.		B
Quarterly Accountability Reports	To receive quarter 4 (2009/10) performance reports		PM
Recommendation Tracking	To monitor progress against the recommendations agreed following previous Scrutiny Board inquiries.		MSR
Leeds Local Involvement Network (LINk) – Annual Report	To receive and consider the annual report of the Leeds Local Involvement Network (LINk).		B

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

APPENDIX 3

Scrutiny Board (Health)
Work Programme 2010 /11

Item	Description	Notes	Type of item
Meeting date – September 2010			
Promoting Good Public Health: The Role of the Council and its Partners	To consider the response to the Boards inquiry report published in May 2010.		RP
Quarterly Accountability Reports	To receive quarter 1 performance reports		PM
Recommendation Tracking	To monitor progress against the recommendations agreed following previous Scrutiny Board inquiries.		MSR
Leeds Strategic Plan and Vision	To receive a formal consultation report. This will provide details of proposed Vision aims, Local Strategic Plan and Business Plan priorities.		DP
Meeting date – October 2010			

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

APPENDIX 3

Scrutiny Board (Health)
Work Programme 2010 /11

Item	Description	Notes	Type of item
Meeting date – November 2010			
Leeds Strategic Plan and Vision	Scrutiny Board involvement in target setting process, linked to the Leeds Strategic Plan and Business Plan priorities		DP
Meeting date – December 2010			
Quarterly Accountability Reports	To receive quarter 2 performance reports		PM
Recommendation Tracking	To monitor progress against the recommendations agreed following previous Scrutiny Board inquiries.		MSR
Meeting date – January 2011			

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 3

Scrutiny Board (Health)
Work Programme 2010 /11

Item	Description	Notes	Type of item
Leeds Strategic Plan and Vision	Composite report to be submitted to Scrutiny Board for agreement prior to submission to Executive Board as part of the Budget and Policy Framework		DP
Meeting date – February 2011			
Meeting date – March 2011			
Quarterly Accountability Reports	To receive quarter 3 performance reports		PM
Quality Accounts	To consider draft quality account submissions for 2010/11		PM

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

APPENDIX 3

Scrutiny Board (Health)
Work Programme 2010 /11

Item	Description	Notes	Type of item
Recommendation Tracking	To monitor progress against the recommendations agreed following previous Scrutiny Board inquiries.		MSR
Meeting date – April 2011			
Annual Report	To agree the Board's contribution to the annual scrutiny report		

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

APPENDIX 3

Scrutiny Board (Health)
Work Programme 2010 /11

Working Groups			
Working group	**Membership**	**Progress update**	**Dates**
Health Service Developments Working Group	*TBC*	• Consideration of forming a working group	*25 June 2010*

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

Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
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. Local (regional) involvement event to be held on 17 June 2010. Discussions around forming a national joint health scrutiny committee to consider the proposals are on-going.
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. Newsletter issued in April 2010. Local involvement likely to be towards the end of 2010.
Narrowing the Gap	To consider the impact of the 'Narrowing the Gap' initiative, in terms of improving healthy outcomes.	Added to the work programme: December 2009, but no formal consideration of issue in 2009/10.

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

Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Foundation Trust Status	To consider LTHT's progress against its aspiration of attaining Foundation Trust status.	Initial and subsequently revised proposals considered in 2009/10. Details regarding anticipated changes in costs to support proposed new governance arrangements requested in May 2010
Primary Care Service Development and use of the Capital Estate	To consider the NHS Leeds' longer-term strategy for developing/ delivering services through its capital estate.	Added to the work programme: December 2009, but no formal consideration of issue in 2009/10. It may be more appropriate to consider this matter across the whole local health economy.
Health Scrutiny – Department of Health Guidance	To receive and consider revised guidance associated with health scrutiny and any implications for local practice.	Revised guidance was due to be published in November 2009, but was subsequently delayed until after the general election. No firm publication date is yet available.

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

Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Specialised commissioning arrangements	To consider the current arrangements for specialised commissioning within the region and the role of scrutiny.	No formal consideration of issue in 2009/10. Regional work with other local authorities is on-going. The next regional member network meeting is scheduled for 15 July 2010.
Openness in the NHS	To consider how the Department of Health guidance is interpreted and implemented locally.	No formal consideration of issue in 2009/10.
Hospital Discharges	To consider a follow up report on progress against the recommendations (i.e. 15, 16 and 17) detailed in the Independence, Wellbeing and Choice inspection report	Identified as potential issue for 2009/10 but insufficient capacity to consider the issue.
Out of Area Treatments (Mental Health)	To consider the report prepared by Leeds Hospital Alert and the response from LPFT.	Leeds Hospital Alert report received 1 July 2009. Responses received from LPFT in July 2009. No formal consideration of issue in 2009/10.

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

Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
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. No formal consideration of issue in 2009/10.

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

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APPENDIX 4

SCRUTINY BOARD PROCEDURE RULES GUIDANCE NOTE 7

INQUIRY SELECTION CRITERIA

1.0 INTRODUCTION

1.1 The Scrutiny Board Procedure Rules require Scrutiny Boards, before deciding to undertake an Inquiry, to:

Consider how a proposed Inquiry meets criteria approved from time to time; and

Consult with any relevant Director and Executive Member

1.2 This is to ensure that Scrutiny Boards, when agreeing to undertake an Inquiry, have considered carefully the reasons for that Inquiry, its objectives, whether it can be adequately resourced in terms of Member and Officer time and have sought the views of the relevant Director and Executive Member.

1.3 The decision whether to undertake an Inquiry or not rests with the Scrutiny Board.

2.0 INQUIRY SELECTION CRITERIA

2.1 At the time of deciding to undertake an Inquiry, the Scrutiny Board will refer to the Inquiry Selection Criteria within this Guidance Note and formally identify which of the agreed criteria the proposed Inquiry meets. The Board will also record the comments of the relevant Director and Executive Member. This process will be recorded in the Scrutiny Board minutes.

INQUIRY SELECTION CRITERIA

Scrutiny Board _____

Inquiry Title _____

Anticipated Start Date _____

Anticipated Finish Date _____

The Inquiry meets the following criteria

- It addresses the Council's agreed Strategic outcomes by reviewing the effectiveness of policy to achieve strategic outcomes as defined by the Leeds Strategic Plan ☐
- Shaping and developing policy through influencing pre-policy discussion ☐

It fulfils a performance management function by

- Reviewing performance of significant parts of service ☐
- Addressing a poor performing service ☐
- Addressing a high level of user dissatisfaction with the service ☐
- Addressing a pattern of budgetary overspends ☐
- Addressing matters raised by external auditors and inspectors ☐

- Addresses an issue of high public interest ☐
- Reviews a Major or Key Officer decision ☐
- Reviews an Executive Board decision ☐
- Reviews a series of decisions which have a significant impact ☐
- Has been requested by the Executive Board/Full Council/Scrutiny Advisory Group ☐
- looks at innovative change ☐

Comments of relevant Director and Executive Member (Attach additional sheet if necessary)

Date