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Leeds CITY COUNCIL

SCRUTINY BOARD (HEALTH)

Meeting to be held in Civic Hall, Leeds, LS1 1UR on Tuesday, 22nd March, 2011 at 10.00 am

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

MEMBERSHIP

Councillors

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

Co-opted Members (Non-Voting)

Arthur Giles - Leeds LINk
Emma Stewart - Leeds LINk

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

Agenda compiled by:
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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:- **No exempt items or information have been identified on this agenda**	

Item No	Ward/Equal Opportunities	Item Not Open		Page No
3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATIONS OF INTEREST** To declare any personal / prejudicial interests for the purpose of Section 81 (3) of the Local Government Act 2000 and paragraphs 8 to 12 of the Members Code of Conduct.	
5			**APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTES** To receive any apologies for absence and notification of substitutes.	
6			**MINUTES OF THE PREVIOUS MEETING** To confirm as a correct record the minutes of the previous meeting held on 22nd February 2011.	1 - 6
7			**REQUEST FOR SCRUTINY - HEALTH IMPLICATIONS ASSOCIATED WITH THE DECISION TO REDUCE THE OPENING HOURS OF GARFORTH SQUASH AND LEISURE CLUB** To consider a report of the Head of Scrutiny and Member Development on a request for scrutiny that has been received in relation to the health implications associated with the decision to reduce the opening hours of Garforth Squash and Leisure Centre.	7 - 8

Item No	Ward/Equal Opportunities	Item Not Open		Page No
8			**NHS OPERATING FRAMEWORK 2011/12** To consider a report of the Head of Scrutiny and Member Development on the introduction of the NHS Operating Framework 2011/12, issued by the Department of Health on 15 December 2010. The Operating Framework is a planning documents that sets out the priorities for the NHS for 2011/12 and this report provides the opportunity for the Scrutiny Board (Health) to explore the local implications and any associated impacts.	9 - 74
9			**JOINT PERFORMANCE REPORT QUARTER 3 2010/11** To consider a joint report of Leeds City Council and NHS Leeds presenting the performance information summarising progress against the joint Council and NHS Leeds priorities as set out in the Leeds Strategic Plan, as well as key NHS Leeds priorities, for third quarter of 2010/11.	75 - 90
10			**NEW STRATEGIC PLANS 2011-15** To consider a joint report of the Chief Executive and Director of Public Health presenting the proposals for the new set of strategic planning documents for advice and consideration before these go to Executive Board and Council for approval.	91 - 106
11			**UPDATED WORK PROGRAMME 2010/11** To receive and consider a report from the Head of Scrutiny and Member Development outlining the Scrutiny Board's work programme for the remainder of the current municipal year.	107 - 118
12			**DATE AND TIME OF NEXT MEETING** To note that the next meeting of the Scrutiny Board will be held on Tuesday 26th April 2011 at 10.00am (Pre meeting at 9.30am)	

SCRUTINY BOARD (HEALTH)

TUESDAY, 22ND FEBRUARY, 2011

PRESENT: Councillor M Dobson in the Chair

Councillors S Armitage, P Ewens, P Harrand, A Hussain, J Illingworth, G Kirkland, G Latty, J Matthews and E Taylor

CO-OPTEE Ms E Stewart Leeds Local Involvement Network

78 Chair's Opening Remarks
The Chair welcomed everyone to the February meeting of the Scrutiny Board (Health).

79 Late Items
The Chair agreed to accept the following document as supplementary information:-

- The Leeds Sexual Heath Commissioning Strategy 2010-2012- Appendix 1 (Agenda Item 8) (Minute 84 refers)

The document was not available at the time of the agenda despatch, but made available on the Council's Internet site prior to the meeting.

80 Declarations of Interest
Councillor E Taylor made a general declaration of personal interest in respect of today's agenda, in her capacity as an NHS employee.

81 Apologies for Absence and Notification of Substitutes
An apology for absence was submitted on behalf of Arthur Giles.

82 Minutes of the Previous Meeting
RESOLVED – That the minutes of the meeting held on 25th January 2011 be confirmed as a correct record.

83 Mental Health Partnership Integration Project
The Head of Scrutiny and Member Development submitted a report presenting to the Board details/proposals associated with the Mental Health Integration Project.

Appended to the report was a copy of document entitled 'NHS Leeds – Proposals for Change – Health Scrutiny Board' for the information/comment of the meeting.

The following representatives were in attendance to present the key issues highlighted in the report and to address any specific questions identified by the Scrutiny Board:

- Michelle Moran (Director of Service Delivery and Chief Nurse) – Leeds Partnerships NHS Foundation Trust (LPFT)
- James Hoult (Project Manager) – Leeds Partnerships NHS Foundation Trust (LPFT)
- John Lennon (Chief Officer (Access and Inclusion)) – Leeds City Council, Adult Social Services

The Director of Service Delivery and Chief Nurse, together with the Project Manager briefly outlined the main proposals associated with the Mental Health Partnership Integration Project. In addition, the Chief Officer (Access and Inclusion), Adult Social Services provided the Board with an update on relevant issues within Adult Social Care.

In summary, it was outlined that the main aim of the project was the integration of care management teams (from LPFT and Leeds City Council) for the benefit of patients. With clearer accountability as an underlying principle, the benefits would include better:

- Management and flow of information to and from patients;
- Use of resources; and,
- Reflection on service user involvement and experience.

It was outlined that, on completion of the project, it was expected that LPFT would provide mental health service on behalf of the Council. While the Council would remain statutorily responsible for such services / functions, this would be achieved through a formal (Section 75) agreement, secondment of staff and transfer of a budget in the region of £7.9M.

There was a wide ranging discussion where a number of points were raised and addressed, including:

- Concerns that too much jargon was contained within the document and the need for more clarity regarding the proposals
- Commissioning arrangements in relation to the new IT system and anticipated completion date
- The process for establishing a the single management structure and joint outcome/ accountability framework
- How the proposals would work in practice, including whether or not the Section 75 agreement and secondments were time limited and around the appointment process / accountability of the Head of Service post
- How the proposals would benefit service users and whether or not services would improve in the short/long term
- The need for stability for those people who go through the service transformation process

- Decision-making processes and the timescales in relation to reporting back proposals to the Council's Executive Board

RESOLVED-

a) That the contents of the report and appendices be noted.
b) That further reports on this issue be presented to the Board for discussion in due course.

(Councillor J Illingworth joined the meeting at 10.15am during discussions of the above item)

(Councillor G Latty left the meeting at 11.00am during discussions of the above item)

84 Leeds Sexual Health Strategy

The Head of Scrutiny and Member Development submitted a report presenting to the Board details/proposals associated with the Leeds Sexual Health Strategy.

Appended to the report was a copy the 'Leeds Sexual Health Commissioning Strategy 2010-2012' for the information/comment of the meeting.

The following representatives were in attendance to present the key issues highlighted in the report and to address any specific questions identified by the Scrutiny Board:

- Victoria Womack (Drugs and Sexual Health Lead) – NHS Leeds
- Ruth Middleton (Head of Commissioning, Staying Healthy) – NHS Leeds

The Drugs and Sexual Health Lead Officer, together with the Head of Commissioning, Staying Healthy outlined the main points within the Leeds Sexual Health Commissioning Strategy 2010-2012.

In brief summary, the main points of discussion were:

- Sexual Health remained a significant issue for some areas of the community, with an increase risk to people under 25 years old
- The focus of the strategy being on:
  - Early access to sexual health assessment and treatment services;
  - Early access to contraception services
  - Prevention
- The HPV vaccine within the context of the Leeds Sexual Health Strategy
  (The Drugs and Sexual Health Lead Officer responded and informed the meeting that HPV did not specifically relate to the strategy; but agreed to supply information of the percentage rates of HPV immunisation to the Board via the Principal Scrutiny Adviser)

- Links with the Student Union in helping to deliver the key messages of the strategy, with reference made to the successful campaigns undertaken in Leeds Colleges around Chlamydia screening
- Consistency of Sex and Relationship Education within Leeds schools.
- How the strategy contributed to the delivery of locality based services

RESOLVED- That the contents of the report and appendices be noted and welcomed.

85 Quality Accounts 2011

The Head of Scrutiny and Member Development submitted a report seeking the Board's view on a range of options for commenting on the Quality Accounts of local health care providers for 2011.

Arising from discussions, the Board agreed to take a practical and pragmatic approach considering and, where appropriate, commenting on the Quality Accounts produced by the full list of NHS healthcare service providers identified in the report: That is:

- Leeds Teaching Hospitals NHS Trust
- Leeds Partnerships Foundation Trust
- Leeds Community Healthcare
- Spire Hospital Leeds
- Nuffield Hospital Leeds
- Fountain Diagnostics
- Commuter Walk-In Centre Leeds

RESOLVED-

a) That the contents of the report be noted.
b) That approval be given to pursuing Option 2b (a devolved working group, with an open membership arrangement) for commenting on the Quality Accounts of local NHS healthcare providers for 2011.

86 Updated Work Programme 2010/11

The Head of Scrutiny and Member Development submitted a report outlining the Scrutiny Board's work programme for the remainder of the current municipal year.

Appended to the report were copies of the following documents for the information/comment of the meeting:-

- Scrutiny Board (Health) – Work Programme 2010/11 (Appendix 1 refers)
- NHS Leeds Board – Notes of a Meeting held on 2nd February 2011 (Appendix 2 refers)
- Leeds NHS - Pharmacy Needs Assessment – Briefing Note (Appendix 3)

The Board's Principal Scrutiny Adviser presented the key issues highlighted in the report and addressed specific points of clarification identified by the Scrutiny Board.

Specific reference was made to the national review of Children's Cardiac Surgery Services and the future delivery options recently agreed for consultation.

RESOLVED-

a) That the contents of the report and appendices be noted.
b) That approval be given to the outline work programme in accordance with the report now submitted.
c) That in relation to Children's Cardiac Surgery Services – national review, consideration be given to raising the profile of this issue via a White Paper Motion to Council and to request the Board's Principal Scrutiny Adviser to write to Area Committee Chair's with a request that this issue be debated at Area Committee meetings in March/April 2011.
d) That in relation to the provision of playing fields in Leeds and the public health implications, this issue be incorporated within the Board's work programme in the new Municipal Year.
e) That in relation to Workforce Planning and the associated problems of city-wide pupils obtaining a place at Medical School, this issue be incorporated within the Board's work programme in the new Municipal Year.

87 Date and Time of Next Meeting

To note that the next meeting of the Scrutiny Board will be held on Tuesday 22nd March 2011 at 10.00am (Pre meeting for Board Members at 9.30am)

(The meeting concluded at 12 noon)

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Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 2474557

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 8th March 2011

Subject: Request for Scrutiny – Health implications associated with the decision to reduce the opening hours of Garforth Squash and Leisure Centre

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

1.0 Introduction

1.1 The purpose of this report is introduce a request for scrutiny that has been received in relation to the health implications associated with the decision to reduce the opening hours of Garforth Squash and Leisure Centre.

2.0 Request for Scrutiny

2.1 The following requests for scrutiny have been received by the Chair of the Scrutiny Board (Health) regarding the decision to reduce the opening hours of Garforth Squash and Leisure Centre.

> *I feel as a Body Line member and a former Fitness Instructor that there are significant implications for the Health of people both living and working in outer East Leeds. Therefore, I am formally asking you that the decision regarding the reduction of hours at Garforth Squash and Leisure Club be heard at the Health Scrutiny Board. (Ms J Walker)*
>
> *As per our conversation, following your receipt of our petition to keep Garforth Squash and Leisure Centre open, on behalf of Garforth residents, could I urge the health scrutiny board to carry out a full investigation into the proposed opening hours having regard to the possible health implications. (Ms N Mitchell)*

2.2 Both Ms Walker and Ms Mitchell have been invited to attend the meeting to present their requests to the Scrutiny Board (Health)

2.3 The Acting Director of City Development has been made aware of these requests and may be represented at the meeting. Any information provided in writing by the Directorate will be made available to Members of the Board as soon as it is available.

2.4 Members of the Scrutiny Board (Health) should be aware that a more general request for scrutiny around the decision to reduce the opening hours of Garforth Squash and Leisure Centre was presented to the Scrutiny Board (City Development) on 8 March 2011.

2.5 The decision of the Scrutiny Board (City Development) was to undertake some work in relation to this decision, however the draft minutes from that meeting were not available at the time of writing this report. The draft minutes and any additional information from the discussion at the Scrutiny Board (City Development) meeting will be provided to Members of the Board as soon as practicable.

3.0 Options for Investigations and Inquiries

3.1 When considering the request for scrutiny, the Scrutiny Board (Health) shall determine:

- what further information the Board needs before considering whether an inquiry should be undertaken
- how the proposed inquiry meets criteria approved from time to time by the Scrutiny Advisory Group
- whether the Inquiry can be adequately resource
- whether an Inquiry should be undertaken

4.0 Recommendations

4.1 The Scrutiny Board is asked to consider the requests for scrutiny received and determine what, if any, further scrutiny can be undertaken on this matter in the light of the information provided.

5.0 Background Papers

Request for Scrutiny of the Decision to Reduce the Opening Hours of Garforth Squash and Leisure Centre - Scrutiny Board (City Development), 8 March 2011

Leeds CITY COUNCIL

Originator: Steven Courtney

Tel: 247 4707

Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 22 March 2011

Subject: NHS Operating Framework 2011/12

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

1.0 Purpose

1.1 The purpose of this report is to introduce the NHS Operating Framework 2011/12, issued by the Department of Health on 15 December 2010. The Operating Framework is a planning documents that sets out the priorities for the NHS for 2011/12 and this report provides the opportunity for the Scrutiny Board (Health) to explore the local implications and any associated impacts.

2.0 Background

2.1 In July 2010, the Government launched its overall vision for the future of the NHS via its White Paper, '*Equity and excellence: Liberating the NHS'.* This set out key proposals for change and reform for the commissioning and delivery of NHS services. In December 2010, the Government published its response to the initial consultation and subsequently published its draft Health and Social Care Bill, which is currently progressing through Parliament.

2.2 Since the initial publication of the proposed NHS reforms, the Scrutiny Board (Health) has taken a keen interest in the proposals and the likely local implications – in terms of the overall local health economy and landscape, and specific implications for the Council and its future additional responsibilities. As part of this work, at its meeting on 25 January 2011, the Board agreed to consider the NHS Operating Framework 2011/12, which was published by the Department of Health on 15 December 2010.

3.0 NHS Operating Framework 2011/12

3.1 The NHS Operating Framework 2011/12 (attached at Appendix 1) sets out the national priorities for the NHS, including maintaining performance on key waiting times, continuing to reduce healthcare associated infections, and reducing emergency readmission rates. It states that the forthcoming financial year is likely to be very demanding for the NHS, as it begins the transition to the new system and structure envisaged in *Equity and excellence: Liberating the NHS.* Nonetheless, delivering improved quality for patients, by improving safety, effectiveness and patient experience, remains the core purpose of the NHS, and the NHS Operating Framework 2011/12.

3.2 The NHS Operating Framework 2011/12 sets out in some detail the over-arching goal of building strong foundations for the new system by:

- Maintaining and improving quality;
- Keeping tight financial control;
- Delivering on the quality and productivity challenge; and,
- Creating energy and momentum for transition and reform.

3.3 To help the Board consider the details of the NHS Operating Framework 2011/12 and its local impact, senior representatives from key organisations have been invited to attend the Board meeting, to outline its implications and challenges for individual organisations and for the overall local health economy. The organisations due to be represented at the meeting are:

- NHS Leeds
- Leeds Teaching Hospitals NHS Trust (LTHT)
- Leeds Partnerships NHS Foundation Trust (LPFT)
- Leeds Community Healthcare (LCH)

4.0 Recommendations

4.1 Members are asked to:

4.1.1 Consider and note the details presented in this report and those discussed at the meeting; and,

4.1.2 Identify any specific matters that require further scrutiny and/or are to be included on the Board's future work programme.

5.0 Background Documents

- The NHS White paper – *Equity and excellence: Liberating the NHS – July 2010*

NHS

The Operating Framework

for the NHS in England 2011/12

DH Department of Health

DH INFORMATION READER BOX

Policy HR/Workforce Management **Planning/Performance** Clinical	Estates Commissioning IM&T Finance Social Care/Partnership Working
Document purpose	Action
Gateway reference	15216
Title	The Operating Framework for the NHS in England 2011/12
Author	DH/NHS Finance, Performance and Operations
Publication date	15 Dec 2010
Target audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Local Authority CEs, NHS Trust Board Chairs, Special HA CEs, Directors of Finance, Communication Leads, Directors of Performance.
Circulation list	Voluntary Organisations/NDPBs
Description	This document outlines the business and planning arrangements for the NHS in 2011/12. It describes the national priorities, system levers and enablers needed to build strong foundations set out in Equity and excellence: Liberating the NHS, maintaining and improving quality, while keeping tight financial control and delivering the QIPP challenge.
Cross ref	N/A
Superseded docs	N/A
Action required	N/A
Timing	N/A
Contact details	David Flory NHS Finance, Performance & Operations Directorate Department of Health Richmond House 79 Whitehall London SW1A 2NS
For recipient's use	

Contents

Foreword by Sir David Nicholson KCB CBE

2011/12 will be a very demanding year for the NHS as we take on the challenge of continuing to deliver high quality care for our patients, while beginning in earnest the transition to the new system envisaged in *Equity and excellence: Liberating the NHS*. Our over-arching goal in this period is to build strong foundations for the new system by maintaining and improving quality, by keeping tight financial control and delivering on the quality and productivity challenge, and by creating energy and momentum for transition and reform.

Maintaining and improving quality and outcomes

Our core purpose remains the delivery of improved quality for our patients, by improving safety, effectiveness and patient experience. The NHS Operating Framework sets out the national priorities for 2011/12, including maintaining performance on key waiting times, continuing to reduce healthcare associated infections, and reducing emergency readmission rates.

In doing this, our focus in 2011/12 will be increasingly on improving the outcomes we achieve, in line with the vision in *Liberating the NHS*. The forthcoming *Improving Outcomes Strategy for Cancer* will set out a clear ambition for improving survival rates, while the new measures of quality for ambulance and Accident and Emergency services to be published shortly will concentrate on measures that link to outcomes.

We shall continue to develop the quality framework in 2011/12 in anticipation of the new role of the NHS Commissioning Board in driving quality improvement across the system. NICE will begin work on 31 new Quality Standards next year to add to the 15 already completed or in development. Meanwhile quality accounts will be extended to cover community services for the first time.

Financial control and QIPP

2011/12 is the first year of the new Spending Review period and today's allocations to PCTs confirm the strong financial settlement for the NHS. Given the current economic context, the settlement represents a real vote of confidence in the NHS and a recognition of the pressures we face due to rising demand, changing demography, and new technologies. It is nevertheless a very challenging settlement in historical terms, which is why we must remain focussed on delivery of the £20 billion efficiency savings for re-investment in improving quality across the Spending Review period.

To this end, this NHS Operating Framework sets out how we will maintain tight financial control during 2011/12. PCTs will continue to be required to invest 2 per cent of their budgets non-recurrently in order to create financial flexibility and headroom to support change. The marginal rate of tariff payment for emergency admissions above baseline thresholds will be maintained, incentivising commissioners and providers to work together in an area that is critical to delivering local QIPP plans.

These measures will no doubt create real challenges in some parts of the system, but they are critical to ensuring we maintain a strong financial position to get the new system on the right footing from the outset. We shall continue to support commissioners and providers to make quality and productivity improvements, as we have done through the recent publication of the *NHS Atlas of Variation* and the review of *Back Office Efficiency and Management Optimisation*.

Developing the new system

As well as maintaining a strong grip on the system during 2011/12, we need to make progress on laying the foundations for the new health and social care system. We recently announced the first wave of pathfinder GP consortia, which already cover a quarter of the population. The pathfinder programme will expand across the country during 2011/12, while the new NHS Commissioning Board will be created in shadow form, meaning the foundations of the new commissioning system will be in place by the end of the year.

On the provider side, we shall look to make early progress on completion of the Foundation Trust pipeline and to prepare for the new system of economic regulation. And 2011/12 is also an important transition year for local government as we test the new arrangements for health and wellbeing boards and the new public health service.

This NHS Operating Framework will also create clearer incentives to drive integration between health and social care by giving PCTs responsibility for securing post-discharge support, with hospitals responsible for any readmissions within 30 days of discharge. PCT allocations also include funding of £150 million for reablement and PCTs will receive separate allocations totalling £648 million in 2011/12 to support social care.

Accountability in 2011/12

It is critical that we maintain clear accountability arrangements during 2011/12, even as parts of the new system come into place in shadow form. Strategic Health Authorities will continue to play a key role during 2011/12 and will remain accountable both for delivery of high quality care within available resources, and for making progress on the transition to the new system across their region.

At local level, Primary Care Trusts will remain statutorily accountable in 2011/12 and 2012/13. However, it is unlikely that we will be able to maintain 151 fully functional separate organisations up to the end of that period, particularly if we want to offer capacity to emerging GP consortia. Because of this, and because of the broader drive to reduce running costs across the system, some regions of the NHS have already developed clusters of PCTs. In order to secure the capacity and flexibility needed for the transition period, this NHS Operating Framework therefore set out plans for a managed consolidation of PCT capacity to create such clusters across all regions of the NHS.

This is a broad and complex agenda and a significant leadership challenge for us all. It requires us to keep a firm grip on delivery for today, facing up to issues such as winter pressures and the need to maintain patient safety during a period of organisational change. And it also requires us to begin to build the new system and to bring about the changes set out in *Liberating the NHS*. We must meet these challenges at a time when staff and leaders across the NHS face personal and professional uncertainty about their futures. I do not underestimate the scale of what lies ahead, but I have confidence, based on our track record of delivery, that we can succeed.

Sir David Nicholson, KCB CBE
NHS Chief Executive

1. Overview

A new direction and vision

1.1 The White Paper, *Equity and excellence: Liberating the NHS*[1] was published on 12 July 2010 and outlines the Government's plans for a new direction for the NHS. We have already started an ambitious programme of reforms in the NHS with the *Revision to the Operating Framework for the NHS in England 2010/11*[2], published on 21 June 2010. This Operating Framework for the NHS in England 2011/12 sets out the challenges in implementing the first full year of the transition. 2011/12 is a critical period that requires all parts of the health service to respond positively to the principles and purposes set out in *Equity and excellence: Liberating the NHS*, whilst ensuring service quality and financial performance are maintained and improved.

1.2 On 20 October 2010, the Government announced the details of the Spending Review covering the four years from 2011/12 to 2014/15. This reflected the Government's commitment to protect health with the total health budget increasing by £10.6 billion over four years. Within this, total revenue increases by £11.1 billion with capital falling by £0.5 billion over the same period. That settlement needs to be considered in the context of reducing management costs and Quality, Innovation, Productivity and Prevention (QIPP) productivity gains which will release up to £20 billion more funding into frontline services for patients over the four years. In 2011/12, the settlement includes an explicit provision from health resources of £800 million, which NHS commissioners will have available to spend on measures which support social care and benefit health in agreement with social care commissioners.

1.3 There is extensive work going on across the health service to support the move to a system that is accountable to local people, focuses on outcomes, empowers patients through choice and information, and liberates commissioners and providers. GPs are already moving into shadow consortia arrangements in many parts of the country and we need to learn from them in terms of developing future consortia, there is more regular publication of key information such as infection rates on a weekly basis and the first NHS Outcomes Framework will be published shortly.

1.4 NHS organisations will need to comply with the public sector duties of the Equality Act 2010, due to come into force in April 2011. The NHS Equality and Diversity Council is developing an Equality Delivery System to advise boards on how to maintain progress and demonstrate compliance with the Act.

1 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353
2 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107

1.5 With that backdrop, this NHS Operating Framework for 2011/12 needs to be viewed in the context of three inter-related themes:

- **transition and reform** – what needs to happen in 2011/12 to begin to realise the challenges set out in the White Paper, taking our staff with us;
- **transparency and local accountability** – what we need to involve public and patients in and give them a better understanding of how and where their money is being spent to improve services and strengthen local accountability; and in doing so make a significant contribution to the Big Society; and
- **service quality** – how we deliver on the quality and productivity challenge through securing improvement in those areas where additional funding has been made available, making the wider productivity gains and quality improvement outlined in QIPP, securing re-investment to meet demand and improve quality and outcomes, and taking more responsibility for working together with local authorities.

1.6 These themes are supported by sections in this NHS Operating Framework that set out:

- **finance and business rules** – where the financial and business rules have been developed to reflect the new agenda and tighter fiscal environment; and
- **accountability** – where a single planning process is set out to hold NHS organisations to account for the delivery of service quality and financial sustainability during 2011/12.

Transition and reform

1.7 2011/12 is the year in which we establish the building blocks for the NHS to respond to the White Paper:

- an NHS Commissioning Board will be created in shadow form during 2011/12;
- a programme of pathfinder GP consortia is in place and we shall support the emergence of new pathfinders throughout 2011/12, ensuring that lessons are learned and shared. New arrangements for local authorities will also be tested in this period; and
- SHAs must identify when each of its NHS trusts will become an NHS foundation trust by 31 March 2014 with an identifiable solution for those trusts who need alternative arrangements – the status quo is not an option.

1.8 The NHS has a strong track record of delivery of widescale change. Delivering change while maintaining performance against the QIPP challenge will mean needing to maximise opportunities for:

- flexible local implementation and choice of how new systems operate;
- working together across organisational boundaries;
- supporting current employees through the change; and
- ensuring running costs start and remain low in the new system.

1.9 To support the transition, this NHS Operating Framework sets out our intention increasingly to deliver business through PCT clusters that will in essence work as transition vehicles for:

- overseeing and accounting for delivery;
- direct commissioning; and
- supporting the development of the new commissioning system.

1.10 2011/12 will also be the year when the NHS fully exploits the benefits of the national contract. Contracts must be agreed on time and reflect the needs of the whole health economy, including efficiency savings, with penalties and sanctions activated when the terms of contracts are not being met.

Transparency and local accountability

1.11 In December 2010, the Department of Health will publish a first NHS Outcomes Framework. The NHS Outcomes Framework will include a set of outcome goals that the Secretary of State will use to hold the NHS Commissioning Board to account when it becomes fully operational from April 2012. Data against all indicators in the NHS Outcomes Framework will be made publicly available to allow local people to make informed choices about the services they use.

1.12 In tandem with the NHS Outcomes Framework, there will be a revolution in patient power. NHS commissioners and providers should be publishing information to support local accountability. For example, there is already a requirement for PCTs to publish locally how they are delivering services in line with the *Quality outcomes for people with dementia: Building on the work of the National Dementia Strategy*[3]. That requirement holds – wherever possible commissioners must be accountable to the people they serve, not the centre. Choice will drive service improvements, putting more decision making under the control of patients and their carers. It will be important that services for young people reflect *Achieving Equity and Excellence for Children*[4] so that services are designed around young people from the outset.

3 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119827
4 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119449

Service quality

1.13 *Equity and excellence: Liberating the NHS* set out a vision for a service that focuses on outcomes rather than processes as its key measure of success and that positions interactions between patients and clinicians, rather than central performance management, as the key agent of change.

1.14 Achieving this change will take time and 2011/12 will be about creating the environment for greater devolution during 2012/13. In doing so, it will require a tighter grip in a limited number of areas during 2011/12 if we are to go into 2012/13 with confidence. Those areas are as follows:

- reform – progress on transition to the new system;
- QIPP – where there will be close monitoring of progress against QIPP key performance indicators, as well as a need to go further on improvements that contribute to quality and efficiency gains;
- maintenance of improvements to date – for instance, in referral to treatment times, where we need to ensure patient confidence in the service being able to treat people within a reasonable time is sustained and encourage waiting times to continue to be reduced at a time of transition; and
- specific improvements in relation to Government priorities – where funding has been identified as part of the Spending Review, for example more health visitors and Family Nurse Partnership schemes.

1.15 Whilst the aim of the reforms is to produce high quality care and better outcomes for patients, we know from the evidence that any organisational change carries a degree of risk. It is important that the NHS takes steps to manage these risks in order to ensure that the significant progress made in improving quality in recent years is maintained and built upon.

1.16 The National Quality Board (NQB) is conducting a review, building on its earlier *Review of Early Warning Systems in the NHS*[5] report, into how best to maintain quality and safety during the transition (Phase 1) and once the new system architecture is in place (Phase 2). The Phase 1 report will be published early in 2011 and will provide further detail on how best to address key questions associated with the transition. These include the need to have a clear strategy for:

- dealing with the potential loss of managerial and clinical talent so as to maintain capacity and capability for quality throughout transition;

5 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113020

- ensuring that the voice of patients, as a vital element of the early warning system, remains heard at all times and is not drowned out by other operational or transitional noise;
- bringing key partner organisations together (both local and national) to consider collectively risks to quality both in relation to specific services or provider organisations and, more broadly, across whole health economies;
- delivering a robust and effective handover to successor organisations with appropriate "due diligence" so that there is no loss in corporate memory on issues relating to quality; and
- identifying and tackling any long-standing and intractable quality issues before handing over responsibilities to successor bodies.

1.17 Every board should ensure that they are familiar with and understand the NQB's report *Review of Early Warning Systems in the NHS* (which stands until April 2012). Further guidance on additional resilience measures will be provided in early 2011 as part of Phase 1 of the NQB's review. This will also include advice on how provider boards can strengthen their governance for quality, given that they are ultimately accountable for the quality of services provided within their organisation.

1.18 Phase 2 of the NQB's work will provide further advice as to how the system will operate once the new architecture is fully in place.

Finance and business rules

1.19 The financial position for the NHS where we move from a position of growth to one of more stable settlements makes it all the more imperative that we get the finance and business rules right, in order that the importance of financial control through the transition period is reinforced.

1.20 For 2011/12, the financial framework will require NHS organisations to ensure they gain the maximum benefit when making investment decisions. Running costs will need to be reduced at every level.

Accountability

1.21 *Equity and excellence: Liberating the NHS* set out a challenging agenda in terms of ensuring NHS organisations respond to their local communities rather than being over burdened with central process requirements.

1.22 To support that transition, there will be a single planning and accountability process for 2011/12 that captures the basis on which NHS organisations will be held to account in terms of quality, resources and reform. It is important that the planning and accountability process supports joined up delivery. For example, NHS commissioners need to demonstrate how they can support the challenges in social care. Reduced length of stay in hospital beds can put greater pressure on social care places. That is why we have put the responsibility on PCTs to secure post-discharge support, with hospitals responsible for any readmissions within 30 days of discharge.

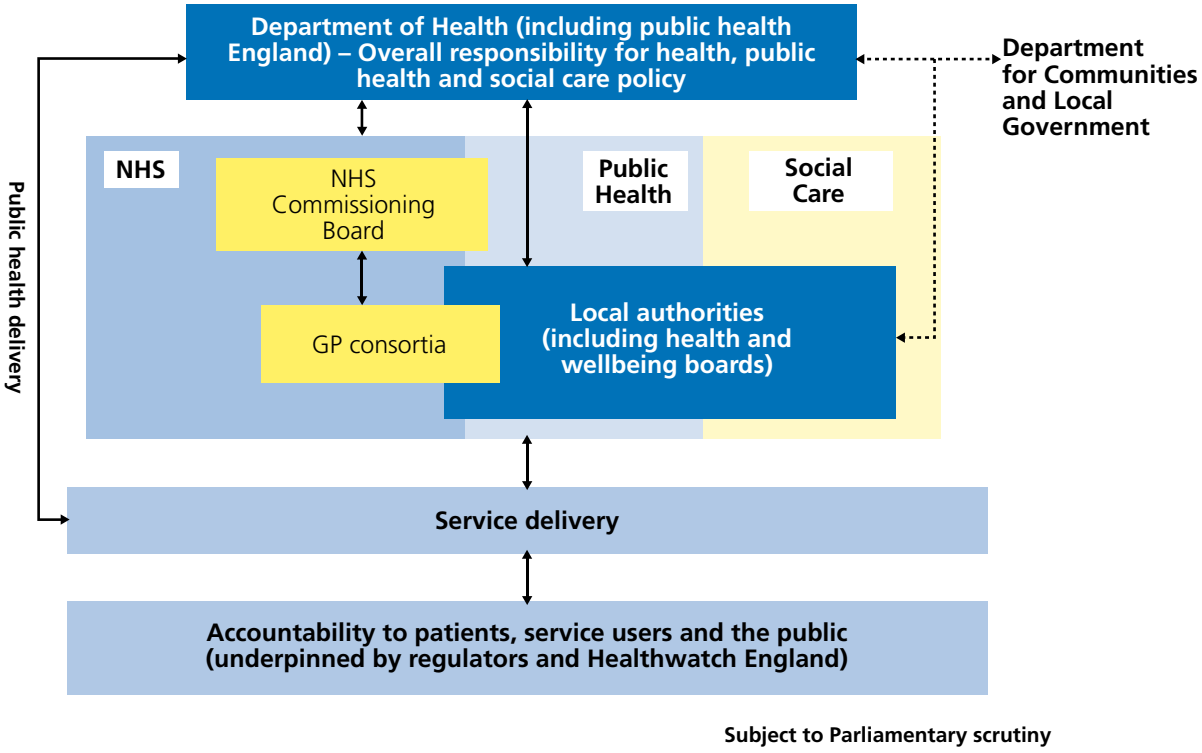
1.23 To ensure NHS organisations can be satisfied that central requests are limited to the minimum necessary to allow them to focus on their local communities, all communications requiring the attention of NHS management in 2011/12 will be consistent with this NHS Operating Framework and include a Gateway reference number.

1.24 This NHS Operating Framework comes at a pivotal moment in the creation of an NHS that is more responsive and better able to reflect the varying needs of the people who require health and care services. This means that a tight grip on finance and performance is called for by all organisations during 2011/12 to support our ambition of greater devolution and liberation during 2012/13 and beyond.

2. Transition and reform

New roles for new and existing organisations

Fig 1: The *Equity and Excellence* system



2.1 *Equity and excellence: Liberating the NHS* set out the blueprint for a new NHS system. 2011/12 is the first full year of the transition to the new system and will require initial changes to be made across all parts of the service. We need to ensure that the current system of accountable organisations is delivering excellent patient care, driving improvements in health outcomes, and improving patient choice and experience within available resources. We need to achieve this in a way that supports the development of the new landscape of organisations, accountabilities and relationships.

2.2 During this transition year, it is essential that organisations continue to fulfil their statutory responsibilities. NHS organisations should ensure that all decisions are taken with due regard to the public sector Equality Duty to ensure that decisions are fair, transparent, accountable, evidence-based and consider the needs and rights of staff and patients.

2.3 SHAs will remain accountable for operational delivery and for leading the transition across their region in 2011/12. They will hold PCTs to account for the delivery of the requirements set out in this NHS Operating Framework both in terms of service delivery and transition to the new arrangements.

2.4 Groups of GP practices, working closely with other health and care professionals, will increasingly take on devolved responsibility for commissioning decisions and consider how best to come together to form prospective consortia.

2.5 PCTs will be undergoing significant change during 2011/12 as emerging GP consortia and the NHS Commissioning Board develop. Without clear action, there is a risk of seeing unplanned loss of capacity and capability in the current commissioning system, notwithstanding the organic development of the new commissioning system. In response to this, and having carefully considered the balance of risks between ensuring continuity of capability and further disruptive change, we have decided that while PCTs will continue to be the statutory unit of accountability during 2011/12, they will increasingly discharge their responsibilities through formal cluster arrangements. In doing so, they need to create space for and support the development of emerging GP consortia.

National level

2.6 Existing accountability arrangements will remain in place at national level during 2011/12, with the NHS Chief Executive remaining accountable for delivery. The NHS Chief Executive will hold the NHS to account for delivery on in-year requirements, QIPP delivery and supporting reform through a single integrated process.

2.7 The NHS Commissioning Board (NHSCB) will be established in shadow form as a Special Health Authority in 2011/12 and will become fully operational from 1 April 2012. When fully established, the NHSCB will be responsible for:

- supporting continuous improvements in quality and outcomes of NHS funded services;
- promoting and extending public and patient involvement and choice;
- ensuring a comprehensive system of GP consortia, supporting them and holding them to account, including working in partnership with local government and other organisations;
- directly commissioning certain services including primary medical care, other family health services, designated services specialised healthcare for those in prison or custody, and some aspects of military healthcare;
- allocating and accounting for NHS resources; and
- promoting equality and reducing inequalities in access to healthcare, in cooperation with Public Health England.

2.8 In 2011/12, the shadow NHSCB will focus its attention on:

- developing its own capability and capacity to ensure that it is fully fit for purpose from April 2012;
- overseeing the development of emerging GP consortia and the associated architecture including systems for authorisation, accountability, intervention and failure; and
- planning for 2012/13.

2.9 To support the implementation of an all foundation trust sector by 1 April 2014, the Provider Development Authority will have been established as a Special Health Authority by April 2012. The Authority will provide overall governance and performance manage NHS trusts until they become foundation trusts. The Authority will be wound down once there is an all foundation trust sector by 1 April 2014.

Regional level

2.10 SHAs will remain accountable at regional level during 2011/12 for operational delivery and the transition to new commissioning arrangements. In doing so, it is essential to ensure that current performance is maintained, and that QIPP delivers the improvement in NHS productivity and service quality set out in local plans. SHAs will oversee the development of PCT clusters and ensure local coherence across the local development of the new architecture, such as relationships between GP consortia pathfinders and local health and wellbeing board early implementers.

Local level

2.11 While PCTs will have a critical role up to April 2013, we do not expect to maintain 151 fully functional separate organisations up to that time, particularly if we want to offer capacity to emerging GP consortia. Because of this, and because of the broader drive to reduce running costs across the system, some regions of the NHS have already developed clusters of PCTs. In order to secure the capacity and flexibility needed for the transition period, we shall undertake a managed consolidation of PCT capacity to create such clusters across all regions of the NHS. Alongside this, staff will be increasingly assigned to emerging GP consortia to support their development.

2.12 The broad role of clusters will be twofold. Firstly, clusters will oversee delivery during the transition and the close down of the old system. In so doing, they will ensure PCT statutory functions are delivered up to April 2013. Secondly, clusters will support emerging GP consortia, the development of commissioning support providers and the emergence of the new system.

In so doing, they will provide the new NHSCB with an initial local structure to enable it to work with GP consortia. In creating clusters, our aim is to maintain the strength of the commissioning system in light of the significant financial challenges ahead.

2.13 Clusters will have a single Executive Team and will be in place by June 2011 at the latest in a form that is sustainable up to April 2013, and potentially beyond that date if the NHSCB chooses. Emerging clusters should be involved in the planning process for 2011/12 in anticipation of their future role. Where clusters are already in place, current geographical coverage will be maintained.

2.14 More specifically, clusters will sustain capacity in the system to:

- maintain and improve the quality and safety of services across their areas through the commissioning and contracting process;
- ensure delivery of 2011/12 and 2012/13 operational plans covering all aspects of operational delivery as set out in Chapter 6 including the development of longer term commissioning provision support in preparation for alternative organisational models beyond 2013;
- oversee management and implementation of medium term QIPP plans;
- oversee the local and regional planning process for 2012/13 and into 2013/14, increasingly involving and handing leadership to GP consortia;
- have oversight of closedown of PCTs;
- oversee commissioning planning, contracting and management for all services in the cluster area not delegated to GP consortia, such as primary care, and nationally and regionally commissioned specialised services;
- ensure governance, proper handling of statutory business, decision making and accountability through PCT boards;
- secure the delivery of PCT statutory responsibilities, ensuring all statutory functions are maintained, with a clear focus on priority issues, such as safeguarding;
- maintain talent and capability, working to retain key individuals through transition, making people available to support new structures and managing staff reductions fairly and effectively;
- ensure GP consortia have access to commissioning support up until April 2013;
- oversee the development of GP consortia during 2011/12, ahead of their authorisation; and

- maintain relationships with local government and other key partners, supporting local work to develop health and wellbeing boards and ensuring joint working is sustained and accelerated.

2.15 In addition, clusters will support the development of GP consortia through offering support, including:

- a development fund of £2 per head to support them in the development of their consortia. This will be resourced primarily from management cost savings realised from the MARS scheme. This should be in addition to, and used alongside, existing PBC funding and can be used flexibly to fund, for example, clinical backfill, training and organisational development;
- a qualified or accredited senior finance manager (this may be shared across consortia);
- an organisational development expert/facilitator;
- an individual with expertise of appropriate governance arrangements/ corporate affairs; and
- a commissioning expert to support the consortium in their assessment of those commissioning activities they will carry out themselves, those where they may choose to act collectively, and/or where they may choose to buy in commissioning support from external organisations both during the transition and beyond.

More detail on the governance arrangements and the process for forming clusters will be set out in the New Year.

2.16 Through cluster arrangements, PCTs must work with consortia to develop their Operating Plans as set out in Chapter 6. QIPP value for money improvement projections should be disaggregated to the level of consortia and developing consortia should be encouraged and supported to take on areas of QIPP delivery for which they are best placed. PCTs should provide support for the consortia development process, and empower consortia to take on new responsibilities when they are ready to do so.

2.17 Support and empowerment provided by PCTs, through cluster arrangements, will include:

- encouraging GP practices to work together to form consortia;
- delegating budgets with a dedicated management resource for consortia ready to take on responsibilities;
- helping consortia to understand and participate in the Joint Strategic Needs Assessment (JSNA) processes, in collaboration with local authority partners;

- creating support teams to provide technical functions that consortia can draw on;
- paving the way for a smooth transfer of existing joint commissioning, pooled budgets and section 75 arrangements; and
- ensuring a partnership approach to the whole commissioning cycle, considering the scope for greater use of joint commissioning where appropriate.

2.18 PCTs will receive specific allocations to support social care. PCTs will transfer this funding to local authorities for spending on social care services to benefit health and to improve overall health and social care outcomes. PCTs and local authorities will need to agree appropriate areas for social care investment and expected outcomes, and will work together in order to achieve these. The Government has recently set out its *Vision for adult social care: Capable communities and active citizens*[6] and updated its carers' strategy, *Recognised, valued and supported: next steps for the Carers Strategy*[7] which should be taken into account when agreeing local investment plans.

General Practice

2.19 All practices should be considering how they will group together into consortia, the objectives of their consortia and the best operating model to deliver these. All practices should ensure that they do this through engagement with their local communities. The support available for the development of GP consortia is set out earlier in this chapter. The Department is considering what support will be needed for leadership development in emerging GP consortia.

6 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121508
7 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122077

Commissioning transition timetable

Now – March 2011	PCTs to involve GP practices and emerging consortia, with other clinicians, in the 2011/12 contracting round and the broader commissioning cycle from 2011/12 onwards
December 2010	Initial GP consortia pathfinders identified
January – March 2011	Delegated responsibilities of pathfinder consortia confirmed with PCTs
January 2011 – March 2012	Further pathfinders identified and emerging consortia encouraged to become increasingly involved in commissioning and take on increasing delegated responsibilities
In 2011/12	NHS Commissioning Board set up in shadow form as special health authority
June 2011	PCT clustering arrangements in place
April 2012	All GP practices in GP consortia and start of NHS Commissioning Board authorisation of consortia
April 2012	NHS Commissioning Board established, takes over relevant responsibilities
April 2012	SHAs abolished and responsibilities allocated to bodies in the 2012/13 architecture
April 2012 – March 2013	NHS Commissioning Board to work with GP consortia that need further support to be ready to take on full statutory responsibilities
April 2013	Authorised GP consortia take on full statutory responsibilities
April 2013	PCTs abolished

Development of health and wellbeing boards

2.20 NHS commissioners will need to work closely with local authorities to establish shadow health and wellbeing boards. These will be the key vehicle for councils to carry out their statutory responsibilities to lead on integrated working and commissioning across the NHS, public health and social care in collaboration with other local agencies.

2.21 Through the health and wellbeing boards, NHS commissioners and councils, with representatives of public voice through local HealthWatch (currently LINks), will:

- do a Joint Strategic Needs Assessment (JSNA) to understand health and wellbeing needs of local populations, and agree shared priorities;
- using the JSNA, agree a Joint Health and Wellbeing Strategy across NHS, public health, social care and children's services; and
- support individual organisations, including GP consortia in linking their commissioning strategies to the Joint Health & Wellbeing Strategy.

2.22 These arrangements will need to be in place from April 2012, when GP consortia have shadow allocations and local authorities have shadow public health budgets. There will be a network of "early implementers" for health and wellbeing boards, linking closely to pathfinders for GP consortia.

Progression to NHS foundation trust status

2.23 All NHS trusts will become NHS foundation trusts (NHS FTs) by the end of 2013/14. This will include the newly established NHS trusts formed out of PCT provider arms. NHS trusts will be held to account at regional and national level for achieving the updated timetables submitted to the Secretary of State at the end of 2010. It will not be an option for organisations to decide to remain as an NHS trust, rather than become, or be part of an NHS FT. Subject to legislation, by 1 April 2014 all NHS trusts will cease to exist.

2.24 Achieving and sustaining the highest levels of quality and financial performance are a key pre-requisite for NHS FTs going forward and those are the standards that aspirant NHS FTs must meet. For NHS trusts who will have difficulty in reaching NHS FT status in their current form, realistic plans for alternative configurations need to be in place.

2.25 Under the leadership of the National Managing Director for Provider Development, SHAs are leading the development of the FT pipeline and must support NHS trusts to make the transition, making maximum use of options for providing support to help address challenges.

2.26 Following ratification of the timetables submitted to the Secretary of State, in January 2011 NHS organisations will receive advice on:

- the key issues NHS trusts face in achieving NHS FT status;
- the steps required to address those issues; and
- the practical actions that need to be taken, including agreements detailing the key work and timetable for achieving NHS FT status as a stand alone organisation, with an existing NHS FT or a different organisational form.

Transforming community services

2.27 A robust set of data for community services will be developed during 2011/12 and commissioners and providers of community services should make the necessary preparations for their introduction. This includes the accelerated deployment and utilisation of clinical applications to improve data collection and data flow and support reducing hospital admissions and demand management.

2.28 As required in the *Revision to the Operating Framework for the NHS in England 2010/11*, by 1 April 2011 all PCT directly provided community services must have been separated from PCT commissioning functions and the divestment of these services from PCTs completed or substantial progress made towards divestment.

2.29 There should be a level playing field for all providers. Commissioners, in their role of promoting greater patient choice and control, subject to affordability and quality considerations, should use the introduction of Any Willing Provider to enable greater participation by social enterprises to provide services, alongside other providers, starting with community services.

2.30 Commissioners, in developing their local commissioning strategies, should also consider how social enterprises and voluntary and community organisations can play a role both in the delivery of services and, through their expert knowledge, scoping the sorts of services and outcomes that communities want and need. Through this engagement and interaction, commissioners can begin to realise the ambitions of the Big Society.

2.31 The Government has recently announced the introduction of a "Right to Provide" for staff working in many public services. We shall issue guidance setting out how this can be applied to the NHS, creating new opportunities for NHS staff to lead service development and transformation through setting up and leading new social enterprises.

Stronger contracting

2.32 The arrangements set out in *Equity and excellence: Liberating the NHS* are predicated on much more effective use of contracting. PCTs and providers must use standard contracts and activate penalties and sanctions when appropriate.

2.33 All contracts between commissioners and providers must be signed before the start of the financial year. They should balance the needs of the whole health economy, including the delivery of QIPP efficiencies, and support participation in national clinical audits. PCTs need to ensure that contracts allow for providers to take responsibility for managing demand within their own organisations and avoid additional costs being placed on the system. For example, PCTs may identify clinically appropriate follow up ratios for out-patient appointments in certain specialties. PCTs may also use contract sanctions if they are not satisfied about the completeness and quality of a provider's data.

2.34 Standard contracts for acute and mental health service organisations that are integrating their local PCT provider arm services have been developed. These two new contracts will sit alongside the other standard contracts. Guidance has been circulated to SHAs on the use of these contracts when integrating PCT provider arm services.

2.35 For 2011/12, the opportunity has been taken to review and simplify the key process clauses in the contracts and to redraft some of the core clauses to improve clarity.

2.36 During 2011/12 and 2012/13, the contracts will be subject to fundamental revision to prepare for the needs of GP consortia and the NHSCB. The core elements of the contract will reflect the standard terms that providers will be expected to agree if they wish to provide services to NHS funded patients. The detailed service requirements to reflect local needs will be agreed with commissioners.

2.37 A bespoke contract based on the community services contract has been developed for the care homes sector. This one year interim contract, which expires on 31 March 2012, will be reviewed during 2011/12.

2.38 As part of the 2011/12 contracting round and for each of the coming contract years, PCTs should be mindful that the contracts with providers of NHS funded services must smoothly transition to GP consortia, and where appropriate, the NHSCB or local authorities. Guidance on this will be issued with the suite of standard contracts for 2011/12. It is essential for PCTs to involve local GPs, existing practice based commissioning and developing

GP consortia in the development and negotiation of their contracts with providers. Development of the tariff as set out in Chapter 5 will strengthen, in parallel, the options for commissioners to secure value and more responsive and integrated services.

Supporting the NHS workforce

2.39 The NHS remains committed to protecting and improving staff health and wellbeing, and reducing unnecessary sickness absence, as set out in Dr Steve Boorman's Review of NHS health and wellbeing[8].

2.40 High levels of staff engagement will help deliver the quality and productivity challenges organisations face and lead to improved outcomes for patients and better financial management in the NHS. The Department of Health and NHS Employers will make materials available to support organisations in achieving or maintaining high levels of staff engagement, particularly during the transition to the new system infrastructure. This will help in ensuring that unnecessary costs in respect of staffing changes between current NHS organisations and GP consortia are avoided.

2.41 The Centre for Workforce Intelligence will support local employers to take a strategic approach to workforce planning, developing a more flexible and responsive workforce and avoiding inappropriate responses to cost pressures.

Education and training

2.42 *Equity and excellence: Liberating the NHS* signalled a new approach to workforce planning, education and training that should give employers greater autonomy and accountability for planning and developing the workforce, alongside greater professional ownership of the quality of education and training. The Department of Health will publish a consultation document about how to put these principles into action. It will be important for providers, with effective local professional engagement, to work with SHAs and with patients, staff, commissioners, universities and other education providers on the design and implementation of the new framework. Advice on workforce planning, education and training will set out how the new system will develop. Providers will need to work in partnership with SHAs to ensure that suitable local arrangements are in place by April 2012.

2.43 NHS organisations will need to ensure they have in place the key components to underpin medical revalidation, in advance of an assessment of readiness in early 2012/13 to help doctors remain up to date and fit to practise throughout their career.

8 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108799

Pay and reward

2.44 The Government has announced a two year pay freeze with effect from April 2011 for those earning more than £21,000. This will help ease pressure on the pay bill as we enter a challenging financial period. Many staff are concerned about their security of employment, particularly over the next two years while we implement the QIPP reforms to release savings. Individual NHS organisations should be working in partnership with local trade unions and staff to redesign services so that they are delivered efficiently and ensure the quality and safety of care. This should include discussions to retain, retrain and redeploy staff wherever possible so as to avoid unnecessary loss of skills. It will be important that unnecessary costs in respect of staffing changes are avoided.

2.45 Proposals being discussed in partnership between NHS Employers and the NHS Trade Unions through the NHS Staff Council would provide staff with significantly improved security of employment in return for foregoing pay increments during 2011/12 and 2012/13 while protecting the integrity of national collective agreement. Any savings released by such proposals would be retained by individual NHS employers to enable them to protect staff from avoidable compulsory redundancies.

2.46 NHS terms and conditions remain competitive but are not always fully appreciated. NHS employers are therefore encouraged to support the maintenance of recruitment, retention, morale and motivation of staff by ensuring they are aware of their overall pay and reward package and the benefits available to them. Plans are in place to introduce total reward statements from 2012 to support this process.

3. Transparency and local accountability

3.1 The reform of organisational structures described in the previous chapter is only one part of the vision for the future NHS. *Equity and excellence: Liberating the NHS* set out a model for the NHS where the outcomes secured by local health services will be much more transparent and understandable by local people. This is part of a fundamental shift in accountability towards local communities, which is at the heart of the reform, creating a revolution in patient power, and enabling informed local discussion and decisions about spending, priorities and improvement. NHS organisations should account clearly for their investment priorities so that the public can understand how money is being spent.

3.2 Early in 2011, we expect to set out a more wide ranging set of proposals on how we intend to support the creation of this revolution in patient power. This NHS Operating Framework sets out some of the mechanisms to support this. Most notably:

- **a new Outcomes Framework for the NHS** – where the focus is on the health improvement achieved;
- **patient experience** – where there needs to be a shift to better collection of and timely action on patient experience and feedback;
- **better information** – where a new information strategy will set out how local commissioners and the people they serve can be better supported in decision making;
- **quality accounts** – which will be extended to cover community services; and
- **local publication** – where there is greater clarity of how expenditure translates into local achievements.

3.3 This transparency and better information will also support choice, allowing patients to make more informed decisions such as where and how they choose to access care. As well as making information more accessible, we shall be extending the range of choices available to patients.

3.4 During this time, *The NHS Constitution for England*[9] remains at the heart of the NHS system. The Government is committed to upholding the NHS Constitution, which codifies NHS principles and values, and the rights and

9 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113613

responsibilities of patients and staff. The Government's ambition for shared decision making by patients, their clinicians and carers builds on, and gives better effect to, the principle of involving people in decisions and their care.

A new Outcomes Framework for the NHS

3.5 The first NHS Outcomes Framework will be published in December 2010. From 2012/13, this is the framework that will be used by Secretary of State for Health to hold the NHSCB to account for improving quality and delivering better health outcomes for people using NHS services. The NHS Outcomes Framework for 2012/13 will not set levels of ambition for improvement in 2011/12. These will be negotiated between the Secretary of State and the NHSCB once it is in place. For this coming year, NHS organisations should take heed of the direction of travel towards focussing on outcomes, collecting data and establishing baselines for all indicators wherever possible and, in doing so, identifying how they will improve on quality.

3.6 The NHS Outcomes Framework will consist of a small set of outcome goals or domains, under each of which will sit overarching indicators and a small set of improvement areas. In the future, each domain will be supported by a suite of NICE Quality Standards[10]. These Quality Standards will support the NHS to commission services that will deliver the outcomes set out in the NHS Outcomes Framework by providing authoritative definitions of what high quality care looks like for a particular pathway of care. The NHSCB will use them to inform development of an outcomes framework for GP consortia and associated incentives for high quality commissioning.

3.7 Delivering the priorities set out in this NHS Operating Framework in 2011/12 will put the NHS in the best possible position to deliver better health outcomes and the ambitions that will be set out in the NHS Outcomes Framework for 2012/13 and beyond. There are some areas of priority that will be directly comparable. For instance, the improvements in relation to healthcare associated infection rates sought in 2011/12 will be an improvement area in the NHS Outcomes Framework for 2012/13. Public Health England will work with the NHS through its own outcomes framework to improve health. There are other areas where the requirements in 2011/12, which may be more focused on process or input improvements, will support improvement of outcomes in the future. For instance, progress on the cancer access indicators should support improvements in cancer survival rates.

3.8 The delivery of QIPP improvements will ensure that we have maximised the resources for frontline services so that they are well placed to continue delivering improvements to outcomes.

10 http://www.nice.org.uk/guidance/qualitystandards/qualitystandards.jsp

3.9 The promotion and conduct of research is a core NHS function. Continued research and the use of research evidence in design and delivery of services is key to achieving improvements in outcomes. The NHS Life Sciences Delivery Board affords the NHS the opportunity to work with the life sciences industries and roll out best practice so that it can deliver the financial savings that are being driven by QIPP. For example, the Board's remit to increase access to cost effective innovative medicines and medical technologies will be pivotal to improving quality and realising savings as the NHS evolves into its new structure.

Patient experience and feedback

3.10 Patient experience must be a key arbiter of all NHS services. PCTs and providers should continue to ensure that appropriate systems are in place to capture the views and experiences of patients, service users and carers. This will include use of local and nationally coordinated patient surveys, but also a range of additional approaches or sources that are locally relevant, such as the use of real-time feedback collected at the point of care (eg SMS texting, Patient Experience Trackers, kiosks), use of complaints data and Patient Reported Outcome Measures (PROMS).

3.11 The current PROMs guidance will be revised during 2011 to set out proposals for extending the use, collection and validity of PROMs across the NHS, wherever practicable.

3.12 PCTs and providers should raise awareness of local feedback options available (including, for example, patient ratings or comments on websites such as NHS Choices), encourage feedback, and also demonstrate to the public how their feedback has been used to improve service quality and patient experience through appropriate reporting mechanisms, such as Quality Accounts.

3.13 PCTs should use the intelligence from a range of sources such as those above to understand what matters most to patients in the widest sense (for instance, supporting patients to remain in employment), to ensure patient and staff feedback is acted upon and priorities for local improvement can be identified.

3.14 PCTs and providers, working with their partners, should ensure that patient experience and feedback are inherent parts of service design, delivery and improvement. PCTs should also make arrangements to ensure existing information and insight about local people's needs and preferences is not lost during transition and may be readily picked up and used by emerging GP consortia. PCTs must continue to ensure their statutory obligations under the Duty to Involve is effectively and efficiently discharged during transition to commissioning by GP consortia.

3.15 NHS organisations should consider the Government Buying Standards for food and catering when they are introduced.

Better information

3.16 The information revolution is a key component of the vision set out in *Equity and excellence: Liberating the NHS*. As well as being required to empower patients with more choice, better information and more control over their care, it plays a vital part in enabling effective commissioning for improved quality and productivity of care.

3.17 To support the NHS in planning and achieving this transformation, an Information Strategy will be published in early 2011 that will include more detail about the approach and priorities identified following completion of the public consultation on this topic[11]. Other key reviews, including the fundamental review of data returns and the Quality Information Strategy[12] will inform the Information Strategy.

3.18 In advance of this, a number of issues have already been identified and should be incorporated within plans for 2011/12:

- introduction of PROMS;
- use of real-time patient and service user feedback to improve quality of care;
- consistent use of the NHS number – from 2012/13, use of the NHS number will be linked to contractual payments from commissioners in line with guidance;
- use of digital technology in key areas to support delivery of the QIPP agenda, including:
  - use of telehealth and telecare to help people stay in their own homes;
  - introduction of digital or online services to deliver greater convenience for patients and to free up face-to-face clinical time for those who really need it;
- informatics requirements to support greater integration across local health and social care services; and
- supporting GP consortia in understanding and fulfilling their information needs, including appropriate skills and resourcing requirements.

11 Liberating the NHS – an Information Revolution: a consultation on proposals October 2010
12 National Quality Board Report on Information on the Quality of Services July 2010

Quality accounts

3.19 In 2011/12, NHS providers will need to publish their quality accounts for 2010/11. In doing so they should meet the requirements set out in guidance in relation to:

- the expectations for 2010/11 quality accounts, including likely revisions to regulations and formal guidance; and
- the extension of quality accounts to community services for 2010/11.

3.20 We expect to see providers build on the first year's quality accounts by demonstrating in 2010/11 quality accounts how they:

- perform on the measures that mean most to patients;
- review services and engage with patients, public and governors, in setting priorities for the future; and
- measure performance over time and in comparison with their peers.

Local publication

3.21 Quality accounts play a part in helping local populations understand how NHS services are improving the care that they provide, but they should not exist in isolation. It has not always been apparent to local people how they can understand where a national strategy translates into a local service. With that in mind, for 2011/12 PCTs should publish local plans where appropriate and, specifically, PCTs are required to publish their local plans to deliver both dementia services and services to support carers.

Choice

3.22 The Government is committed to extending the range of choices available to patients. By April 2011, all patients referred for an outpatient appointment should be able to choose a named consultant-led team. The guidance on choice informing providers' obligations under the NHS standard contracts will be amended such that, from April 2011, providers will be required to:

- accept patients who are referred to a named consultant-led team, as long as the referral is clinically appropriate;
- list their services on Choose and Book in a way that allows users to book appointments with named consultant-led teams; and
- publish information about services so that people can use it to make choices about their healthcare, and support people to use this information.

3.23 Following conclusion of the consultation process on choice, further changes to the guidance on choice informing providers' obligations under the NHS standard contracts may follow during 2011 to set out any new obligations with respect to choice as set out in *Equity and excellence: Liberating the NHS*:

- from April 2011, patients should be offered greater choice of treatment and provider in some mental health services;
- during 2011, patients should be offered greater choice in diagnostic testing and post-diagnosis care; and
- during 2011, choice should be introduced in care for long term conditions as part of personalised care planning.

3.24 The commitment to allow patients to choose any healthcare provider for the majority of NHS funded services, as long as the provider can deliver care within the NHS, meeting NHS standards and within the NHS tariff, will be introduced in a phased manner. Guidance on implementation will be published. From April 2011, patients should be able to start to choose any healthcare provider in a range of community services.

3.25 PCTs will need to work with GP practices and other stakeholders to make preparations for introduction of choice of GP practice from April 2012, subject to the policy framework to be published in 2011.

3.26 PCTs should develop and implement plans for shared decision making and information giving and should include these areas in contracts. PCTs should also publish, via *Your Guide* or similar mechanisms, an account of how they have delivered shared decision making and information giving.

Choice in maternity services

3.27 Choice in maternity services is a key Government commitment. Commissioners should use feedback gained from women and their families to ensure that appropriate information is provided for women and their partners so that they can make informed choices about their maternity care from preconception care, through pregnancy and after birth. Providers working in maternity networks are encouraged to use the data items suggested in the maternity and children's dataset to review, inform and plan the provision of care to meet the needs of women. Work will continue to develop the maternity tariff to ensure that money follows a woman's choices.

Personal health budgets

3.28 The Government is committed to expanding the use of personal budgets for service users. As set out in *Equity and excellence: Liberating the NHS*, this includes continuing and developing the personal health budget pilot programme, both extending existing sites and encouraging proposals for additional sites in 2011/12. The learning from the pilot programme will inform wider rollout in 2012. Personal budgets will allow greater integration between health and social care at the level of the individual and give people more choice and control over their care.

4. Service quality

Overall approach

4.1 This is a time of significant change. In 2011/12, we need to create the building blocks of the new architecture for the health and care system and deliver on the first year of the QIPP challenge to realise up to £20 billion in efficiencies for re-investment into services over the next four years.

4.2 The challenge in 2011/12 is to ensure that we effect the necessary changes while maintaining service quality, including the improvements that the NHS has worked hard to deliver to date. Successful transition to the new system will require a tight grip to be maintained on current performance, financial stability and the quality of services.

4.3 As part of this NHS Operating Framework, we have developed a list of key indicators against which PCTs and clusters will be held to account during 2011/12. The list is included as an Annex to this NHS Operating Framework and brings together:

- key performance indicators to support QIPP efficiencies;
- indicators relating to new commitments and reform; and
- clinically relevant indicators from existing measures.

4.4 It is important not to regard these indicators in isolation from each other or from the wider requirements set out in this NHS Operating Framework. For example, QIPP aims to release hospital capacity to allow the better use of community services. The requirement to reduce length of stay needs to be considered in the context of higher day case rates, increased responsibility on acute providers around emergency readmission rates and sufficient care home places. Thus, a PCT could meet its responsibilities to provide post-discharge support by securing additional social care places ensuring that, where clinically appropriate, patients are discharged both quickly and with sufficient capacity to support them outside hospital.

4.5 Through the transparency agenda, the focus is changing with a bigger role for local accountability and quality of services across the board in the NHS, delivering the outcomes that matter to all patients and their carers. At the same time, the Care Quality Commission is empowered to use its judgement to ensure NHS providers are meeting minimum standards and thus assure local people about the safety of their services. In this time of change, the NHS needs to keep a forensic focus on maintaining and improving quality

including patient safety, particularly in relation to older people. Delivery of the priorities in this NHS Operating Framework needs to be achieved alongside the core delivery and safety of services. The work of the National Quality Board will be particularly important to maintain and improve quality during the transition and beyond, as set out in Chapter 1.

Data quality

4.6 The NHS should use the Secondary Uses Service (SUS) as the standard repository for performance, monitoring, reconciliation and payments by April 2012, operating in shadow form from October 2011. During 2011/12, progress on delivery of this will be performance managed and commissioners will be expected to use contract sanctions if they are not satisfied about the completeness and quality of a provider's data.

Quality, innovation, productivity & prevention (QIPP)

4.7 The NHS has been preparing to meet the challenge of driving quality improvements against a much more restricted financial environment since the autumn of 2009. At that stage, it was working on scenarios of either flat real or flat cash funding from 2011/12 onwards, leading to an efficiency challenge of £15-20 billion over three years.

4.8 Three things have changed since those assumptions were made:

i) the Spending Review settlement for the NHS is better than the autumn 2009 assumption, with NHS revenue budgets growing in real terms over the next four years;

ii) the adoption of a pay freeze for most NHS staff for two years, whilst a tough decision, makes a positive impact on the remaining efficiency requirement for the first part of the QIPP period; and

iii) the deeper than originally modelled reductions in management and administration costs, whilst again tough and needing to be realised, make a positive impact on the remaining efficiency requirement.

4.9 Taken together, our assessment is that the prudent response to these welcome improvements is to retain the overall up to £20 billion challenge, but to extend the expected period to the end of 2014/15. This provides further time to produce the longer term change to services described in local QIPP plans, and should ease to some extent the measures required in early phases of local plans. It does not change the need for focus on delivery.

4.10 The single operational plan as set out in Chapter 6 needs to identify how QIPP will be delivered during 2011/12, which will include making the most of

the opportunities presented by the national workstream plans, for instance, the national workstream on long term conditions. This single operational plan should demonstrate how improved quality and outcomes will be delivered within the available resources, how other critical functions will be maintained through the transition and allow for the investment of savings to improve quality and outcomes as demand changes to reflect an ageing and growing population, new technology and ever-higher expectations.

4.11 NHS organisations must continue to ensure that they maximise efficiencies through reducing energy consumption and expenditure in line with guidance.

Reconfiguration

4.12 Changes to services will sometimes be required but must be consistent with the four key tests for service reconfigurations set out by the Secretary of State in May 2010[13]:

- support from GP commissioners;
- strengthened public and patient engagement;
- clarity on the clinical evidence base; and
- consistency with current and prospective patient choice.

4.13 PCTs must continue to ensure their statutory duty to consult Overview and Scrutiny Committees about substantial service change is maintained throughout transition. These tests are to support and improve the planning process and reduce the blockages that come from a perceived lack of transparency.

Key new commitments

Health visitors

4.14 PCTs should ensure they develop effective health visiting services, with sufficient capacity to deliver the new service model to be set out in the *Health Visitor Implementation Plan 2011-2015 – A Call to Action*, to deliver the Healthy Child Programme, provide greater support to families and develop local community capacity in support of children and families, working closely with Sure Start Children's Centres and other local services. The Government is committed to developing an expanded and stronger health visiting service as a key element in improving support to children and families at the start of life. This will entail ending the decline in workforce numbers, beginning to increase posts, workforce numbers and training capacity in the short term, and increasing overall numbers of health visitors by 4,200 by April 2015.

13 http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_116442

Family Nurse Partnerships

4.15 The NHS is expected to expand the Family Nurse Partnership programme to improve outcomes for the most vulnerable first time teenage mothers and their children. This licensed programme offers intensive preventive support from early in pregnancy until children are two years old. The Government intends that the current capacity of over 6,000 clients in England at any one time should more than double to a capacity of at least 13,000 by April 2015. PCTs should therefore consider how to maintain existing delivery, alongside planning for an expanded service in appropriate areas.

Cancer Drugs Fund

4.16 As set out in *Equity and excellence: Liberating the NHS,* a new Cancer Drugs Fund will be established. This fund will operate from April 2011 and will help NHS patients get the additional cancer drugs their doctors recommend. £200 million is being provided to the NHS in 2011/12 for this fund and the level of annual funding available will remain constant over the life of the fund. Advice will be provided on the detailed operation of the fund following consultation.

Military and veterans' health

4.17 It is important that SHAs develop and maintain their Armed Forces Networks to ensure the implementation of the Ministry of Defence/NHS Transition Protocol for those who have been injured in the course of their duty, meeting veterans' prosthetic needs and ensuring the implementation of the Murrison Report (*Fighting Fit – A mental health plan for servicemen and veterans*)[14] to improve mental health services for veterans. SHAs must ensure continuity of this work during the NHS transition period. At the same time, there is an expectation that NHS employers should be supportive towards those staff who volunteer for reserve duties.

Services for people with autism

4.18 NHS commissioners and trusts will be required by new guidance, to be issued in December 2010, to take action to assess the needs of people with autism in their areas, then plan and commission services as appropriate to address those needs. This guidance, which is intended to give effect to the Adult Autism Strategy – *Fulfilling and rewarding lives: the strategy for adults with autism in England* [15] will be issued under Section 2 of the Autism Act 2009[16].

14 http://www.mod.uk/DefenceInternet/AboutDefence/CorporatePublications/PolicyStrategyandPlanning/FightingFitAMentalHealthPlanForServicemenAndVeterans.htm
15 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113369
16 http://www.legislation.gov.uk/ukpga/2009/15/contents

Dementia services

4.19 People with dementia and their carers need information to help them understand the range and quality of local services. NHS organisations are expected to make progress on the National Dementia Strategy, including the four priority areas as set out in the implementation plan published in September 2010:

- good quality early diagnosis and intervention for all;
- improved quality of care in general hospitals;
- living well with dementia in care homes; and
- reduced use of antipsychotic medication.

4.20 NHS organisations should also agree with their social care commissioning partners the aspects of the strategy that could be delivered by using section 75 flexibilities.

Support for carers

4.21 NHS organisations should consider *Recognised, valued and supported: next steps for the Carers Strategy*[17] which focuses on four priority areas:

- identifying carers earlier;
- supporting carers to achieve their full education and employment potential;
- personalised support for carers so they can live a full life; and
- supporting carers to remain mentally and physically well.

4.22 It has not always been apparent how funding to support carers has been used in each PCT. The Spending Review has made available additional funding in PCT baselines to support the provision of breaks for carers. PCTs should pool budgets with local authorities to provide carers' breaks, as far as possible, via direct payments or personal health budgets. For 2011/12, PCTs should agree policies, plans and budgets to support carers with local authorities and local carers' organisations, and make them available to local people.

17 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122077

Maintaining quality improvements

4.23 To reflect the move to a more outcomes focussed approach, the Revision to the NHS Operating Framework for 2010/11 ended performance management of 18 weeks waiting times and changed the four hour A&E standard. As we move to a transparency and outcomes approach, both of these areas will still be important during 2011/12 but will be approached differently in performance terms.

Referral to treatment times

4.24 Patients' rights to access services within maximum waiting times under the NHS Constitution will continue and commissioners should ensure that performance does not deteriorate and where possible improves during 2011/12. With that in mind, providers should be expected to offer maximum waiting times to patients and there will be monitoring of compliance with this and the 95th percentile of waiting time. The median wait will also continue to be monitored with a view to improvement. The existing cancer waiting times standards support better clinical outcomes and will continue to apply.

Accident and emergency (A&E) services

4.25 Working with the College of Emergency Medicine and the Royal College of Nursing, the National Clinical Director for Urgent and Emergency Care has developed a set of indicators to look at the performance of A&E departments in the round. For 2011/12, the expectation is that there is an improvement in performance across this set of indicators.

4.26 In line with the recommendations made by Professor Sir John Temple in *Time for training*[18] (May 2010) and those of Professor Sir John Collins in *Foundation for Excellence*[19] (November 2010), providers should take opportunities to redesign urgent and emergency care services as increasing numbers of emergency medicine doctors complete their training.

Ambulance services

4.27 Working with ambulance trusts, the National Ambulance Director has developed a set of indicators to provide a broad overview of the clinical quality achieved by ambulance services. For 2011/12, the expectation is that there is an improvement in performance across this set of indicators in ambulance trusts, with all trusts meeting the Category A response time standards.

18 http://www.mee.nhs.uk/PDF/14274%20Bookmark%20Web%20Version.pdf
19 http://www.mee.nhs.uk/pdf/401339_MEE_FoundationExcellence_acc.pdf

Healthcare associated infections (HCAI)

4.28 The NHS has made good progress in reducing MRSA bloodstream and *Clostridium difficile* infections. There is still scope to drive these and other healthcare associated infections (HCAIs) down further. NHS organisations should aim for a zero tolerance approach to all HCAIs and all organisations must identify and adjust plans so that they can operate at the level of the best. NHS providers and commissioners should ensure that their HCAI improvement plans deliver at least the level of performance set by the HCAI indicators.

4.29 Following the extension of mandatory reporting for meticillin sensitive *staphylococcus aureus* (MSSA) and *E. coli* bloodstream infections, organisations must ensure this data is entered in a timely manner. NHS providers and commissioners should set local ambition for these infections by agreeing stretching goals through contracts.

Eliminating mixed sex accommodation (MSA)

4.30 All providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient, in accordance with the definitions set out in the Professional Letter CNO/2010/3[20].

4.31 From April 2011, all providers of NHS funded care must routinely report breaches of sleeping accommodation, as set out in national guidance, and will attract contract sanctions in respect of each patient affected. Each year, on or by 1 April, all such organisations must declare that they are compliant with the national definition or face financial penalties. PCTs should report to SHAs, on an exception basis, those organisations that have had financial sanctions applied, or those whose compliance status has changed.

4.32 Breaches relating to bathroom / WC accommodation, provision of women-only day areas in mental health units, and "passing through" opposite-sex areas should be monitored and managed through contract performance mechanisms. Where action plan milestones are missed, commissioners may impose financial consequences as set out in the national contract guidance.

20 http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Professionalletters/Chiefnursingofficerletters/DH_121848

End of life care

4.33 The NHS should continue to ensure implementation of the *End of Life Care Strategy – promoting high quality care for all adults at the end of life*[21], working to offer patients the choice of where to be cared for as they approach the end of life, and where to die, regardless of their condition. It should ensure that staff are trained for this, including using the e-learning modules available as part of blended learning.

4.34 The QIPP End of Life Care workstream is driving the first two steps on the strategy's end of life care pathway – identifying people as they approach the end of life and planning for their care, including asking about their preferences for care. To make that choice a real option requires implementation of the other strands of the strategy – commissioning the care people want, coordinating care across sectors and training the workforce to provide it. In particular, commissioners need to ensure that adequate 24/7 community services are available in their locality.

Cancer reform

4.35 The NHS will be expected to implement the forthcoming *Improving Outcomes Strategy for Cancer*. Patients should have timely access to diagnosis and treatment and be seen by the right person with the appropriate expertise. In particular:

- commissioners and local providers will need to ensure services are being planned, commissioned and delivered based on the current suite of cancer waiting time standards;
- commissioners and local providers will want to consider the four priority areas for diagnostics for improving earlier diagnosis of cancer and ensure continuity of commissioning and provision is secured in the move to commissioning by the NHSCB and GP consortia:
  - **chest x-ray**: to support diagnosis of lung cancer;
  - **non-obstetric ultrasound**: to support diagnosis of ovarian cancer;
  - **flexi sigmoidoscopy/colonoscopy**: to support the diagnosis of colorectal cancer; and
  - **MRI brain**: to support diagnosis of brain cancer.
- to improve outcomes from radiotherapy treatment for cancer patients, commissioners should develop local plans to ensure that access rates to radiotherapy and the use of advanced radiotherapy techniques, such as Intensity Modulated Radiotherapy are appropriate for their populations;

21 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086277

- commissioners should work with their cancer networks on implementation of NICE Improving Outcomes Guidance (IOG). There remain some services that are not yet compliant with some of the IOGs, particularly upper gastro-intestinal, urology, head and neck and haematology; and
- to provide the data needed to assess whether progress is being made on improving survival rates through earlier diagnosis, providers are expected to include staging information in their cancer registration dataset.

Cancer screening

4.36 Screening improves clinical outcomes. Commissioners need to work with their cancer networks to ensure that all screening services are able to:

- continue to take part in the breast screening age extension randomisation project, either screening women aged 47-49 or 71-73, depending on the randomisation protocol;
- ensure that all local centres maintain the two-year screening round for bowel cancer. The extensions begun in 2010/11 should continue and be maintained for 2011/12. Those centres whose end of original round is in 2011/12 should implement extension on completion of the original round. Those whose two-year screening round falls beyond 2011/12 should prepare to expand on completion of the original round; and
- ensure that cervical screening results continue to be received within 14 days. Commissioners should work with their local services and NHS Cancer Screening Programmes to implement HPV testing as triage for women with mild or borderline results, leading to a more patient centred service and major cost savings.

Stroke

4.37 The Stroke Strategy, published in late 2007, is a ten-year programme for implementing high quality stroke care across the care pathway from prevention to long term care and support. Good progress has been made to date including the response to the 2010/11 Accelerating Stroke Improvement programme. There remains scope for improving outcomes by:

- **prevention**: improving diagnosis and treatment of people with atrial fibrillation and ensuring that people who are at high risk of stroke who present with a transient ischaemic attack (TIA) are assessed and treated as emergencies. A best practice tariff is being introduced for out-patient TIA services in April 2011 to support high quality care for this group of patients;
- **acute care**: ensuring all stroke patients are admitted directly to a stroke unit, access timely scanning, and all patients are assessed for thrombolysis, receiving it if clinically indicated;

- **post hospital discharge and longer term care**: for example, developing Early Supported Discharge arrangements and community specialist stroke rehabilitation, with effective reablement support where responsibility rests with the PCT.

Mental health

4.38 The Mental Health Strategy, due to be published in early 2011, will make clear the interdependence of physical and mental health and the need for a balanced approach to investment to achieve improved health outcomes for all age groups. The strategy will encompass the twin objectives of improvement of public mental health and wellbeing, and delivery of high quality patient centred outcomes by health services. Early intervention and prevention should be used further to reduce the likelihood of mental illness developing, including within groups at high risk such as offenders. To support treatment for offenders, NHS organisations should work with local partners to deliver joined up local commissioning of drug services based on the Prison Drug Treatment Strategy Review Group's outcome framework.

4.39 Access to evidence based early intervention services in the community should continue to be available to all young people who need these services. Community teams providing home treatment and acute inpatient services should work together to avoid unnecessary hospital admissions, or unnecessarily long stays, while maintaining high quality care. Subject to the outcome of consultation, we also propose to increase choice and control for many users of mental health services, including introducing *Any Willing Provider* for a range of services.

Increasing access to psychological therapies (IAPT)

4.40 The NHS is expected to continue expanding access to psychological therapy services in 2011/12 as part of the overall commitment to full roll-out of this programme by 2014/15. This will comprise continuing training programmes to develop the workforce and a choice of NICE-approved therapies and delivering the measurable outcomes of patient recovery and improvements in employment.

4.41 In partnership with the NHS, the Department of Health will extend access to talking therapies for children and young people, older people, for people with severe and enduring mental health problems and for people with co-morbid mental and physical health long term conditions.

Safeguarding children

4.42 The findings of the Munro Review of child protection will be completed in April 2011. The response to this review is likely to impact on the way the NHS contributes to safeguarding children. In the meantime and throughout the transition period, the NHS should continue to build on the improvements to date in this area and ensure that statutory duties, as set out in the statutory guidance *Working Together to Safeguard Children*[22], and partnership working arrangements are maintained and handed over to new organisations in good order.

Dentistry

4.43 PCTs should continue to commission improvements in access to NHS dentistry, and seek to improve efficiency through effective management of dental contracts to minimise unnecessary recalls and split courses of treatment. They should work with dentists and other agencies to promote improvements in the oral health of children. As part of the development of a new dental contract, the Department of Health will announce proposals for contract pilots in 2011/12, and seek volunteers to take part. PCTs are encouraged to identify and support potential pilot sites.

Areas for improvement

Healthcare for people with learning disabilities

4.44 The NHS should ensure momentum is maintained in improving care and outcomes for people with learning disabilities, in the light of the *"Six Lives" Progress Report*[23], the Government's response to the 2009 report of the Parliamentary and Health Service Ombudsman and Local Government Ombudsman on health for this group. Using information gathered locally in partnership with people with learning disabilities and their families, PCTs should ensure they are taking action to improve healthcare and health outcomes.

4.45 Findings presented to the Ombudsman suggest particular emphasis should be given to ensuring staff are trained to make reasonable adjustments, communicate effectively and follow the *Mental Capacity Act (2005) Code of Practice*[24] in all their interactions with patients with learning disabilities to ensure full compliance with the law in respect of capacity, consent and best interest decision making. Annual health checks for people with learning disabilities remain an important means of ensuring improved access to health services.

22 http://publications.education.gov.uk/eOrderingDownload/00305-2010DOM-EN.pdf
23 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_120251
24 http://www.publicguardian.gov.uk/mca/code-of-practice.htm

Children and young people's physical and mental health

4.46 Both the report by Sir Ian Kennedy[25], commissioned by Sir David Nicholson, and *Achieving Equity and Excellence for Children*[26], which sets out how the NHS White Paper relates to children and young people, highlight the need for the NHS to pay greater attention to the needs of children, young people and families in commissioning and delivering services. NHS organisations should consider the issues they raise, particularly in the management of transition throughout 2011/12 and, as identified, pay particular attention to groups with specific needs including disabled children, palliative care, and child and adolescent mental health services (CAMHS), children in care and families with multiple problems.

Diabetes

4.47 All people with diabetes should be offered screening for early detection and, if needed, treatment of retinopathy. NHS commissioners and providers must do more to ensure insulin pumps are available for those people with diabetes that meet the criteria recommended by NICE.

4.48 PCTs should be commissioning the relevant structured patient education to support people newly diagnosed with diabetes and at appropriate points in their life as their condition progresses.

4.49 NHS providers should consider the overall management of inpatients with diabetes in order to reduce their length of stay, improve their experience of care, ensure that they do not develop diabetic foot complications whilst in hospital and that their blood glucose is managed safely. This is particularly relevant to the safe administration of insulin by healthcare professionals.

Sharing non-confidential information to tackle violence

4.50 All acute trusts should share non-confidential information with Community Safety Partnerships in order to support reductions in the number of violence-related attendances in A&E departments.

Violence against women and girls

4.51 In November 2010 the Department published *Improving services for women and child victims of violence: the Department of Health Action Plan*[27]. Women and children who are victims of violence or abuse use all NHS services; in particular primary care, maternity care, genito-urinary medicine (GUM) and mental health services. NHS organisations should ensure that they properly identify these patients and have suitable care pathways in place to ensure that they get the sensitive, ongoing care they need.

25 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119445
26 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_119449
27 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122003

Regional trauma networks

4.52 All regions should be moving trauma service provision into regional trauma network configurations in 2010/11. Tariff changes will be introduced from April 2011 that are designed to recompense for the complexity of multiple-injury patients. Designated Major Trauma Centres should be planning the continuous provision of consultant led trauma teams, immediate CT scan options, and access to interventional radiology services for haemorrhage.

Respiratory disease

4.53 The 2010 public consultation on a Strategy for Services for Chronic Obstructive Pulmonary Disease (COPD) in England revealed strong consensus support for the 24 recommendations and PCTs are asked to continue the task of delivery. Diagnosis of COPD is a particular problem with individuals often presenting late with disabling disease. If these patients were identified and managed effectively, the burden of those who progress to severe or very severe disease would be significantly reduced for the NHS as well as for patients and their carers.

Maintaining quality in public health

4.54 *Healthy lives, healthy people: Our strategy for public health in England*[28] sets out a mission to create a new public health service with strong local and national leadership. This will include creating a new, dedicated public health service – Public Health England – as part of the Department of Health. Subject to Parliamentary approval, Public Health England will take on full responsibilities from 2012, including the formal transfer of functions and powers from the Health Protection Agency (HPA) and the National Treatment Agency for Substance Abuse (HTA).

4.55 Directors of Public Health will be responsible for key public health functions, using their position as part of local authorities to tackle the wider determinants of health. Local authorities will have shadow allocations from 2012/13, in anticipation of receiving full allocations from 2013/14.

4.56 The NHS will continue to have a crucial role in public health. Preventing ill health, supporting people with long term conditions, improving access to care for the whole population, reducing inequalities and tackling health emergencies are all key functions of the NHS. NHS commissioners should be working with local authorities on ensuring the healthy living programme is in place. This will involve creating an identifiable health improvement budget, working closely with local authorities and health and wellbeing boards.

28 http://www.dh.gov.uk/en/Publichealth/Healthyliveshealthypeople/index.htm

4.57 In 2011/12, the NHS must continue to lead on improvements to public health, ensuring that public health services are in the strongest possible position when responsibilities are devolved to local authorities. That will involve realising the ambitions of the Big Society though greater involvement of social enterprises in the commissioning of services.

4.58 NHS organisations must continue to maintain performance whilst also managing the transition towards the new commissioning and governance arrangements of the NHSCB and GP consortia and local authority health and wellbeing boards. This is vital in relation to the prevention component of the QIPP challenge.

4.59 NHS organisations will continue to be held to account against the existing public health indicators.

Pharmacy

4.60 It is important that NHS organisations continue to maintain and develop pharmaceutical services, including local enhanced services to meet pharmaceutical needs. Optimising the use of medicines in people with newly diagnosed long term conditions, and targeting of Medicines Use Reviews are areas that SHAs and PCTs should actively engage in. In addition, evidence continues to build for the provision of public health services through community pharmacies, as highlighted in *Healthy Lives, Healthy People: Our strategy for public health in England.*

Emergency preparedness

4.61 Emergency preparedness and resilience across the NHS continues to be a high priority. All NHS organisations, other contracted healthcare providers, local authorities and other local organisations should maintain and test plans and arrangements to deliver an effective response to threats and hazards, including Chemical, Biological, Radioactive and Nuclear (CBRN), conventional terrorism, fuel and supplies disruption, flooding and public health incidents and any impact from climate change. They should have robust and tested command and control systems, as well as meeting their local obligations under the Civil Contingencies Act 2004. PCTs must also ensure that they maintain the current capability and capacity of the existing 12 Hazardous Area Response Teams (HARTs) in Ambulance Trusts now that funding for HARTs is in their allocations.

4.62 It is essential that all NHS organisations have well developed plans in place to manage exceptional surges in activity. Experience from swine flu demonstrated the benefits of robust planning and leadership for NHS resilience more widely and these lessons should be fully embedded in local

plans. In particular, all NHS organisations will need to ensure that they have the necessary plans in place to maintain service provision and meet any additional demands arising from events associated with the Olympic and Paralympic Games in 2012.

4.63 Pandemic influenza remains a serious threat and NHS organisations will wish to ensure that the ability to operationalise and coordinate their pandemic response plans across local areas is maintained and continues to be tested with their local partners. All local plans should be able to deal with a range of potential levels of pressure, from the relatively mild, such as swine flu, through to much more severe pandemics.

Physical activity

4.64 PCTs should engage with local authorities and other partners to support and embed community physical activity initiatives for all ages alongside activity in schools in preparation for the 2012 Games. Implementing the *Let's Get Moving* physical activity pathway will enable GPs and other healthcare practitioners to identify adults who do not currently meet recommended activity levels and support them in being more active. Directors of Public Health, working with local authorities, are encouraged to promote activities that improve the health of all sections of the populations they serve, such as schemes to promote physical activity, building on and complementing 5-A-DAY activity and the *Change4Life* campaign.

NHS Health Check programme

4.65 Whilst improvements continue to be made in managing people with heart disease, stroke, diabetes and kidney disease, the NHS Health Check programme works to prevent these diseases, or spot them earlier, and will significantly contribute to the NHS achieving better outcomes. Most PCTs now have a programme in place and are looking at ways to ensure that it positively contributes to reducing health inequalities. PCTs are asked to continue to progress the implementation of their programmes and ensure that, when doing so, they look at ways to reduce health inequalities from vascular disease. During 2011/12, the results of pilots of health checks for carers will be published, PCTs should consider the findings of this work in the development of NHS health check.

Abdominal aortic aneurysm screening

4.66 Phased implementation of the NHS Abdominal Aortic Aneurysm national screening programme is in progress, with complete coverage planned by the end of 2012/13. PCTs are expected to:

- continue screening for programmes that are currently operational;
- implement screening as planned for the 2011/12 phases; and
- develop a robust implementation plan for 2012/13, ensuring surgery providers fulfil the requirements for implementation of screening.

Fragility fractures in the elderly, especially in women

4.67 The introduction of the best practice tariff for hip fracture in 2010 has proved successful in transforming the care on admission of those who suffer fragility fractures each year. PCTs are also asked to take steps to reduce incidence. The best way to prevent this transformative injury is to recognise precursor or "herald" fractures and give patients a bone health assessment and treatment when they first show clear signs of being at risk.

5. Finance and business rules

Surplus strategy 2011/12 onwards

5.1 During 2010/11, the PCT/SHA sector has continued to deploy the revenue surplus, which has built up over the last few years, while maintaining a strong financial position.

5.2 As we move forward into a period of significant change, the emphasis of the NHS financial strategy will be to ensure that PCTs and SHAs are in the best possible position to implement the objectives of *Equity and excellence: Liberating the NHS*. This will mean that PCTs and SHAs should continue to maintain a strong financial position underpinned by demonstrable financial flexibility.

5.3 In line with current policy, the aggregate surplus delivered in 2010/11 by SHAs and PCTs will be carried forward to 2011/12 and continue to be available to those organisations. In 2011/12, the expected drawdown of surplus will be up to £150 million with the additional expectation that this drawdown will come from the PCT sector surplus. SHAs will determine and agree with the Department of Health the level of aggregate PCT/SHA sector surplus for their area to be delivered in 2011/12 and how that agreed surplus is distributed between their PCTs and themselves.

5.4 The Department continues to require that no PCT will plan for an operating deficit in 2011/12. NHS trust operating deficits will only be accepted where this is part of a planned recovery path agreed with the relevant SHA and the Department.

5.5 In the 2010/11 NHS Operating Framework we introduced the requirement for SHAs to ensure that there was at least 2 per cent non-recurrent expenditure from PCT recurrent resources at a regional level to mitigate financial risk. We shall build on this in 2011/12 and require every PCT to ensure that 2 per cent of their recurrent funding is only ever committed non-recurrently. PCTs will have the discretion to increase this percentage.

5.6 To reinforce financial control in 2011/12, this 2 per cent of recurrent resource will be held by SHAs, with PCTs being required to submit business cases to access the funding that demonstrate the non-recurrent nature of the expenditure proposed. The business case will need to be supported by the SHA Directors of Finance group.

5.7 Any surplus drawn down by a PCT cannot count against the 2 per cent of its resources held by the SHA.

5.8 Building upon and maintaining the non-recurrent expenditure is crucial for both managing the transition and maintaining the financial health of the NHS.

5.9 The utilisation of the 2 per cent of recurrent resources must retain the characteristic of being recurrently uncommitted, ie the related expenditure is a "one-off" or can be stopped in year. Further detail about what should be classified as non-recurrent expenditure will be laid out in the financial planning guidance.

5.10 GP consortia will have their own budgets from 2013/14. They will not be responsible for resolving PCT legacy debt that arose prior to 2011/12. PCTs and clusters must ensure that through planning in 2011/12 and 2012/13, all existing legacy issues are dealt with. During this period we expect developing GP consortia to work closely with PCTs to ensure that financial control and balance is maintained to prevent PCT deficits in those years. This will reduce the risk for GP consortia that they could have responsibility for any post 2010/11 PCT deficit unresolved at the point of PCT abolition.

5.11 It is important that the strong financial position that the NHS has built up over the last few years is maintained, particularly during the period of transition. A key factor in achieving this will be the need to maintain financial control. As such, the Department will require SHAs and PCT clusters to have an increased focus on maintaining strong financial control and good governance during transition.

PCT allocations

5.12 PCTs' recurrent allocations for 2011/12 are published alongside this NHS Operating Framework. In headline terms, average growth in recurrent allocations for PCTs is 2.2 per cent. Minimum growth is 2.0 per cent. 2011/12 PCT recurrent allocations now include funding of £150 million for reablement. Separate allocations to PCTs, outside recurrent allocations, are also published for support for social care, primary dental services, general ophthalmic services and the pharmaceutical services global sum. Total PCT allocations increase by £2.6 billion, ie 3.0 per cent with a minimum increase of 2.5 per cent and a maximum increase of 4.9 per cent. PCT recurrent allocations are based on a revised weighted capitation formula, details of which are also being published.

Running costs

5.13 2010/11 will be the last year for reporting PCT and SHA management costs. In order to prepare for the new system, from 2011/12, PCTs and SHAs will be required to report their running costs. The precise definition for running costs will be included within the financial planning guidance, but in broad terms, the definition will include any cost incurred that is not a direct payment for the provision of healthcare or healthcare related services.

5.14 By 2014/15 the overall running costs of the new NHS superstructure, compared to the running costs of the current NHS superstructure, will decrease by one third. This decrease includes the over 45 per cent reduction in management costs detailed in *Equity and excellence: Liberating the NHS*, in relation to SHA and PCT non provider management costs. The detailed trajectory for releasing the running cost savings will be included within the financial planning guidance.

5.15 In addition, the financial planning guidance will allocate this running costs reduction by region and it will be for SHAs to determine how the target reduction is managed across the region. SHAs should ensure that plans are not limited to simply achieving the target and should aim to go further to ensure all possible efficiencies are realised.

5.16 *The Revision to the Operating Framework for the NHS in England 2010/11* said that we would set out how resources will be released from the infrastructure and running costs of SHAs and PCTs in order to provide a running cost allowance for GP consortia. The expectation is that GP consortia will have an allowance for running costs that could be in the range of £25 to £35 per head of population by 2014/15. We will not determine the exact amount until further work has been undertaken with pathfinders. This work will explore the optimal balance between ensuring sufficient investment in organisational sustainability with maximising resources for front line services. Before this, during their development phase, the running costs will be locally agreed within the running cost envelope for each region.

5.17 In 2011/12, in line with NHS foundation trust reporting, NHS trusts will no longer be required to report on management costs.

QIPP reporting and monitoring

5.18 Moving into 2011/12 and beyond, the Department will monitor performance against QIPP requirements through the single process set out in Chapter 6. This will aid consistency and accuracy, and intends to simplify how reporting on QIPP is progressing at a local, regional and national level.

5.19 Monitoring of efficiencies will focus on several key areas, including those savings which are driven by changes in demand, and those which are cash releasing. Monitoring will also assess the re-investment of these savings.

5.20 Details on the regularity and format of monitoring will be included in the planning guidance.

Capital

5.21 Capital allocations to cover trusts' capital resource limit (CRL) and external financing limits (EFLs) will be based on capital expenditure plans agreed by SHAs, subject to national affordability. The primary source of capital funding will continue to be internally generated cash with additional finance provided through interest bearing loans. As with previous years, any unspent capital allocation in 2010/11 will not be carried forward. There is no expectation that a central capital budget programme for allocation to the NHS will exist in 2011/12. All NHS capital requirements will therefore be handled as part of the planning process.

5.22 In 2011/12, there will be no automatic capital allocation for PCTs, with necessary capital funding for PCTs being granted on a case-by-case basis. Capital funding for community services will follow the regime for NHS trusts, where new community trusts have been created, or the regime applicable for the organisation they transfer into. There are no changes planned in 2011/12 to the capital regimes currently operating in the NHS trust or foundation trust sectors.

5.23 The Spending Review has set a reduced capital envelope for health and social care. Maintenance and essential smaller improvement schemes should not be affected by this reduction and trusts should take account of the effects of investment on ongoing expenditure, with greater scrutiny of economic returns in business cases. The NHS has pledged to provide a clean and safe environment that is fit for purpose, based on national best practice. Therefore, NHS trusts must prioritise urgent backlog maintenance work to deliver this duty. Provision of additional single en-suite rooms needs to be included in considering capital investment to eliminate mixed sex accommodation (MSA), improve patient's privacy and dignity and provide increased isolation facilities for infection control.

Social care

5.24 In 2011/12 PCTs will receive allocations totalling £648 million to support social care. Indicative allocations, totalling £622 million, will also be set out for 2012/13[29]. This is in addition to the funding for reablement services that is incorporated within recurrent PCT allocations of £150 million in 2011/12 rising to £300 million from 2012/13.

29 These allocations are based on the adult social care relative needs formulae, in order to reflect social care need.

5.25 PCTs will need to transfer this funding to local authorities to invest in social care services to benefit health, and to improve overall health gain. Transfers will need to be made via an agreement under Section 256 of the 2006 NHS Act.

5.26 PCTs will need to work together with local authorities to agree jointly on appropriate areas for social care investment, and the outcomes expected from this investment. This could include current services such as telecare, community directed prevention (including falls prevention), community equipment and adaptations, and crisis response services. The Department would expect these decisions to take into account the Joint Strategic Needs Assessment for their local population, and the existing commissioning plans for both health and social care. PCTs should work with local authorities to achieve these outcomes in a transparent and efficient manner, with local authorities keeping PCTs informed of progress using appropriate local mechanisms.

Financial planning guidance

5.27 As part of the single planning process set out in Chapter 6, financial planning guidance will be issued in January 2011 and will include the detailed rules underpinning the financial strategy and the financial plans required for 2011/12.

Tariff

5.28 *The Revision to the Operating Framework for the NHS in England 2010/11* and *Equity and excellence: Liberating the NHS* set out priorities for the development of the payment system. The design and structure of the national tariff for 2011/12 signals the start of a series of changes to be made over the coming years, and has been informed by a number of key priorities:

- Quality and outcomes
- Efficiency and value for money
- Integration and patient responsiveness
- Expanding the scope of the tariff

5.29 The coverage of best practice tariffs, first introduced in 2010/11, will be expanded to cover a number of new service areas, and it is anticipated that this expansion will accelerate in 2012/13 and beyond. Best practice tariffs are designed not only to promote better patient outcomes and experience, but also to deliver gains in productivity and efficiency.

5.30 To drive efficiency further in the tariff we are changing the way in which long stays in hospital are funded by introducing a five-day trim point floor, so that relatively short stays do not attract a long stay payment. In addition, we have set all tariffs 1 per cent below the average as an initial step in pricing policy to set tariffs below the national average level. The change to the calculation of trim points, setting tariffs below the average, and the expansion of best practice tariffs, mean that a 2 per cent efficiency requirement has been "embedded" into the tariff. This has been taken into account when determining the efficiency deflator set out in the pay and prices tariff adjustment.

5.31 The national efficiency requirement in 2011/12 is 4 per cent and the uplift for pay and price inflation is assessed at 2.5 per cent. Consequently, the prices for services outside the scope of the national tariffs should reflect a reduction of 1.5 per cent compared with those of 2010/11 before negotiated and agreed developments. Tariff prices for 2011/12 also reflect the 4 per cent efficiency requirement: 2 per cent is embedded in tariff design with the remaining 2 per cent offsetting the pay and prices uplift resulting in a final tariff adjustment of 0.5 per cent.

5.32 Taking both the 2 per cent efficiency requirement embedded in the tariff design and the 2 per cent general efficiency deflator, off-setting pay and prices uplifts, results in an overall tariff reduction between 2010/11 and 2011/12 of 1.5 per cent. This 1.5 per cent reduction will apply to non-tariff services and is consistent with the current NHS Operating Framework statement that over the next three years tariff adjustments will not be better than 0 per cent.

5.33 In 2011/12 hospitals will not be reimbursed for emergency readmissions within 30 days of discharge following an elective admission, and all other readmissions within 30 days of discharge will be subject to locally agreed thresholds, set to deliver a 25% reduction, where possible. This is to ensure that, wherever possible, hospitals have good discharge arrangements in place to avoid readmissions. PCTs should work with providers, GPs and local authorities to manage the savings arising from non-payment of emergency readmissions to fund reablement and post discharge support.

5.34 Detailed operational guidance on the implementation of this new approach will be contained in PbR Guidance for 2011/12, which will also specify the services that are excluded from this policy.

5.35 PCTs have received £70 million additional funding in 2010/11 to support people for 30 days following discharge from hospital. PCTs were required to develop local plans in conjunction with GPs and local authorities to develop seamless care for patients on discharge from hospital and to prevent

readmission to hospital. PCTs should use these plans as a basis for coordinating activity on post-discharge support from 2011/12 onwards, keeping plans and outcomes under review in conjunction with GPs and local authorities. PCTs will need to work closely with their local authority partners to develop local reablement capacity. The NHS will have £150 million available for reablement in 2011/12 and £300 million each year from 2012/13 to 2015 incorporated within their recurrent allocations in addition to those savings as a result of the change to the readmissions payment policy.

5.36 During 2011/12, the Department will work with early implementers to identify appropriate increases to tariffs that will take effect from 2012/13 to reimburse providers for the cost of reablement and post-discharge support for 30 days following discharge from hospital.

5.37 While there will be limited expansion in the scope of the mandatory tariff in 2011/12, we are making some changes, including the introduction of a number of new outpatient attendance tariffs. We intend to expand the scope more substantially in future years, and as a move in this direction in 2011/12 we shall:

- bring adult renal dialysis into the scope of PbR by mandating a transition path to national prices;
- mandate currencies (but not prices) for contracting for adult and neonatal critical care;
- seek to amend the scope of ambulance service reference cost data collection to underpin currencies for use in 2012/13;
- introduce currencies for smoking cessation;
- mandate a national currency for cystic fibrosis services, which reflects the care that patients receive over the course of a year;
- develop a local currency for podiatry services, based on a simple treatment episode or package of care;
- mandate the allocation of service users to mental health care clusters.

5.38 The development of new currencies and tariffs should be led locally by the NHS, not centrally by the Department. To support this objective, the PbR Development Sites programme will continue throughout 2011/12, harnessing the ideas and expertise of NHS organisations.

5.39 The development and implementation of new currencies and tariffs should support the integration of services where this is appropriate and is in the best interests of patients. Flexibilities will continue to be made available to permit changes to the tariff where there have been changes in service provision.

5.40 Following the review of specialised service top-ups which was signalled in the 2010/11 NHS Operating Framework, changes are being made to the scope and level of top-up payments. Specialist children's and orthopaedic services will continue to attract a top-up, albeit at a lower rate, and two specialist services will become eligible for top-ups in 2011/12; spinal and neurosciences. We have reviewed, and where appropriate amended, the lists of providers that are eligible to receive top-up payments.

5.41 In 2010/11 we postponed plans to move to Healthcare Resource Group version 4 (HRG4) as the payment currency for A&E services. This change will go ahead in 2011/12.

5.42 The 30 per cent marginal tariff rate for emergency admissions, above a contractual baseline, introduced in 2010/11, will continue in 2011/12, as an incentive for providers and commissioners to work together to minimise the number of avoidable emergency admissions to hospital. This policy will again operate on the basis of 2008/09 being the baseline year.

5.43 The flexibilities set out in the 2010/11 NHS Operating Framework will remain largely in place for 2011/12. One new flexibility being introduced in 2011/12 is the opportunity for providers to offer services to commissioners at less than the published mandatory tariff price, where both commissioner and provider agree. Commissioners will want to be sure that there is no detrimental impact on quality, choice or competition as a result of any such agreement.

CQUIN framework

5.44 In 2011/12 we shall extend the CQUIN framework to the new NHS standard contract for care homes. For all standard contracts, the amount that providers can earn will be 1.5 per cent on top of Actual Outturn Value. CQUIN goals should reflect local priorities and those within this NHS Operating Framework, without duplicating specific minimum expectations of providers set out in contract performance and quality requirements. Beyond the first year of a CQUIN scheme, all goals must require the delivery of stretching quality improvements. Transaction costs should be minimised.

5.45 The existing national CQUIN goals on VTE risk assessment and on responsiveness to personal needs of patients must again be included in acute CQUIN schemes with some adjustment to the timings of measurement for 2011/12 and, unless commissioners decide there is negligible room for improvement, they must again be linked to around one fifth of the value of schemes. Commissioners must share agreed schemes on the NHS Institute website.

Extended list of never events

5.46 Care that falls seriously short of basic standards is not acceptable in the NHS. The NHS standard contract extends the list of incidents defined as "never events" – serious, largely preventable patient safety incidents that should not occur if healthcare providers have implemented available, preventative measures. If a provider delivers care that involves a "never event", then the commissioner of that care will be able to recover the costs associated with that care.

SHA bundle

5.47 The proposed value of the bundle of central initiative budgets devolved to SHAs for local management is £6,243 million, compared with the value of the bundle issued in 2010/11 of £6,246 million. Within this, a limited number of budget amendments have been made, and the funding for a small number of policy programmes has reduced, mostly as planned, whilst others have increased. The most significant of these is the additional funding for prison drug treatment services that reflects a transfer of responsibility from the Ministry of Justice to the NHS.

5.48 Discussions are continuing between the SHAs and the Department to determine the final detail of the bundle, including the impact on the regional running cost limits that will be set out in the Financial Planning Guidance or 2011/12.

5.49 This will be the last year for the SHA bundle. During 2011/12, DH will work with the shadow NHS Commissioning Board and SHAs to agree how the activities currently funded from the bundle will be managed from 2012/13 onwards.

6. Accountability

6.1 In the future, the NHS Commissioning Board will be held to account by the Secretary of State for the outcomes that it delivers. In 2011/12, the accountability arrangements for the NHS need to be strong enough to give the system, at every level, the information to help secure and monitor quality and value for money improvements and to provide assurance that organisations are on track to deliver QIPP and the preparatory steps for the new system.

6.2 Planning arrangements for 2011/12 are about maintaining grip on current performance levels while delivering quality and productivity improvements that will in turn release further funding to frontline services. This is a transition year prior to the NHSCB being fully functional from April 2012 and the expectation is that the NHS will be in a healthy position throughout transition in terms of service quality and financial stability.

6.3 The priorities set out in this NHS Operating Framework need to be planned for in the context of the system levers:

- the NHS Constitution, which secures patient and staff rights;
- the contract, which needs to be the pre-eminent means of doing business between commissioners and providers;
- the Care Quality Commission, who provide regulatory assurance that essential levels of safety and quality are being met; and
- Monitor's Compliance Framework, which ensures that NHS FTs are meeting their terms of authorisation, including delivery against the national priorities set out in this NHS Operating Framework.

6.4 Until responsibilities are formally handed over to new organisations, PCTs, clusters and SHAs and, through them, providers will be held to account for delivering the service, quality and financial requirements set out in this document. Under-performance will trigger proportional action that may include intervention from the centre.

Planning arrangements

6.5 For the NHS accountability arrangements in 2011/12, there should be one integrated plan that brings together all of the key requirements across the areas of quality, resources and reform. Plans will be geographically based, covering a balanced range of measures, rather than functionally based.

6.6 Those plans will evolve from the regional visions and subsequent QIPP plans and set long term expectations over the Spending Review period and the short term delivery commitments and milestones that will track progress towards them. They will need to describe the overall improvements as envisaged over the next four years in terms of quality, productivity, management of resources and the capacity building for the new system.

6.7 The expectation is that each locality will have a clear strategic vision for improvements in quality and productivity, and plans for transition to the new system. Organisations should ensure that their plans support the delivery of the priorities in this NHS Operating Framework.

6.8 In order to meet the quality and productivity challenge and to reform the system, planning needs to focus on the long term agenda. As the plans will outlive the lifespan of SHAs and PCTs, existing and emerging GP consortia should be involved as fully as possible in shaping the development of their PCT's plan. Emerging clusters should also be involved in the planning process.

6.9 PCTs need to ensure their operational plans support wider local arrangements particularly in terms of shared agreements with local authorities and voluntary organisations, and that they take into account the need for consistency with the Joint Strategic Needs Assessment. PCT plans also need to be consistent with the contracts agreed with local providers.

Performance monitoring and assessment

6.10 The annex to this NHS Operating Framework sets out the indicators and milestones to be used for planning and to assess how SHAs and PCTs are delivering on those plans during the year of transition. The indicators and milestones are grouped under three domains:

- **quality**, covering safety, effectiveness and experience;
- **resources**, covering finance, workforce, capacity and activity; and
- **reform**, covering commissioning, provision, partnership building, putting patients first and development of the new public health infrastructure.

6.11 The annex sets out the indicators for central monitoring and within them a small set that will be used actively to judge organisational and system health. There will be further, more detailed technical guidance issued on the definitions underpinning each measure.

6.12 In addition to these indicators, the expectation is that to support the principles of transparency for quality improvement, and the move to an outcomes approach, local analysis, publication and benchmarking should take place where possible for all available performance measures, including:

- existing public health and social care indicators;
- all requirements for publication on NHS Choices;
- local measures for assessing progress on QIPP schemes; and
- measures from the NHS Outcomes Framework when that is published (this will increasingly be the central pillar of NHSCB accountability in the future).

6.13 Organisations should also be aware of and acting upon other national and locally relevant intelligence, such as the CQC's quality and risk profiles.

6.14 This approach requires focus from NHS organisations and the Department of Health in order to streamline data requirements. The Department has initiated a fundamental review of data returns with the aim of culling returns of limited value.

6.15 The Department of Health's External Gateway function[30] serves to ensure all national communications to NHS and social care audiences from the Department are fit for purpose in terms of content and policy governance. This includes compliance with the NHS Operating Framework as well as other key aspects such as ensuring financial affordability and meeting our obligations in terms of better regulation and promoting equality and inclusion. All communications requiring the attention of NHS management during 2011/12 will include a Gateway reference number.

System requirements

6.16 By the end of March 2011, the Department of Health will review the regional plans with each SHA. In doing so, the Department shall apply key assurance tests to the plans to ensure that they:

- represent a long term vision with quality improvement and value for money at their heart;
- are based on robust demand and activity assumptions that support delivery of QIPP over four years;
- provide assurances on the delivery of national priorities, including transition, and reconcile these across all areas of the plan;

30 www.dh.gov.uk/dhexternalgateway

- provide assurances that they are robust in the light of changes to organisational arrangements and have the support of emerging consortia and clusters;
- are consistent with contracts agreed locally with providers; and
- are integrated with shared priorities with local authorities for health, public health, social care and children's services.

Timetable

6.17 We shall collect SHA plans for 2011/12 in two stages. A first, initial draft will be due on 28 January 2011 covering the full scope of the plan and a second and final draft will be due on 25 March 2011.

6.18 A transition assurance process will take place in each region from March to June 2011 where each SHA will be visited by the NHS leadership team to provide assurance on its agenda for quality, productivity and reform.

Annex

Integrated performance measures for national oversight

	Headline measures	Supporting measures
Quality (Safety, Effectiveness & Patient Experience)	• HCAI measure (MRSA & CDI) • Patient experience survey[2] • Referral to Treatment waits (95th percentile measures) • MSA breaches • A&E Quality Indicators (5 measures)[1] • Ambulance quality (Cat A response times) • Cancer 2 week, 62 day waits (2 aggregate measures) • Emergency Readmissions	• MRSA – delivery of objective • VTE Risk assessment • Ambulance quality indicators (all other measures)[1] • Cancer waits (all 9 measures) • Community services • Access to NHS dentistry • PROMS scores • Mental health measures (EI, CR/HT, CPA, IAPT) • Smoking Quitters • Breast screening • Cervical screening test results • Referral to Treatment waits (median wait measures) • People with Long Term Conditions feeling independent and in control of their condition • Emergency admissions for Long Term Conditions • CDI – delivery of objective • % deaths at home (inc care homes) • A&E quality indicators (all other measures) • Stroke indicator • Carers breaks • Staff engagement[2] • Maternity 12 weeks • Low value procedures • Breastfeeding at 6-8 weeks • Bowel screening • Diabetic retinopathy screening • Coverage of NHS Health Checks • Safeguarding
Resources (Finance, Capacity & Activity)	• Financial forecast outturn & performance against plan • Financial performance score for NHS Trusts[3] • Delivery of running cost targets • Progress on delivery of QIPP savings • Acute Bed Capacity • Non elective FFCEs • Numbers waiting on an incomplete Referral to Treatment pathway • Health visitor numbers • Workforce productivity	• Total pay costs • Year to date financial position • Delivery of 2% recurrent headroom • Underlying financial position of PCTs and NHS Trusts • Daycase rate • GP written referrals to hospital • First outpatient attendances following GP referral • Elective FFCEs • Ambulance Urgent & Emergency Journeys • Staff absences • Clinical staff numbers • Redundancy numbers • Total workforce (WTEs) • NHS Trusts Breakeven duty • PCT legacy debt position • Length of stay (Acute and MH) • Delayed Transfers of Care (Acute & MH) • Other referrals for a first outpatient appointment • All first outpatient attendances • A&E attendances • Community activity • Temporary staffing costs • Management numbers
Reform (Commissioner, Provider & building capability and partnership)	• FT pipeline • Transforming Community Services (TCS) successfully achieved • GP Consortia progress and transfer of relevant functions NHS CB/LAs • Establishment of PCT clusters • Choice • Information to Patients • Competition	**Provider development:** % of orgs progressing along pipeline to milestones agreed between SHA, trust and DH % of organisations behind expected position along the FT pipeline by over 3 months. % of organisations behind expected position along the FT pipeline by over 3 months that are in the unsustainable providers categorisation Uptake of community services Right to Request scheme and forecast uptake in Right to Provide % (value) of community and mental health services by PCT subject to Any Willing Provider **TCS:** Extent of completion of TCS programme – separation and divestment of provider services **GP Consortia:** % of GPs (a) in pathfinder consortia and (b) in pipeline to become pathfinders % of PCT commissioning spend delegated to GP practices Running costs per head of pop. delegated from PCTs to consortia for start up costs **NHS CB:** Has SHA completed full analysis of current levels of staffing and arrangements for those region-wide (SHA and PCT) functions, which will transfer to the NHS CB? **Choice:** Bookings to services where named consultant led team was available (even if not selected Proportion of GP referrals to first OP appointments booked using Choose and Book Trend in value/volume of patients being treated at non-NHS hospitals. **Information:** % of patients with greater control of their care records **Capacity & Capability:** Secure leadership capacity in critical posts in PCTs, clusters and SHAs

1 Suites of measures – a drop in performance on a single indicator may not trigger intervention as long as there has been no worsening in performance of the suite overall.
2 Monitored through local data collections as well as national annual survey 3 The finance domain score for NHS Trusts in the NHS Performance Framework.

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Leeds City Council and NHS Leeds Joint Performance Report

Meeting: Health Scrutiny Board

Date: 22nd March 2011

Subject: Joint Performance Report Quarter 3 2010/11

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

1 Executive Summary

1.1 This report presents the performance information summarising our progress against the joint council and NHS Leeds priorities as set out in the Leeds Strategic Plan, as well as key NHS Leeds priorities, for third quarter of 2010/11. The report includes two action trackers from the Leeds Strategic Plan which are from the small number of key performance areas as identified by CLT in Dec 2009. The purpose of these extra trackers is to enable officers and members the opportunity to more closely performance manage these high risk areas and ensure that as necessary appropriate remedial action is taken. In addition a Performance Indicator (PI) report is provided and of the indicators which can be reported at this time 71% are currently predicted to hit target. However, the board should note that only half of the indicators are available quarterly with the rest provided annually.

2 Purpose of the Report

2.1 The purpose of this report is to present an overview of performance against our priority outcomes so that the Board may understand our current performance and, as necessary, take appropriate action. This joint report also enables the Board to fulfil their role to scrutinise the performance of NHS Leeds.

3 Background Information

3.1 The agreed performance reporting process for the joint priorities in the Leeds Strategic Plan provides PI reports only at Quarters 1 and 3 with Action Trackers and PI reports at Quarters 2 and 4. The action trackers report progress against our LSP priorities and bring together qualitative and quantitative information including progress against targets for aligned performance indicators, the delivery of key actions/activities

and relevant challenges and risks. An overall traffic light rating is assigned by the Accountable Officer and agreed with the Accountable Director. This is supplemented by a direction of travel arrow that indicates whether progress is improving, static or deteriorating. In December 2009 CLT identified a small number of high risk performance areas where they wanted to receive a more regular update and for these areas actions trackers are produced on a quarterly basis.

3.2 A number of appendices of information are provided with this report and these are summarised below:

- **Appendix 1** – action trackers for the high risk performance area from the Leeds Strategic Plan which are relevant to the Health Scrutiny Board. These trackers include a contextual update as well as key performance indicator results.
- **Appendix 2** – performance indicator report showing the Q3 results and predicted year end traffic lights for all key performance indicators aligned to the LSP which are relevant to the Health Scrutiny Board as well as indicators relating to the key priorities for NHS Leeds.

4 Analysis of Performance

Improvement Priorities

4.1 The table below sets out the overall progress rating of the one high risk improvement priority from the Leeds Strategic Plan which is relevant to the Board and how this has progressed over the past year or so.

Improvement Priority	2009/10 Q3	2009/10 Q4	2010/11 Q1	2010/11 Q2	2010/11 Q3
HW-1d/CYPP 7 Reduce teenage conception and improve sexual health	↓	↓	↔	↔	↔
HW-1a Reduce premature mortality in most deprived areas	↑	↓	↓	↔	↔

4.2 Both these trackers remain red and static but at the current time we do not have any new data for the health inequalities tracker.

Performance Indicators

4.3 An analysis of the new cohort of Performance Indicators for the Board is shown below with xx% of these performance indicators currently predicted to hit their 2010/11 targets. However, the board should note that only half of the indicators are available quarterly with the rest provided annually.

	Number	%
Red	1	14%
Amber	0	0%
Green	11	71%
Unable to traffic light	3	14%

5 Implications for Council Policy and Governance

5.1 The Leeds Strategic Plan is part of the council's Budget and Policy Framework. Effective performance management enables senior officers and Elected Members to be assured that the Council is making adequate progress and provides a mechanism for them to challenge performance where appropriate.

6 Legal and Resource Implications

6.1 The Leeds Strategic Plan fulfils the local partners statutory requirement to prepare a Local Area Agreement. These government agreed targets are subject to performance reward grant - however this is currently under review by Government.

7 Conclusions

7.1 This report provides the Health Scrutiny Board with a Q3 update of the performance against the joint LCC/NHS Leeds improvement priorities in the Leeds Strategic Plan and the key priorities for NHS Leeds. This report highlights areas where progress is not on track and Members need to satisfy themselves that these areas are being addressed appropriately and where necessary involving partners in any improvement activity.

8 Recommendation

8.1 Members are asked to consider the overall performance information provided against the strategic priorities and where appropriate, recommend action to address the specific performance concerns raised

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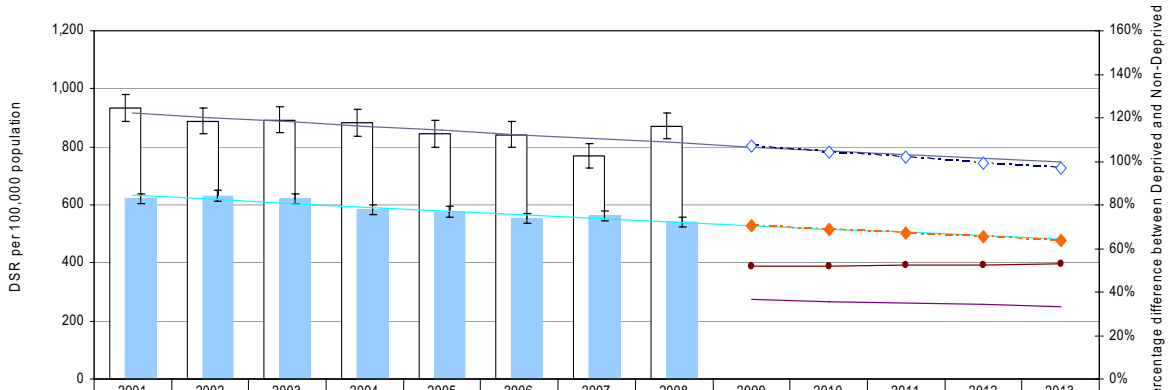
Improvement Priority – Reduce Premature Mortality in the Most Deprived Areas

Lead Officers – John England, Brenda Fullard

Overall Progress

Why is this a priority	In Leeds 20 % of the population live in the 10% most deprived Super Output Areas (SOAs) in England. There are health inequalities within Leeds for men and women by areas of deprivation: • There is a 10.1 year gap in life expectancy for men between City & Hunslet and Harewood (71.6 years:81.7years) • There is a 9.6 year gap in life expectancy for women between City & Hunslet and Adel/Wharfedale (76.1year:85.7years

Leeds Deprived and Non-deprived Gap in Mortality Rates - All Persons



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Deprived Leeds actual	934	889	893	881	844	842	768	871					
Non-Deprived Leeds actual	621	631	621	583	577	553	563	541					
Deprived Leeds trend line	917	902	886	871	857	842	828	814	800	786	773	760	747
Non-Deprived Leeds trend line	634	619	605	592	579	566	553	541	529	517	505	494	483
Deprived Leeds -0.50% yr on yr improvement on trend									801	782	764	745	728
Non-Deprived Leeds -0.25% yr on yr improvement on trend									527	514	501	489	477
gap									274	268	263	256	251
gap as percentage difference									52%	52%	52%	52%	53%

year

sources: YHPHO, NHS Leeds and LAA trajectory submissions

Overall progress to date and outcomes achieved

Summary

All age all cause mortality remains a significant issue in deprived areas of Leeds however this rate has decreased each year from 2001 to 2007 but there was increase in 2008. Based on the actual figures from the five year average periods 2001-2005 to 2004-2008 a forecast continuing at the same rate shows that difference in female and male life expectancy between the 10% most deprived and 10% least deprived LSOAs will continue to increase.

Achievements since the last report

- Leeds Strategy – City Priority plan for health and wellbeing includes a high level outcome to reduce inequalities and is being finalised for February 2011
- NHS Commissioning for health Inequalities plan –performance management process in place through NHS Leeds public health leadership team
- Joint workforce development programme Framework developed and agreed in principal by Health Improvement Board to increase the number of Health Champions and LCC/ NHS staff skilled to address the reduction of health inequalities through their individual work objectives. Action to reduce Health inequalities are now formally required in all LCC Service plans. Three Health innovation events planned for LCC and partners to take place in March/April 2011 led by the Local Government Improvement and Development.
- NHS Health Checks – 9,557 checks have been completed (2 quarters data) for 2010/11. 36.2% of last years check carried out with people from the most deprived quartile
- Healthy Living Services – A pilot scheme has started with Cardiology Department at Leeds Teaching Hospital Trust and 6 practices within the 10% most deprived areas. The pilot aims to achieve long term behavioural change and improve health outcomes for the most vulnerable groups. Projects within the programme include: rapid appraisal of the effectiveness of stop smoking and weight management services.
- Under age sales of alcohol and tobacco- West Yorkshire Trading Standards in partnership with NHS Leeds one year project to reduce illegal sales of substances to those under age in Armley and Middleton commenced June 2010
- Reducing Excess Winter deaths – Excess winter deaths are being addressed in a number of areas to identify high risk populations, including GP practices through predictive modelling and LCHC services including Cardiac rehab. High risk patients will be pro-actively and systematically offered, and

Improvement Priority – Reduce Premature Mortality in the Most Deprived Areas

Lead Officers – John England, Brenda Fullard

supported to take up, a suite of interventions prior to the onset of winter 2011. Work is progressing to set up systems within predictive modelling and LCHC service plans are being updated to include this activity.

- Childhood obesity- Services have been redesigned and programmes and initiatives are in place to work with families, children and young people to provide support to help them achieve a healthy weight. A detailed update on progress is provided under the Improvement Priority – 'Reduce the rate of increase in obesity and raise physical activity for all'.
- Infant Mortality – The 2 Demonstration Sites (Chapeltown and Beeston Hill) continue to implement an intensive programme of interventions. Evaluation of the programme is now complete. Initiatives to improve the accessibility of maternity services to women continue. Combined antenatal screening for Down's syndrome (before 12 weeks gestation) is now in place. The Family Nurse Partnership has received funding to continue for the next 3 years. A Social Marketing campaign to reduce Sudden Unexplained Death of an Infant has been commissioned: for roll out March 2011. Seven Doulas have been recruited as part of the Haamla Doula service to support women from BME communities in pregnancy, childbirth and beyond.
- Increasing Community Capacity – NHS Leeds have agreed commissioning of the VCSF sector to focus on increasing healthy lifestyle behaviour leading to reduction of obesity and increasing physical activity linking people to support in GP practices . Funding has been identified to ensure more people identified with obesity can use Local Authority facilities using the Leeds card.
- Locality based Health and Wellbeing Partnerships- DH funding has been obtained for a programme to increase early diagnosis of lung cancer by increasing X-Ray case finding in inner South and East Leeds, the project has commenced.
- Health Promoting Hospital: Leeds Teaching Hospital Board has approved their Public health strategy and a programme of activity is now in place to introduce the first phase of this work in the Cardiac unit targeting patients. A Knowledge transfer partnership worker has been appointed to provide the steering group with insight into the drivers, levers and barriers in LTHT becoming a Health promoting hospital, results due in May 2011.
- Financial Inclusion: Review of CAB/ Welfare advice services in primary care completed. Services being reoriented to areas of deprivation. 12 out of 18 sessions provide opportunity for debt advice in areas of deprivation. 2 million pounds of unclaimed benefits claimed by patients in Leeds. (2009/2010). 2million pounds debt managed (2009/2010)

Challenges and Risks

- NHS Health Check and Healthy Living Services - Given the financial climate a 'no increase' or a reduction in investment could lead to lower levels of clinical engagement, lower uptake in key communities and inability to produce local and national monitoring requirements
- The change process resulting from the White paper 'Liberating the NHS' and the series white papers published on health, social care and public health is likely to affect both the content and future timescales of commissioning and health improvement plans
- Increasing the integration of health improvement and reducing health inequalities across plans and objectives across all Directorates of LCC
- To increase the priority given to obesity and increasing physical activity against context of structural reorganisation and cost improvements.
- Capacity of Children's Centres to deliver HENRY given likely reduction in LCC resources
- Lack of strategic support for health agenda due to ongoing structural re-organisation within both NHS and LCC
- Significant reduction in investment available to enable commissioning of physical activity for inactive children living in deprived Leeds.
- The high level of investment in the promotion of unhealthy foods by the food industry
- Infant Mortality - The rising birth rate in Leeds, together with the changing ethnic profile of the child bearing population and the impact of recession on economic wellbeing (32% of Leeds births take place within SOAs which fall into the 10% most deprived nationally), are all likely to impact on infant mortality rates.

Approved by		**Date**
Delivery Board		

Improvement Priority – Reduce Premature Mortality in the Most Deprived Areas

Lead Officers – John England, Brenda Fullard

Key actions for the next 6 months			
Action	**Lead Officer**	**Milestone**	**Timescale**
Health and wellbeing priorities plan will be completed using a framework developed and based in the recommendations set out in the 2010 national strategic review of health inequalities: Fair Society, healthy Lives (Marmot review) plus the actions from the NHS commissioning for reducing health inequalities plan	John England/Brenda Fullard	Secure joint ownership of a revised Health and Wellbeing Partnership City priority plan with short to medium term objectives agreed	February 2011
Joint workforce development programme	Brenda Fullard / John England	**Agreed and project plan in place to increase in the number of LCC and NHS Leeds staff skilled to address the reduction of health inequalities through their individual work. Three Health Innovation events completed.**	April 2011
Infant mortality: the evaluation of the two Reducing Infant Mortality Demonstration Sites to be finalised and presented at an event in March	Sharon Yellin	Further reduction of infant mortality in demonstration sites	March 2011
Building on the outcomes of the regional workshop held in February 2010, develop and agree a joint approach to improve health and **reduce health inequalities through spatial planning is ongoing and includes an approach to rapid HIA of the LDF**	Christine Farrar	Joint approach to improve health and reduce health inequalities through spatial planning agreed	March 2011
Increase in number of people reducing lifestyle risk through NHS Health Check and Healthy Living Services.	Lucy Jackson/Ruth Middleton/ Brenda Fullard	Rapid appraisal of healthy living services completed, brief intervention capacity building programme commenced and healthy living database completed.	April 2011
Reduce under age sales of alcohol and tobacco in Armley and Middleton	Tony Downham/Heather Thomson	Initial results to be reported	February 2011
Implement NHS Leeds and LCC joint programme of work to reduce excess winter deaths, including reducing fuel poverty,	Dawn Bailey// John England	Increase in the number of at risk people identified and offered intervention programme	March 2011
Agree the LTHT health promoting hospital plan and recruit a programme manger with the aim of implementing and measuring action to reduce lifestyle risk in patients, visitors and staff	Phil Ayers/Dawn Bailey	1. Health promotion Hospital project manager recruited 2. Working example in cardiology commenced 3. Benchmarked against HPH standards in best hospitals with a view to proposal to join network to Board	March 2011

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HW-1d/CYPP 7 - Reducing teenage conception

Lead Officer – Sarah Sinclair

Overall Progress
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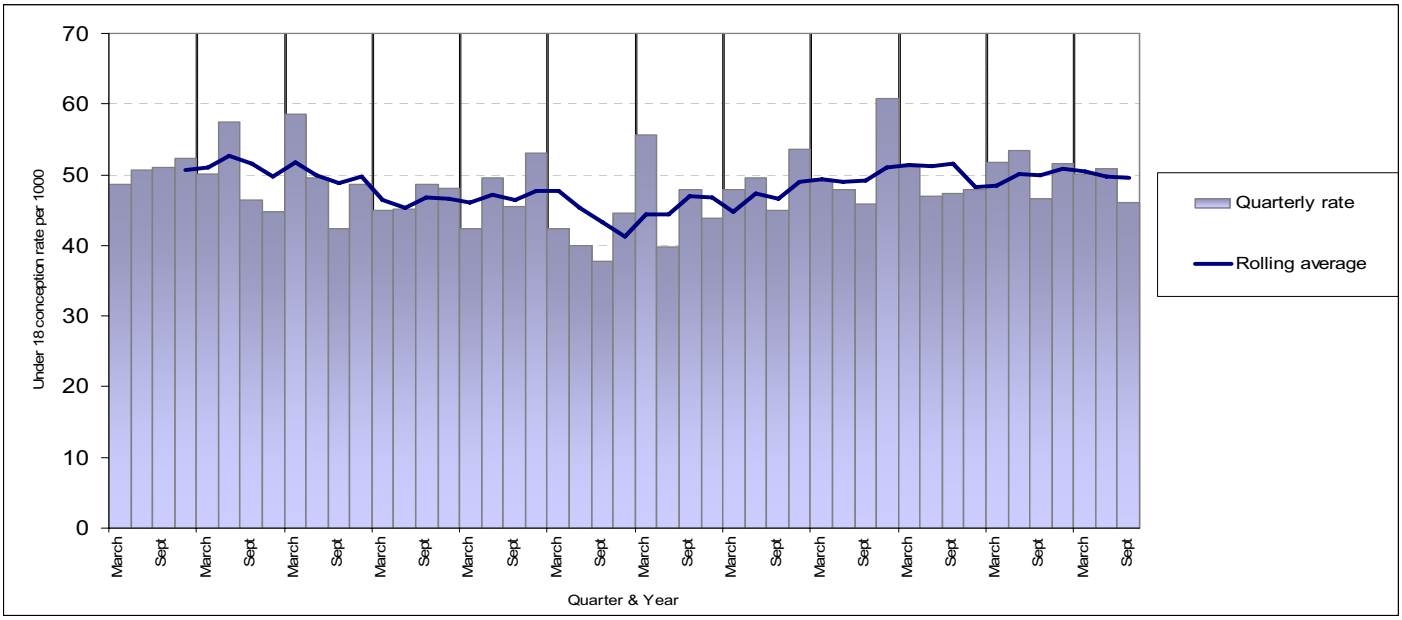
Why is this a priority	Evidence shows that having children at a young age can damage young women's health and wellbeing and severely limit their education and career prospects. Long term studies show that children born to teenagers are more likely to experience a range of negative outcomes in later life and are up to 3 times more likely to become teenage parents themselves. Teenage parents are shown to be high users of services compared to other parents and are therefore a significantly higher cost to communities in comparison to those who become parents in later life.



NB Our performance is measured nationally against Office of National Statistics (ONS) conception rates for 15 -17 year old young women. There is a 14 month time delay in the data due to the nature of the information being collected and the significant number of suppliers of data. New data on under 18 conceptions rates from ONS will be available for the whole of 2009 in February 2011.

Overall progress to date and outcomes achieved – Quarter 1 2010-11

Overall Summary

The latest available position for Sept 2009 shows that this was the lowest quarterly rate since 2006 and that the rolling 12 month average for teenage pregnancy has now fallen for three consecutive quarters. However these are modest improvements and our overall judgement is that performance remains static without evidence of a consistent reduction towards the local partnership target. External support and review from the National Support Team suggests Leeds is the using the right strategy. We must therefore question whether we are applying our collective resources, from across the local authority and from partners, appropriately to change the direction of travel. As a result we have assigned a red rating for this priority and it is probable that it will continue as priority indicator in the new Children and Young People's Plan, supported by effective actions to reducing teenage conception rates. This does not negate the ongoing efforts outlined below to improve our strategic approach and to both support prevention and young parents. Our challenge is to translate these efforts into greater impact.

Activity achievements since the last quarter

Strategic

- The Children's Scrutiny Board and Health Scrutiny Board have agreed to work collectively to review and challenge progress and identify joint actions between Health and the Local Authority.
- The Health and Social Care Improvement Board has been instigated bringing together the local authority and NHS Leeds leadership into a closer working relationship to address shared actions for health and social care outcomes. Actions on children and young families work will address contributory issues for teenage conception including early effective parenting support and mental health support for young people.

HW-1d/CYPP 7 - Reducing teenage conception

Lead Officer – Sarah Sinclair

Data

- Improved locality information reporting at Middle-layer Super Output Areas (MSOAs) and Postal Sector will allow local Children's Service Leadership Teams and Area Committees to review local progress.

Communications

- The '12 days of mythmas' campaign run jointly by the Council and NHS Leeds is intended to challenge common myths young people have about sexual health. The campaign is available online (**www.mythmas.co.uk**) and was promoted through both radio and posters sent to schools prior to the Christmas holidays. A breakdown of the take-up of the campaign will be available soon.
- Consistent advertising and development of a young person focused information portal on sexual health shows evidence of good take up from young people. October-December 2010 had a large increase in hits at Leedssexualhealth.com, a 49.3% increase compared to the same quarter the previous year. The number of visits to the site were 17,908 in this period, the most popular information viewed being was how to access STI testing and contraception services.
- Health and Wellbeing Board and Director of Public Health have agreed on strong alignment and integration between sexual health public health resources held in local authority and NHS Leeds which will improve the communications approach across the public health agenda for sexual health maximising coherence and minimising costs.

Work within education settings

- Attainment for teenage parents improved this year. GCSE results for pregnant schoolgirls and school-age mothers and fathers in Leeds, increased by 10% for girls and 20% for boys. High GCSE attainment reduces likelihood of repeat teenage conception.
- 80% of schools have committed to support and develop Healthy Schools and a range of activity is in place to support the successful roll out of the initiative. 8 schools have come forward to provide leadership and mentor schools in their area in a peer support role. All teenage pregnancy priority schools are engaged with the new Healthy Schools Enhancement Model and will be focussing on teenage pregnancy as one of their first priorities.

Sexual Health Services

- City-wise and Marie Stopes International have achieved the 'You're Welcome' accreditation. This is a significant first step to services being young people friendly.
- A further one year Strategic Health Authority (SHA) grant has been secured and action plan agreed towards improving access to contraception eg the drop in sexual health clinics with FE colleges have been commissioned for a further year.

Workforce Development

- The SRE Training Team was re-launched in December with a wider remit to support staff delivering SRE in settings other than schools. Work has begun to train up SRE Champions at Leeds City College campuses to provide peer support for colleagues delivering SRE. This will improve both the confidence and the quality of the delivery of SRE.

Work with parents and carers

- Leeds has one of the UK trial projects for the Family Nurse Partnership approach proven effective with young and vulnerable mothers in the USA. A third year evaluation of the UK trial indicated that this service is effective in promoting good parenting, reducing swift second (repeat) teenage pregnancies and improving parents access to work. This approach is supported by the recently published Allen Review on Early Intervention and we are actively creating an opportunity for joint investment between the local authority and children's services to extend this approach as priority for joint investment.
- Ciaran Moore, a young father supported by the Education Leeds Specialist Learning Mentor for School Age Fathers, has been short listed for the Brook UK Young Person of the Year Award 2011.

HW-1d/CYPP 7 - Reducing teenage conception

Lead Officer – Sarah Sinclair

Risks and Challenges

- To replicate the impact achieved in other core cities our challenge is to use the new Children's And Young People's Plan and Children's Trust Board framework to improve our approach to systematic joint working that addresses the causes behind teenage pregnancy. To effect this we must ensure that membership of the Teenage Pregnancy and Parenthood Partnership is of sufficient senior level to drive change; and ensure that causative factors are being addressed through services considering teenage pregnancy and parenthood as a priority. A reduction in teenage conception is not achievable without a renewed significant joint systemic approach across the local authority and partners.
- Reducing resources and competing service change may challenge further improvement in services. One response to this has been a review of all planned expenditure across partners of TP related services, this was undertaken for the 2011-12 budget in order to look for opportunities to improve efficiency and effectiveness through reducing investment in low impact targeted services. Recommendations are being taken forward.
- Leeds has a lower investment in community based health services which young people can access for their sexual health needs than other leading Core Cities. The challenge will be whether we can meet the demand for service use with the likely reduced investment levels in this area.
- With changes in the relationship with schools there is a risk that universal settings do not consistently implement high quality SRE and promote access to sexual health services, especially to vulnerable groups at high risk of teenage conceptions, eg pupils with Special Educational Needs
- The risk that family support and parenting services not consistently prioritising the needs of teenage parents across the city could leave some of the most vulnerable young parents without the support they need. This will also mean that we will not sufficiently reduce risk taking behaviours.

All the challenges and risks identified above are being considered by the Teenage Pregnancy Board with mitigating actions included in the action plan

Council / Partnership Groups	Teenage Pregnancy and Parenthood Partnership Board		
Approved by *(Accountable Officer)*	Paul Bollom/ Sarah Sinclair	**Date**	19/01/11
Approved by *(Accountable Director)*	Nigel Richardson	**Date**	03/02/11

HW-1d/CYPP 7 - Reducing teenage conception

Lead Officer – Sarah Sinclair

Key actions for the next 6 months					
	Action	**Lead Officer**	**Milestone**	**Timescale**	**Date Action Last Reviewed**
1	Creating local prevention approaches in the identified hotspot areas in Inner West Leeds. (NB locality work already underway to address hotspots in Inner East and Inner South Leeds)	Paul Bollom	• "Westnet" event to be held in West of Leeds to challenge and support local services in the area to develop a shared objective and accountability. • Development of a local action plan addressing SRE, positive activities and good access to services with local accountability	13/1/11 Feb 2011	
2	Research on effective sexual health services in schools (HYPS) requires they take place more than once a week in any one school and are delivered in partnership between the school, school health and youth services.	Gary Milner	• Future of youth work provision to be agreed for funding and priorities clarifying contribution to HYPS services in future.	February 2011	11 January 2011
3	Effective cities in reducing teenage conception require all services in contact with young people to be young person friendly and able to support young people confidently in their sexual health needs. All CaSH, Genitourinary Medicine (GUM) and the Termination of Pregnancy (TOP) providers will be 'You're Welcome' accredited. Target set for GP practices in high rate localities	Vicky Womack Barbara Newton	• Four GP practices in high rate areas nominated to complete You're Welcome accreditation. • Children's Services in Leeds aim to make Leeds a 'Child Friendly City' which would include the aim of all services for children and young people, including sexual health services, being friendly and children centred. Actions to address this to be developed as part of the new CYPP.	November 2011 July 2011	11 January 2011
4	Effective services for young fathers are not evidenced in Leeds. We undertake to research the current service offer and the needs of young fathers and ensure services are in place for these parents.	Jenny Midwinter	• Research into the needs of young fathers in Leeds via a longitudinal study in Leeds begun in partnership with the Timescape project at University of Leeds. This will be presented to policymakers in Westminster	Mid 2011	11 January 2011

Performance Indicators
NI 112 - Under 18 conception rate per 1000 girls ages 15-17 - The 2009 figures are released in February 2011

	PI Type	Ref	Title	Service	Frequency & Measure	Rise or Fall	Baseline	Last Year Result	Target	Quarter 1	Quarter 2	Quarter 3	Predicted Year End Result	Direction of Travel	Data Quality
1	Leeds Strategic Plan - Partnership Agreed	NI 123A	16+ current smoking rate prevalence (City Wide)	PCT	Quarterly %	Fall	Not set	22.00%	21.00%	22.60%	22.43%	22.75%	21.00%	⬆	No Concerns with data quality
		NI 123B	16+ current smoking rate prevalence (10% SOA)	PCT	Quarterly %	Fall	31.00%	30.00%	27.10%	29.67%	29.59%	29.94%	27.10%	⬆	
		It is noted that there is an unexpected slight rise in smoking prevalence across Leeds both in terms of the smoking prevalence in deprived Leeds and across the city. This may in part be due to the suspension of the DH media campaigns which has resulted in a reduction of referrals coming to the smoking cessation service from the national helpline. In addition to local marketing and campaigns NHS Leeds is currently developing a number of innovative areas of work to address the smoking prevalence rates including: - Promoting a more routine and systematic approach to the delivery of smoking cessation interventions and referrals to services by front line health care staff. Initially working in collaboration with GP consortia to identify practices where referral of smokers into services is less than the recommendations stated within NICE guidance. With cardiac rehab services, the systematic approach aims to encourage at least 5% of the smoking population to set a quit date with stop smoking services. This work will also look at the training needs and the accurate recording of smoking status. - Collaborating with other areas of 'healthy living' to establish a website, to provide information about available services and access to self help guides. - Conducting a feasibility study to test a social norms approach to working with young people which aims to reduce the initiation of smoking.												
2	Leeds Strategic Plan - Government Agreed	NI 40	Number of drug users recorded as being in effective treatment	Community Safety	Quarterly Number	Rise	2,939	3,325	3,149	3,025	3,048	3,094	3,150	⬇	No concerns with data quality
		Rolling Year to Date = 3,094 (NB this is subject to a 3 month time lag as this data is validated by the National Treatment Agency). The actual number in effective treatment looks to have dropped signficantly between Q4 2009/10 and Q1 2010/11 but this was due to a national data quality exercise undertaken by the National Treatment Agency. Performance in the current year is improving and is on track to meet the year end targets. This data is compiled by the Community Safety and is based on a snapshot taken each quarter. It does not represent the National Treatment Agency's refreshed data, which can be made available by the Community Safety, if required												

	PI Type	Ref	Title	Service	Frequency & Measure	Rise or Fall	Baseline	Last Year Result	Target	Quarter 1	Quarter 2	Quarter 3	Predicted Year End Result	Direction of Travel	Data Quality
3	National Indicator	NI 51	Effectiveness of child and adolescent mental health (CAMHS) services	NHS Leeds	Quarterly Number	Rise	16 out of 16	13 out of 16	15 out of 16	14 out of 16	15 out of 16	15 out of 16	15 out of 16	↑	No concerns with data quality
		This measure is assessed by answering a series of four questions each worth 4 points enabling a maximum score of 16. The assessment focuses on the following areas: 1. range of CAMH services - assessed at 4 2. access to services and accommodation appropriate to their age and level of maturity - assessed at 4 3. availability of 24 hour cover to meet urgent mental health needs - assessed at 4 4. range of early intervention support services delivered in universal settings - assessed at 3. Quarter 3 shows an improvement from the beginning of the year position and is static from the last quarter. The final area of improvement to achieve the full 16 score is: 'an increase in early intervention support services delivered in universal settings'. A key stakeholder event is planned in February, following the recent National Support Team visit, to promote area and to support the rollout of the Targeted Mental Health in Schools (TaMHS) model. If successful this will address performance in this final element of the assessment.												
4	National Indicator	NI 53A	Coverage of breast-feeding at 6-8 wks from birth (Breastfeeding coverage)	NHS Leeds	Quarterly %	Rise	89.0%	90.9%	95.0%	93.3%	96.9%	98.8%	96.4%	↑	No concerns with data quality
		The coverage rose again this quarter to 98.75%. This is the result of significantly improved and timely inputting of the data by health visitors.													
		NI 53B	Prevalence of breast-feeding at 6-8 wks from birth (Breastfeeding prevalence)	NHS Leeds	Quarterly %	Rise	41.0%	40.8%	44.0%	44.9%	49.0%	50.6%	48.2%	↑	No concerns with data quality
		The prevalence rate increased again this quarter and remains above the year end target for 2010/11. Work continues on encouraging breastfeeding and there is targeted work in specific postcode areas with low prevalence.													

	PI Type	Ref	Title	Service	Frequency & Measure	Rise or Fall	Baseline	Last Year Result	Target	Quarter 1	Quarter 2	Quarter 3	Predicted Year End Result	Direction of Travel	Data Quality
6	National Indicator	NI 125	Achieving independence for older people through rehabilitation/intermediate care	Access & Inclusion	Quarterly %	Rise	91.9%	78.8%	85.0%	85.7%	87.8%	88.3%	88.3%	↑	No Concerns with data quality
		During the first three quarters of 2010/11 on 121 of the 137 occasions where people were discharged from a hospital setting for intermediate care the person was living in their own home three months subsequent to discharge.													
7	National Indicator	NI 131	Delayed transfers of care	PCT	Quarterly Number	Fall	5.2	4.4	Not Set	6.5	6.7	6.7	6.7	↓	No Concerns with data quality
		The figures represent an average of 41.4 delayed discharges per week during the year, an increase of 0.3 on Quarter 2. However, delayed discharges arising due to social care related reasons have fallen from an average of 16.5 per week in Quarters 1-2 to around 11.0 per week for Quarter 3 (14.7 for the year as a whole). Conversely, those arising from health related reasons have increased from 24.6 to 31.0 per week for Quarter 3 (26.7 for the year as a whole). The most recently available national data (for Qtr1 2010-11) shows that Leeds continues to perform better than the national average and better than most core cities on this indicator.													
8	National Indicator	NI 113	Prevalence of Chlamydia in under 25 year olds measured through % percentage of the resident population aged 15 - 24 accepting a test/screen for chlamydia	PCT	Quarterly	Rise	n/a	32025	49106	7736	6829 YTD 14565	7162 YTD 21727	28000	↓	No Concerns with data
		The chlamydia screening programme continues to focus on positivity rates as oppose to the number of screens. This approach has been agreed by NHS Leeds' board and endorsed by the SHA. The citywide GP locally enhanced service (LES) was not renewed in November as the positivity rate was only 3.56%. The LES continues in those practices with a positivity rate greater than 10%. To the end of Q3 the programme has screened 21727 persons. Screening continues to be offered to those most vulnerable via the voluntary sector, CaSH, prisons and termination services. Postal tests through freetestme were discontinued from December due to low prevalence and cost. The screening programme is being delivered within budget.													
9	PCT Vital Signs	VSA01	Incidence of MRSA - number of cases	PCT	Quarterly Number	Fall	n/a	n/a	34	9	7	8	>34	↓	No Concerns with data
		NHS Leeds, to the end of Q3 were on target, as shown above. However, early data for Jan and Feb now shows 34 cases for the year, meaning that it is very likely that the annual maximum number of cases will be exceeded. A high number of LTHT MRSA cases has contributed significantly to the current NHS Leeds figures. Until Dec, both LTHT and NHS Leeds were on target to meet their objectives. In Jan and Feb the number of cases has increased significantly. Several issues, identified through root cause analyses, have contributed to the rise. Remedial actions in progress include reviewing the approach to managing intravenous lines and a recommended increased resource for improving line care; systems for ensuring staff follow protocols relating to MRSA screening/status are being strengthened; ward cleaning has been reviewed and the cleaning regime at LTHT is being increased; isolation procedures have been improved and cases of flu have decreased.													
10	PCT Vital Signs	VSA03	Incidence of C difficile - number of cases	PCT	Quarterly Number	Fall	870	425	579	81	92	111	400	↓	No Concerns with data
		Whilst the number of cases is within the agreed trajectory, the numbers of cases is rising, which is of concern. The issue is being followed through with LTHT, who are likewise experiencing a rise in occurrence.													
11	PCT Vital Signs	VSA13	% patients waiting no more than 62 days from referral to treatment for cancer	PCT	Quarterly %	Rise	n/a	84.78%	85%	83.3%	80.4%	87.2%	85%	↑	No Concerns with data

	PI Type	Ref	Title	Service	Frequency & Measure	Rise or Fall	Baseline	Last Year Result	Target	Quarter 1	Quarter 2	Quarter 3	Predicted Year End Result	Direction of Travel	Data Quality
		Whilst performance has dipped during this year, more recent data is showing a recovery. Actions in place seem to be having an effect. LTHT now undertake root cause analysis (RCA) when a speciality has two or more breaches and where YTD performance is less than target.													
12	PCT Vital Signs	VSA12	Cancer: 31 day wait standard - diagnosis to treatment and subsequent surgery	PCT	Quarterly %	Rise	n/a	96.99%/ 89.93%	96%/ 94%	96.3%/ 96.3%	96.5%/ 91.5%	98.6%/ 95.7%	96%/ 94%	⬆	No Concerns with data
		The 31 day subsequent surgery indicator is now back on track. Key problem areas have been identified and addressed.													
13	PCT Vital Signs	VSA12	Cancer; 31 day wait standard - subsequent drug and radiotherapy	PCT	Quarterly %	Rise	n/a	99.53%/ 90.40%	98%/ 94%	98.8%/ 93.1%	99.8%/ 96.9%	99.5%/ 98.7%	98%/ 94%	⬆	No Concerns with data
		These indicators are at satisfactory performance levels.													
14	PCT Vital Signs	VSB 10	% Children who completed immunisation by recommended ages	PCT	Quarterly %	Rise	n/a	n/a	95%	77.5% to 94.7%, across the range	84.5% to 95.1% across the range	84.8% to 95.6% across the range	85% to 95%	⬆	No Concerns with data
		Performance is reported on a matrix of 12 metrics, combined into 7 indicators, to give an overall score. Performance has been improving, over recent months, though some specific immunisations continue to present performance issues.													

Leeds CITY COUNCIL

Originator:
Heather Pinches

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Report of the Chief Executive and Director of Public Health

Meeting: Health Scrutiny Board

Date: 22 March 2011

Subject: New Strategic Plans 2011-15

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

1 Executive Summary

1.1 This report presents for Scrutiny the proposals for the new set of strategic planning documents for advice and consideration before these go to Executive Board and Council for approval. This includes the proposals for the long term partnership strategy for the city the Vision for Leeds 2011 to 2030 as well as the set of delivery plans for the first 4 years. These proposals have been developed in light of the current financial situation which means that we need our priorities to be much more focused than previous plans. These proposals also take into account the results of two recent public consultations on the Vision for Leeds and Spending Challenge.

2 Purpose of the Report

2.1 Scrutiny of the proposals for the most important plans and strategies, as specified within the Budget and Policy Framework, ensures that these plans are robust and include the issues that are important to local people. Therefore, this report brings to the Board the proposals for the new Vision for Leeds 2011 to 2030 along with the first set of priorities which will be delivered by the council, and its partners, over the next 4 years. In addition, this report also includes the shared cross council priorities from the Council Business Plan.

3 Background Information

3.1 In December Executive Board considered changes to the partnership and planning framework which would enable a better alignment between the partnership structures, strategic plans and our supporting performance management arrangements. Allied to this in the current financial climate there is a need for our strategic plans to focus on a

smaller number of priorities to provide a more targeted and focused approach to delivering our long-term ambitions for the city.

3.2 In particular, a number of changes to the planning framework are in the process of being discussed and approved with amendments to the Council's Budget and Policy Framework (contained in Article 4 of the Constitution) in train. These changes are scheduled to go to the General Purposes Committee in March and Full Council in April. The new city planning framework is shown in appendix 1 and the role and function of each of these plans is detailed below:

3.2.1 **Vision for Leeds 2011 to 2030** - is the Leeds Sustainable Community Strategy which sets-out the long term ambition and aspirations for the city. It is being developed by the Leeds Initiative in conjunction with all local partners, including the public, private, and third sectors. The draft Vision was subject to an extensive consultation with the public and stakeholders through the 'What if Leeds' campaign.

3.2.2 **City Priority Plans 2011 to 2015** – these are new city-wide partnership plans which identify the key outcomes and priorities to be delivered by the council, and its partners, over the next 4 years. They replace the Leeds Strategic Plan and are aligned to the new Strategic Partnerships which are listed below. .

- Children's Trust Board
- Safer and Stronger Communities Board
- Sustainable Economy and Culture Board
- Regeneration Board
- Health and Wellbeing Board

These partnerships will own the plans and be responsible for ensuring the delivery of the agreed priorities. They are structured around a small set of short term (4 years) priorities each of which is measured through a headline indicator. As such they are the "must-do" priorities or "obsessions" for each partnership and may be supported by more detailed plans as the partnership sees fit. They are not the only things the partnerships will be responsible for but for the next 4 years they will be their top priorities. In the case of the Health and Wellbeing Partnership there will be requirement by statue to have a Health and Wellbeing Strategy in place by April 2012 and work will be on-going during 2011/12 to develop this document .

The priorities are to be written in clear, simple language that will be meaningful to everyone including the public. The headline indicators are crucial and have been carefully selected in order to galvanise efforts to drive improved outcomes across the partnership and should also bring with it progress across a wider set of outcomes. For example increasing the proportion of people in Leeds who are physically active will in turn improve mental health, reduce cardiovascular disease, reduce sickness levels, prevent falls in the elderly, reduce obesity (for adults and children), reduces risk of premature death etc. In this way we can ensure that the effort of the partnership is sufficiently focused but as many of the proposed priorities are closely linked to other areas of challenge they will also drive the delivery of a broader range of outcomes across the city.

3.2.3 **Council Business Plan 2011 to 2015** – this is the single plan for the council that brings together all the priorities for the council alongside the medium term financial plan. It has two main elements; a small number of cross council priorities and a set of directorate priorities. The cross council priorities are clearly aligned to the council's values and will drive change across the whole of the organisation. The directorate element of the plan

will outline the Directors own objectives and as such may include service transformation, service delivery and any significant contributions to the relevant City Priority Plans so that that are the most significant 'must do' priorities for the directorate.

3.3 These plans will run for a period of 4 years in order to align better to our financial planning cycles but will be reviewed after two years. They will be supported by more detailed plans within each partner organisation; as well as by more detailed service and locality plans within the Council. Service plans will continue to be published to provide members with a more detailed picture of the actions and activities happening across the authority. For this year in order to enable service plans to better reflect these priorities the deadline for completion has been extended until 30th June 2011.

3.4 The timeline for approval of the plans is for them to go to Executive Board in May; and for approval by Council in July 2011. However Members should note that the City Priority Plans for Regeneration and Sustainable Economy and Culture may have to follow a different timetable as the relevant Strategic Boards do not currently exist and need to be constituted first.

4 Main Issues

4.1 The ambition of the draft Vision for Leeds 2011 to 2030 proposes that Leeds should aim to be locally and internationally recognised as the "best city in the UK" – an aim which was well supported in the public consultation. The Council Business Plan also proposes the ambition to be the "best city council in the UK". We recognise that these are challenging ambitions but having this clear goal provides some clarity on what we need to tackle first in order to achieve this aim. It is also important that we set out clearly what this means in order to be able to judge our progress and ultimately our success. The five City Priority Plans and the Council Business Plan seek to do this and set out the first set of the "must-do" priorities that will help us achieve our ambition. In addition direct links can be seen from the Vision to the City Priority Plans where Boards have described what 'best city' means for each theme, e.g. 'the best city for children and families'.

4.2 Performance reporting arrangements are currently being developed but will be focused around the priorities in these plans. In addition it is anticipated that the Leeds Initiative Board will have a role to provide challenge to the 5 Strategic Boards in the following areas:

- Is there a sufficient level of ambition within the plans ie is each board doing enough to work towards the achievement of the aim to be the Best City?
- Examining how well the city is doing overall in tackling poverty and inequality looking across all 5 boards and challenging whether sufficient progress is being made.

4.3 In drawing up our new long term Vision and 4-year delivery plans we have had to balance a number of conflicting demands. This is as a result of the difficult situation we find ourselves in with the toughest local government funding settlement in many years. This is on top of a 'funding gap' arising from changes to the make up of the city like an aging population, rising birth-rates and the overall growth of the city. At the same time the city is experiencing a difficult economic climate with for example rising unemployment, inflationary pressures, increasing demands for social housing and reforms to the welfare systems. Many of these factors are resulting in greater demands on local authority and partner services as well as reductions in our income. This has led us towards the approach proposed where our plans are focused on the absolute "must-do's" and, therefore, inevitably do not include everything. The challenge for us is to ensure that we have got the right balance between focus while still including the most important issues

for the city. As well as balancing our ambition for the city with what is realistic and achievable in light of the agreed Budget.

4.4 The priorities of relevance to the Health Scrutiny Board are set out in Appendix 2 and includes the following elements:

- Vision – overall Vision aim to be recognised as 'the best city in the UK, locally and internationally' as well as the three supporting aims, to be a city which is:
  - fair, open and welcoming;
  - prosperous and sustainable; and
  - successful.
- City Priority Plans – the appendix includes the outline of all 5 City Priority Plan in order to enable Members to look across the entirety of the city's priorities. The Board may wish to particularly focus their attention on the Health and Wellbeing plan. However, it is important the Board understands the overall picture.
- Council Business Plan – the Board are asked for their views on the 5 Cross Council Priorities. The new public health duty for the local authority will transfer in April 2013, along with a ring fenced public health budget. National consultations on Public Health are currently underway with more details on future arrangements, covering Children and adults, expected in the summer. In view of this Directorate priorities for Public Health will be further developed and consulted upon and added to the Council Business Plan at a later date.

4.5 In drawing up our new long term Vision and 4-year delivery plans we have had to balance a number of conflicting demands. This is as a result of the difficult situation we find ourselves in with the toughest public sector funding settlement in many years including a significant reduction in government grant. This is on top of a 'funding gap' arising from changes to the make up of the city like an aging population, rising birth-rates and the overall growth of the city. At the same time the city is experiencing a difficult economic climate with for example rising unemployment, high inflation, pressures on social housing and reforms to the welfare systems. Many of these factors are resulting in greater demands on local authority and partners services as well as reductions in our income. This has led us towards the approach proposed where our plans are focused on the absolute must-do and therefore inevitably do not include everything. The challenge for us is to ensure that we have got the right balance between focus while still including the most important issues for the city. As well as balancing our ambition for the city with what is realistic and achievable in light of the agreed Budget.

4.6 Members are asked to look across the proposed set of strategic priorities and consider the following questions:

- Are the plans clear, simple and meaningful to all relevant audiences?
- Do the City Priority Plans and Council Business Plan clearly articulate the absolute must-do's for the next 4 years?
- Work is currently on-going to further develop the indicators that will be used to measure progress. Members are asked for their views/input into these and particularly what they would like to see reported to them in order to enable them to fulfil their Scrutiny role?

Public Consultation

4.7 We have recently received the results of two major consultation exercises (on the Vision for Leeds 2011 to 30 and the Spending Challenge) and the outcomes of these

consultations can be clearly seen within these proposed plans. Appendix 3 sets out the key issues that the public told us were important in these consultations and shows how these are included within the proposed set of priorities in the plans.

4.8 Clearly these plans with their stated aim of providing simplicity, clarity and focus do not include detail about what actions will be taken. It is proposed that each Cross Council and City Priority will be supported by an action plan and this will form the structure and focus for the performance reporting. Work is currently underway to develop these and it is proposed that these are brought to the relevant Scrutiny Board early in 2011/12.

4.9 The delivery of many of the priorities are inextricably linked and there are a number of cross cutting areas that have been raised as important issues such as tackling child poverty and improving the wider social determinants of health (ie good housing, access to employment, income levels etc). Many of the specific drivers for making improvements in these areas are already priorities which are included within the 5 City Priority Plans but it is recognised that we might want to bring these together to ensure progress is sufficient. Further work is underway to consider the role of the Main Partnership Board in challenging progress in these cross cutting areas. Once the action plans underneath have been developed (see above) a piece of work will be undertaken to identify these cross cutting areas that will inform further discussions about whether these are being adequately addressed.

5 Implications for Council Policy and Governance

5.1 The formal amendments to the Constitution to specifically include the City Priority Plans as a replacement to the Leeds Strategic Plan are underway but have not yet been completed. A report is being taken to the General Purposes Committee in March to consider these changes and make recommendations to full Council in April. Within this report it is proposed that all City Priority Plans are added to the Budget and Policy Framework alongside the Vision and the Council Business Plan which are already included. Provided that this amendment is agreed then the Vision for Leeds, the 5 City Priority Plans and Council Business Plan would collectively represent the medium and long term policy and strategy for the city. Therefore, they are being brought to Scrutiny at this time in line with the Budget and Policy Framework procedure rules for discussion and challenge.

5.2 Members should note that these priorities are also being consulted on with Partners across the city through the relevant strategic partnerships or with key stakeholders where these boards have not yet been constituted.

6 Legal and Resource Implications

6.1 It is important that the outcomes and priorities within our strategic plans are realistic and achievable and, in particular, that they align with the agreed budget. Members are specifically asked to consider this issue and provide their views as part of this consultation.

6.2 From April 2011 the Council will have a general public duty under the Equalities Act to

- eliminate unlawful discrimination, harassment, and victimisation
- advance equality of opportunity, and
- foster good relations

This is underpinned by specific duties which require public bodies to develop specific, measurable and reasonable equality objectives to further the aims of the general duty and to publish data and performance relating to these. As part of the specific duty the equality information needs to be accessible and the decision has been made in Leeds that the most pragmatic way of ensuring this is the case is to provide all the appropriate information in one place ie to produce an Equality Scheme. The priorities within these plans (well as the action plans that sit underneath) will be used as the basis for the development of this Scheme.

6.3 During the consultation period work will be undertaken to consider equality in each of these plans and will be subject to the council's equality impact assessment process.

7 Conclusions

7.1 This report brings to the Board the long term Vision and strategic priorities for the next four years. Members are asked to look across these priorities and make sure that they provide enough focus while also including all the most important things for the next 4 years while at the same time being realistic and achievable in terms of the resources available. These plans will be our focus for the next 4 years and it is vital that Members can collectively own them and that they reflect Member's ambitions for the council and for the city.

8 Recommendation

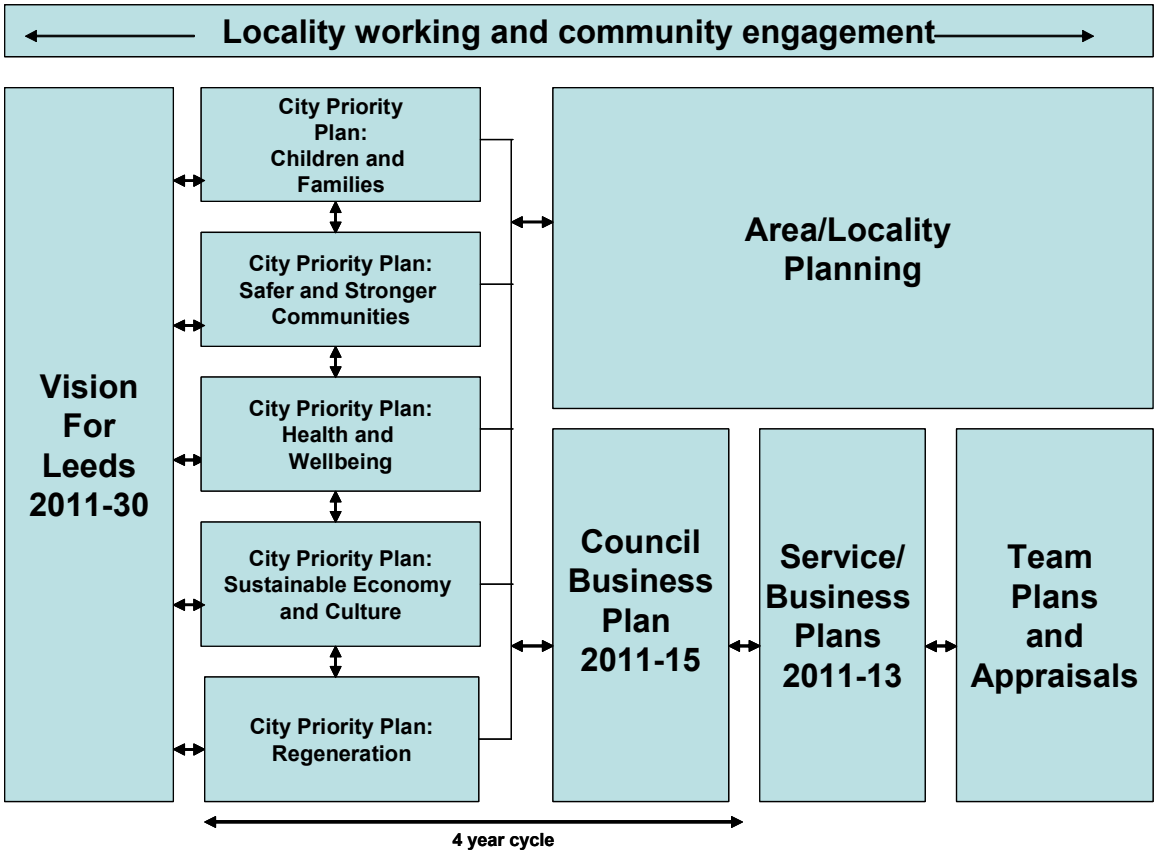
8.1 Members of the Board are asked to provide their views and feedback on the proposals for the new Vision and first set of strategic priorities to deliver the Vision over the next 4 years. In particular Members are asked to consider the following questions:

- Are the plans clear, simple and meaningful to all relevant audiences?
- Do the City Priority Plans and Council Business Plan clearly articulate the absolute must-do's for the next 4 years?
- Work is currently on-going to further develop the indicators that will be used to measure progress. Members are asked for their views/input into these and particularly what they would like to see reported to them in order to enable them to fulfil their Scrutiny role?

Background Papers

Executive Board Report on "Revenue Budget and Council Tax for 2011/12" 11th Feb 2011
Executive Board report on "Proposed changes to the Leeds Initiative Partnership and the City Planning Framework" 10th Dec 2010
Budget and Policy Framework Procedure Rules

Appendix 1 - The new city planning framework



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Appendix 2 – Outline Framework

Vision for Leeds 2011 to 2030

'By 2030, Leeds will be locally and internationally recognised as the best city in the UK .

Our Aims
By 2030, Leeds will be fair, open and welcoming. Leeds will be a place where everyone has an equal chance to live their life successfully and realise their potential. Leeds will embrace new ideas, involve local people, and welcome visitors and those who come here to live, work and learn.

To do this Leeds will be a city where:

- people from different backgrounds and ages feel comfortable living together in communities;
- people are treated with dignity and respect at all stages of their lives;
- we all behave responsibly;
- people have a shared sense of belonging;
- there are good relations within and between communities;
- the causes of unfairness are understood and addressed;
- people feel confident about doing things for themselves and others;
- our services meet the diverse needs of our changing population;
- people can access support where and when it is needed;
- local people have the power to make decisions that affect us;
- people are active and involved in their local communities; and
- everyone is proud to live and work.

By 2030, Leeds' economy will be prosperous and sustainable. We will create a prosperous and sustainable economy, using our resources effectively. Leeds will be successful and well-connected offering a good standard of living.

Leeds will be a city that has:

- a strong local economy driving sustainable economic growth;
- a skilled workforce to meet the needs of the local economy;
- a world-class cultural offer;
- built on its strengths in financial and business services, and manufacturing, and continued to grow its strong retail, leisure and tourism sectors;
- world-class, cultural, digital and creative industries;
- developed new opportunities for green manufacturing and for growing other new industries;
- improved levels of enterprise through creativity and innovation;
- work for everyone with secure, flexible employment and good wages;
- high-quality, accessible, affordable and reliable public transport;
- successfully achieved a 40% reduction in carbon emissions (by 2020);
- adapted to changing weather patterns;
- increased use of alternative energy supplies and locally produced food; and
- buildings that meet high sustainability standards in the way they are built and run.

By 2030, All Leeds' communities will be successful. Leeds' communities will thrive and people will be confident, skilled, enterprising, active and involved.

To do this Leeds will be a city where:

- people have the opportunity to get out of poverty;
- education and training helps more people to achieve their potential;
- communities are safe and people feel safe;
- all Leeds' homes are of a decent standard and everyone can afford to stay warm;
- healthy life choices are easier to make;
- community-led businesses meet local needs;
- local services, including shops and healthcare, are easy to access and meet our needs;
- local cultural and sporting activities are available to all;
- there are high quality buildings, places and green spaces, which are clean and looked after.

City Priority Plans 2011 to 2015

Partnership Board Vision/Outcomes	4 Year Priorities	Headline Indicator
Best City… for Children – Children's Trust Board Leeds will be a Child Friendly City where children will: • be safe from harm • do well in learning and have skills for life • choose healthy lifestyles • have fun growing up • be active citizens who feel they have voice and influence	Help children to live in safe and supportive families	Number of Looked after Children (LAC)
	Improve behaviour, attendance and achievement	Level of attendance / Rate of persistent absence (Primary and Secondary)
	Increase the levels of young people in employment, education or training	16 to 18 year olds that are not in Education, Employment or Training (NEET)
Best City… for Business – Sustainable Economy and Culture Board Leeds will be a great place for people and businesses, where • Significant new job opportunities are created; • Businesses are supported to start up, thrive and grow; • People enjoy a high quality and varied cultural offer • People choose sustainable travel options; and • We all benefit from a low carbon economy	More jobs are created	The creation of xx new jobs[1]
	Improved skills	Number of apprentices recruited
	Supporting the recovery of the Leeds economy	Redevelopment of xx Ha of brownfield land[2]
	More people get involved in the city's cultural opportunities	Proportion of adults and children who regularly participate in cultural activities
	Improved journey times and reliability of public transport	Reduced Bus journey time variability on the core network
	A better quality environment through reduced carbon emissions across the partnership	Per capita reduction in CO2 emissions in the LA area (NI186)

[1] needs further development but intention is to link to identified work programme (e.g. Trinity, Eastgate Arena etc)
[2] needs further development but intention is to link to identified an identified area/quantity of land & work programme (e.g. MEPC, International pool site, Quarry hill, Sovereign Street etc)

Partnership Board Vision/Outcomes	4 Year Priorities	Headline Indicator
Best City… for Communities – Safer and Stronger Leeds Board Leeds will be an attractive place to live, where: • People are safe and feel safe • The city is clean and welcoming • All communities are truly empowered, valued and engaged • People get on well together	Reducing crime levels and its impact across Leeds	Reduction in overall crime rate /head of population[3]
	Effectively tackle and reduce anti-social behaviour in our communities	Improved Public perception rates that ASB is being managed effectively[4]
	Ensure that local neighbourhoods are clean	Improvement on city-wide cleanliness measure (NI195 a – d)
	Increase a sense of belonging that builds cohesive and harmonious communities	% people who believe people from different backgrounds get on well together in the local area[5]
Best City… for Health and Wellbeing – Health & Wellbeing Board Leeds will be a healthy and caring city for all ages where: • everyone lives longer, healthy lives • everyone has the opportunity to improve their health • people will live safe and fulfilling lives in their own homes • everyone has active and independent lives	More people will make healthy lifestyle choices	Smoking prevalence in adults (over 18)[6]
	More people live safely in their own homes	Rate of emergency admissions to hospital Rate of admission to residential care homes
	People will have choice and control over their health and social care services	Proportion of people with long-term conditions feeling supported to be independent and manage their condition

[3] Improving our core cities position
[4] baseline and % improvement to be agreed
[5] previously measured through Residents Survey (and Place Survey) but the methodology and frequency of this is currently being revised but it is unlikely that we will be able to compare with other core cities so will have to aim to improve on the baseline position
[6] With a possible stretch target for the most deprived SOA's

Partnership Board Vision/Outcomes	4 Year Priorities	Headline Indicator
Best City… to Live - Regeneration Board Leeds will be a great place to live, where: • The growth of the city is sustainable and provides long-term benefits for all • Regeneration activity is creating the right physical environment for the delivery of vibrant and sustainable communities • A range of quality housing exists in different types, sizes and tenures that can meet the full range of residents' needs in a growing city • Local people benefit from regeneration investment	Maximise regeneration investment to deliver a range of housing options.	Number of new homes per year[7]
	Enabling growth of the city whilst minimising the impact on the environment or Enabling growth of the city whilst protecting the distinctive green character of the city *We know the wording for this priority is not quite right yet. We are trying to capture the balance that needs to be achieved between accommodating the growing population of the city whilst maintaining the character of the city and the surrounding towns and villages as well as providing good quality green space.*	TBA but may include: • Quality of green space – but it is unclear how we might measure this • Improved local Biodiversity (proportion of local sites where positive conservation management has been or is being implemented)? • Public satisfaction of quality of the environment • Design Standard Mark • Investment in green space arising from S106 developments
	Improve housing conditions and energy efficiency	Number of properties enhanced with energy efficiency measures

[7] target to be provided from the Corporate Planning Strategy due in summer 2011

Council Business Plan 2011-15

Cross Council Priorities and Indicators

	Value	Improvement Priority (delivered over first 1 or 2 years)	Measure/Target
1.	Working as a team for Leeds	Staff have clear understanding of their role, have clear objectives and performance targets which are monitored through a quality appraisal	100% staff have had an appraisal
2.	Being open, honest and trusted	Staff are fully involved in delivering change and feel able to make an impact on how services are delivered	% staff who feel engaged[8]
3.	Working with communities	We will consult with local people on changes that may affect their lives	% of key and major decisions which have evidence that consultation has taken place with local people[9]
4.	Treating people fairly	Equality Impact Assessments (EIA) influence council policy and decision making	% of key and major decisions where there is evidence that Equality issues have been fully considered[10]
5.	Spending Money Wisely	All directorates/services deliver within their approved budget with no overspends	No variation from approved directorate level revenue budget in year

Public Health Priorities and Indicators

These will be developed and added at a later date in line with the transfer of the public health duty to the local authority in 2013.

[8] This indicator would require some form of staff survey to take place on a regular basis, perhaps on a sampling basis. Options are being developed in conjunction with HR. This would not be a direct question but would be drawn from a number of questions that assess the factors that influence staff engagement like communication and leadership.

[9] This is a new indicator that is being built into the new report writing guidance to be launched in the new municipal year and reported via Governance Services. This will include all Executive Board and key/major decisions and the guidance asks the authors to provide links to relevant consultation on Talking Point or provide a reason why consultation is not required for this decision.

[10] This is a new indicator that is being built into the new report writing guidance to be launched in the new municipal year and reported via Governance Services. This will include all Executive Board and key/major decisions and the guidance asks the authors to provide with the report either a screening form or an Equality Impact Assessment in addition the guidance specifies that the cover report includes any key actions taken to address issues raised by the EIA.

Appendix 3 – How recent consultations are reflected in the new Plans

"What if Leeds.." Consultation on the new Vision	
Key Issues identified from the consultation	**Where this appears in our delivery plans**
Developing a sense of community, and doing things more locally;	This is broadly included in our developing approach to locality working which is a priority for Planning, Policy and Improvement but there is also a specific priority to: • Increase a sense of belonging that builds cohesive and harmonious communities
An acceptance that residents will need to do more for themselves and for their community;	This is broadly included in our developing approach to locality working which is a priority for Planning, Policy and Improvement as well as within the 2011/12 budget where a number of specific community asset transfers are proposed.
No list of capital projects, reflecting the current economic situation	This is reflected in the reduced capital programme
Environment, particularly in terms of cleanliness, but also in terms of developing green businesses, and businesses taking advantage of green technologies;	This is reflected in the following priorities: • Ensure that local neighbourhoods are clean • Enabling growth of the city whilst minimising the impact on the environment (wording not yet finalise) • More jobs are created and improved skills – together these should encourage green business but it did not seem sensible in the short term to restrict this to a specific sector
Transport, particularly improving public transport, especially cost and reliability;	This is reflected in the following priority: • Improved journey times and reliability of public transport
Jobs and work;	This is reflected in the following priorities: • More jobs are created • Improved skills
Tackling inequalities;	This is included across many of the City Priority Plans and will be a cross cutting issue that will be picked up by the Main Board. Key actions are also brought together within the council 's Equality Scheme and specific issues will also be brought out within the performance reports for many of the priorities.
Better culture and entertainment;	This is reflected in the following priority: • More people get involved in the city's cultural opportunities
A city that is friendly for everybody, both in the city centre and the communities.	This is reflected in the following priority: • Increase a sense of belonging that builds cohesive and harmonious communities

Spending Challenge Consultation	
Key Issues identified from the consultation	**Where this appears in our delivery plans**
Prioritising Services for Vulnerable People including the elderly and disabled	This is reflected in the increased budget allocation for Adult Social Care in 2011/12 and the further planned investment within the medium term Financial Strategy.
Supporting people to stay in their own homes	This is reflected in the following priority: • People will live safe and fulfilling lives in their own homes
Giving choice in social care services	This is reflected in the following priority: • People will have choice and control over their health and social care services
Tackling the worst anti-social behaviour	This is reflected in the following priority: • Effectively tackle and reduce anti-social behaviour in our communities
Encouraging more recycling	This is reflected in the following priority: • Ensure that local neighbourhoods are clean – there are also likely to be more specific priorities within the Environment and Neighbourhoods Directorate priorities but these are not yet confirmed
More Affordable Housing	This is reflected in the following priority: • Maximise regeneration investment to deliver a range of housing options.
Creating more jobs especially for local people	This is reflected in the following priorities: • More jobs are created
Improving transport infrastructure particularly public transport	This is reflected in the following priority: • Improved journey times and reliability of public transport
Encouraging the community to take responsibility for their own actions/place	This is broadly included in our developing approach to locality working which is a specific priority for the Planning, Policy and Improvement Directorate.
Being involved in decision making and service design	This is broadly included in our developing approach to locality working but more specifically there is a cross council priority and indicator to ensure that consultation is embedded in our decision making processes. Through monitoring this closely at the highest level this will also have an impact on the quality of consultation.
Better use of buildings	This is broadly reflected with the cross council value and priority to "Spend Money Wisely" and the Budget and medium term Financial Strategy include a number of specific actions. Also the Changing the Workplace programme is specifically about more efficient use of our buildings and this is a Directorate priority for Planning, Policy and Improvement albeit that it will involve all Directorates. In addition the City Development Directorate priorities includes the delivery of the Council's Asset Management plan.

Leeds CITY COUNCIL

Originator: Steven Courtney

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Report of the Head of Scrutiny and Member Development

Scrutiny Board (Health)

Date: 22 March 2011

Subject: Updated Work Programme 2010/11

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

1.0 Purpose

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

2.0 Background

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

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

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

2.3 As such, and as in previous years, the work programme, including any emerging issues, will continue to be routinely presented to the Scrutiny Board for consideration, amendment and/or agreement: The work programme was most recently presented and agreed at the Scrutiny Board meeting held on 25 January 2010, and an updated version is now presented at Appendix 1 for consideration.

3.0 Update on specific work areas and associated activity

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

NHS proposed reforms

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

3.3 While the draft Health and Social Care Bill makes its way through Parliament and the precise detail is still to be confirmed, representatives from the major NHS organisations across the City will be attending the Board (elsewhere on the agenda) to outline the NHS Operating Framework 2011/12 and the specific implications for the organisation and the City.

Children's Congenital Cardiac Services – national review

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

3.5 The Joint HOSC's first meeting is scheduled fro 14 March 2011, details of which will be reported at the meeing.

Inquiry into Teenage Conception

3.6 Following the Scrutiny Board's decision to undertake some joint scrutiny with Scrutiny Board (Children's Services), an initial working group meeting to help sope this work has been scheduled for 20 April 2011. Precise attendance from members of the Scrutiny Board (Health) is still to be confirmed.

Health Service Developments Working Group

3.7 As reported at the previous meeting, the Health Service Developments Working Group, scheduled for 15 February 2011 was postponed. A further meeting of the working group is still to be arranged.

Dermatology Services

3.8 Members of the Board will be aware of the ongoing concerns of members of the Leeds Dermatology Patients Panel (LDPP) regarding changes to both in-patient and out-patient services.

3.9 At a recent meeting between the Chair and representatives of the LDPP, it was agreed to invite Leeds Teaching Hospitals NHS Trust to the April meeting of the

Board to discuss its plans for dermatology services and the concerns expressed by the LDPP.

4.0 Work programme (2009/10)

4.1 Members will be aware that the Scrutiny Board's work programme should be regarded as a 'live' document, which may evolve and change to reflect any in-year change in priorities and/or emerging issues. Nonetheless, when considering additions and/or other amendments to the work programme, members of the Board as advised to consider the relative priority of any additional areas and reflect on the capacity for undertaking any additional work.

4.2 In the context of the information presented in this report and discussed at the meeting, the Scrutiny Board is asked to consider the current work programme (Appendix 1) and agree / amend as appropriate.

5.0 Recommendations

5.1 Members are asked to consider the details presented in this report (and supporting appendices) and to agree / amend the current work programme, as appropriate.

6.0 Background Documents

- Scrutiny Board (Health) – Work programme (June 2010)
- Scrutiny Board (Health) – Work programme (February 2011)

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APPENDIX 1

Scrutiny Board (Health)
Work Programme 2010 /11

Item	Description	Notes	Type of item
Meeting date – March 2011			
Operating framework 2011/12	To consider the Operating framework (2011/12) and its implications for the local health economy.	Added to work programme in January 2011	B
Health Priorities	To consider draft health priorities for Leeds		B
Quarterly Accountability Reports	To receive quarter 3 performance reports		PM
Meeting date – April 2011			
Recommendation Tracking	To monitor progress against the recommendations agreed following previous Scrutiny Board inquiries.		MSR
Quality Accounts	To consider draft quality account submissions for 2010/11		PM
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 1

Scrutiny Board (Health)
Work Programme 2010 /11

Working Groups			
Working group	**Membership**	**Progress update**	**Dates**
Health Service Developments Working Group	All Board members (subject to availability)	• Working Group established in July 2010 • Working group meeting held on 14 September 2010, and 14 December 2010 • Working group meeting scheduled for 15 February 2011 cancelled. • Future meeting to be arranged	14 Sept. 2010 14 Dec. 2010 15 Feb. 2011 April 2011 (TBC)

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
PM	Performance management	B	Briefings (Including potential areas for scrutiny)
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Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Healthier Communities	To consider the outcome of the recent peer review and the associated actions/ improvement plan.	Process for publication to be confirmed. Member of the peer review team to be invited to present the report (TBC).
Narrowing the Gap	To consider the impact of the 'Narrowing the Gap' initiative, in terms of improving healthy outcomes.	Added to the work programme: December 2009, but no formal consideration of issue in 2009/10. Highlighted as an area to consider in July 2010.
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. Briefing note produced by National Specialised Commissioning Team (NSCT) published in August 2010. Discussions around forming a series of joint health scrutiny committee to consider the proposals are on-going.

Key:			
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Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Children's Neurosurgery Services	To contribute to the national review and consider any local implications.	**Carried over from 2009/10.** First bulletin published (September 2009) National stakeholder event held 30 November 2009. Newsletter issued in April 2010. Local involvement likely to be towards the end of 2010.
Foundation Trust Status	To consider LTHT's progress against its aspiration of attaining Foundation Trust status.	**Carried over from 2009/10.** Initial and subsequently revised proposals considered in 2009/10. Details regarding anticipated changes in costs to support proposed new governance arrangements requested in May 2010
Primary Care Service Development and use of the Capital Estate	To consider the NHS Leeds' longer-term strategy for developing/ delivering services through its capital estate.	**Added to the work programme in December 2009**, but no formal consideration of issue in 2009/10. It may be more appropriate to consider this matter across the whole local health economy.

Key:			
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Scrutiny Board (Health)
Work Programme 2008/09

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

Key:			
RFS	Request for scrutiny	MSR	Monitoring scrutiny recommendations
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Scrutiny Board (Health)
Work Programme 2008/09

Unscheduled / Potential Items		
Item	**Description**	**Notes**
Dermatology Services	To consider proposals for the delivery of dermatology services.	Follow up to the issues considered in 2009/10. **Added to work programme in July 2010.**
Hospital Discharges	To consider a follow up report on progress against the recommendations (i.e. 15, 16 and 17) detailed in the Independence, Wellbeing and Choice inspection report	Identified as potential issue for 2009/10 but insufficient capacity to consider the issue. **Highlighted as a potential area for scrutiny by the Executive Board member in June 2010.**
Out of Area Treatments (Mental Health)	To consider the report prepared by Leeds Hospital Alert and the response from LPFT.	Leeds Hospital Alert report received 1 July 2009. Responses received from LPFT in July 2009. No formal consideration of issue in 2009/10. **Carried over from 2009/10.**

Key:			
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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.	**Carried over from 2009/10.** Various correspondence exchanged and clarification sought. The Board to maintain a watching brief and kept up-to-date with any developments. No formal consideration of issue in 2009/10.

Key:			
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