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SCRUTINY BOARD (HEALTH AND WELL-BEING AND ADULT SOCIAL CARE)

Meeting to be held in Civic Hall, Leeds on
Wednesday, 21st November, 2012 at 10.00 am

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

MEMBERSHIP

Councillors

P Truswell	-	Middleton Park;
G Hussain	-	Roundhay;
T Murray	-	Garforth and Swillington;
J Walker	-	Headingley;
C Fox	-	Adel and Wharfedale;
S Armitage	-	Cross Gates and Whinmoor;
K Bruce	-	Rothwell;
J Illingworth (Chair)	-	Kirkstall;
S Varley	-	Morley South;
S Bentley	-	Weetwood;
M Robinson	-	Harewood;

Co-optees

Joy Fisher	Leeds LINk
Sally Morgan	Equality Issues
Betty Smithson	Leeds LINk
Emma Stewart	Alliance of Service Users and Carers

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

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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 Head of Governance Services at least 24 hours before the meeting).	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND THE 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 on this agenda.**	

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			**DECLARATION OF DISCLOSABLE PECUNIARY AND OTHER INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-18 of the Members' Code of Conduct. Also to declare any other significant interests which the Member wishes to declare in the public interest, in accordance with paragraphs 19-20 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 meeting held on 24th October 2012.	1 - 10
7			**TRANSFORMATION OF HEALTH AND SOCIAL CARE SERVICES IN LEEDS** To consider a report of the Head of Scrutiny and Member Development on the transformation of Health and Social Care Services in Leeds.	11 - 142

8			**REVIEW OF CHILDREN'S CONGENITAL HEART SERVICES IN ENGLAND; JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (YORKSHIRE AND THE HUMBER) - REFERRAL TO THE SECRETARY OF STATE FOR HEALTH (DRAFT REPORT)** To consider a report of the Head of Scrutiny and Member Development on the review of Children's Congenital Heart Services in England; Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) - Referral to the Secretary of State for Health (Draft Report).	143 - 152
9			**WORK SCHEDULE** To consider a report of the Head of Scrutiny and Member Development setting out a provisional work schedule for the Board for consideration.	153 - 180
10			**DATE AND TIME OF THE NEXT MEETING** Wednesday 19th December 2012 at 10.00am (Pre-meeting for Board Members at 9.30am)	

SCRUTINY BOARD (HEALTH AND WELL-BEING AND ADULT SOCIAL CARE)

WEDNESDAY, 24TH OCTOBER, 2012

PRESENT: Councillor J Illingworth in the Chair

Councillors S Bentley, K Bruce, N Buckley, C Fox, M Harland, G Hussain, T Murray, P Truswell and S Varley

CO-OPTED MEMBERS:

Joy Fisher, Leeds LINk
Betty Smithson, Leeds LINk
Emma Stewart, Alliance of Service Users

47 Chair's Opening Remarks

The Chair welcomed everyone to the October meeting of the Scrutiny Board (Health and Well-being and Adult Social Care).

48 Declaration of Disclosable Pecuniary and other Interests

The following other significant interest was declared at the meeting:-

- Joy Fisher (Leeds LINk) in her capacity as a member of the 'Making it Real' Expert Advisory Group involved with preparation of the document entitled 'Better Lives Explained, a Leeds draft Local Account of Adult Social Care for 2012/13 (Agenda Item 9) (Minute 53 refers)

49 Apologies for Absence and Notification of Substitutes

Apologies for absence were received on behalf of Councillors M Robinson and J Walker and Sally Morgan, Co-optee (Equality Issues).

Notification had been received for Councillor N Buckley to substitute for Councillor M Robinson and for Councillor M Harland to substitute for Councillor J Walker.

50 Minutes of the Previous Meeting

Councillor P Truswell referred to the Review of Children's Congenial Cardiac Services (Minute 39 refers) and asked for the Chair to provide an update on progress.

The Chair informed the meeting that the issue had been referred to the Secretary of State for determination but there had been a delay in completing the supporting referral report from the Scrutiny Board and the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) (Joint HOSC), due to significant delays in obtaining all the relevant background information

from the Joint Committee of Primary Care Trusts (JCPCT) and its supporting secretariat.

Councillor T Murray enquired about the timescales in relation to this authority presenting a case to the Minister.

The Principal Scrutiny Adviser informed the meeting that it was hoped to finalise the supporting referral reports and submitted within approximately four/five weeks. It was noted that an additional meeting of the Scrutiny Board (Health and Wellbeing and Adult Social Care) may be required to agree the referral report.

Joy Fisher, Leeds LINk referred to the Update on Recommendations following deputation to Scrutiny by the National Federation of the Blind (Minute 40 refers) and informed the meeting that attendees in the audience at the last Board meeting had raised concerns that the debate had not been an honest account of the current situation.

The Principal Scrutiny Adviser informed the meeting that the Head of Scrutiny and Member Development had received a letter from the National Federation of the Blind on this issue. A reply had been sent requesting specific details of any inaccurate and/or misleading information that had been presented to the Scrutiny Board. The Principal Scrutiny Adviser also advised that to date no further details had been provided.

In terms of the way forward, the Principal Scrutiny Adviser informed the meeting that a further dialogue was required with Service Users and that there would be discussions with the Chair around how the National Federation of the Blind might contribute to the discussion when the Scrutiny Board re-visited this issue later in the municipal year.

RESOLVED –

(a) That the update and additional information provided be noted.

(b) That the minutes of the meeting held on 26th September 2012 be approved as a correct record.

51 2012/13 Performance Report - Quarter 1

The Head of Scrutiny and Member Development introduced aspects of a report from the Assistant Chief Executive (Customer Access and Performance) deferred from the previous meeting. The report summarised the performance against the strategic priorities for the council relevant to Health and Wellbeing and Adult Social Care Scrutiny Board.

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

- Performance Reports for the four Health and Wellbeing City Priority Plan Priorities (Appendix 1 refers)

The following representatives were in attendance and responded to Members' queries and comments:-

- Councillor L Mulherin (Executive Board Member for Health and Wellbeing), Leeds City Council
- Dr. Ian Cameron (Joint Director of Public Health) – NHS Airedale Bradford & Leeds/Leeds City Council

At the request of the Chair, Councillor Mulherin and the Joint Director of Public Health reported on the public health elements of the report. In their respective presentations they focused on smoking and health inequalities as identified in the Health and Wellbeing City Priority Plan and provided the meeting with background information and on the measures and initiatives that were currently in place for both priority areas.

Smoking

A number of specific issues around smoking prevalence and reducing the level of smoking across the City, including the following matters, were highlighted and discussed:

- Performance had plateaued – with fewer people attempting to stop smoking, and of those attempting to stop, fewer attempts were being made
- Tackling the issue of niche tobacco was being addressed through a partnership approach with other authorities and West Yorkshire Trading Standards
- Secured funding to undertake a peer review of the smoking action plan to assess its robustness and overall effectiveness
- The health of employees and reducing potential exposure to second-hand smoke
- The proposed introduction of smoke free zones immediately outside public buildings to limit general and potentially concentrated exposure to second-hand smoke
- Interventions to prevent school-aged children smoking and Leeds work to contribute to the evidence base in this area, which was highlighted as being relatively weak (currently)
- Issues and approaches associated with 'changing behaviours', generally and within specific communities, including BME communities
- The need for multi-facetted interventions and approaches across a range of public health matters, including reducing levels of smoking

Health Inequalities

In relation to health inequalities, the Joint Director of Public Health reported that the data included within the report was out of date and that up-to-date data was expected in early November 2012. Reference was made to the overall number of deaths in Leeds and the number of deaths in deprived areas. Through a better understanding of the data (and the

underlying reasons) it was hoped to areas address issues of health inequalities across the City.

A number of specific issues relating to health inequalities across the City, including the following matters, were highlighted and discussed:

- Addressing issues associated with health inequalities and the relationship with successful delivery of the associated action plans on:
    - to ensure children have the best start in life;
    - to maximise income and reduce debt;
    - improve housing, transport and the environment;
    - increase employment and healthy workplaces;
    - to maximise educational attainment; and,
    - improve access to services that prevent and treat ill health

  Members requested copies of the current action plans and discussed the balance between targeting those area likely to provide 'quick wins' and those likely to have longer-term benefits

- The need for multi-facetted interventions and approaches across a range of public health matters
- Difficulties associated with measuring the differences in health outcomes between different areas of the City – particularly in terms of demonstrating progress. This included discussion around the rationale for not using current life expectancy as the benchmark for measuring progress
- An outline of the work currently being undertaken in the 3rd sector with Leisure/Children's Services around physical activity and health

RESOLVED –

a) That the contents of the report and appendices be noted.
b) That the specific information requested by individual Board Members be forwarded to the Principal Scrutiny Adviser for dissemination.
c) That in consultation with the Principal Scrutiny Adviser, the Joint Director of Public Health be requested to submit a report to a future Board meeting on how the transfer of public health functions to the Council were being developed and progressed.

52 Balancing the Council's duties as a planning authority with its future public health responsibilities

The Head of Scrutiny and Member Development submitted a report to assist the Scrutiny Board's consideration of issues associated with balancing the Council's duties as a planning authority with its future public health responsibilities.

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

- Changes to Core Strategy Text (Appendix 1 refers)

- Core Strategy – Leeds Local Development Framework – Health Background Topic Paper – Publication Draft – February 2012 (Appendix 2 refers)
- Fair Society, Healthy Lives – The Marmot Review – Executive Summary – Strategic Review of Health Inequalities in England post 2010 (Appendix 3 refers)
- Public Health in Leeds City Council – New Responsibilities – Report of Director of Public Health – Executive Board – 20th June 2012 (Appendix 4 refers)

The following representatives were in attendance and responded to Members' queries and comments:-

- Councillor L Mulherin (Executive Board Member for Health and Wellbeing), Leeds City Council
- Dr. Ian Cameron (Joint Director of Public Health) – NHS Airedale Bradford & Leeds/Leeds City Council
- David Feeney (Head of Forward Planning and Implementation) – City Development, Leeds City Council

At the request of the Chair, the Head of Forward Planning and Implementation provided the meeting with the background context and reiterated that health was an important consideration within the Council's overall Local Development Framework (LDF).

The Head of Forward Planning and Implementation advised the Scrutiny Board that:

- The Core Strategy would form part of the overall Local Development Framework (LDF) and a detailed site allocations plan would follow once the Core Strategy had been agreed
- The details presented were approved for consultation by Executive Board in February 2012
- Details of proposed changes to the consultation draft were included in the Scrutiny Board's agenda papers
- A report on the outcomes of the consultation is scheduled to be considered by Executive Board on 7 November 2012, prior to the proposed final version being presented to Full Council later in November 2012

The Joint Director of Public Health advised the Scrutiny Board that Public Health had contributed to the development of the document presented to the Scrutiny Board. The Joint Director of Public Health added that in considering the draft Core Strategy, he had considered three broad questions, namely:

(1) Whether the Core Strategy reflected planning's contribution to health;
(2) Whether the Core Strategy covered the breadth of planning's contribution to health; and,

(3) In terms of implementation, whether there was sufficient assurance that the health and wellbeing aspect of planning would become incorporated as developments occur

The Joint Director of Public Health outlined that while the Core Strategy reflected the Council's emerging Public Health duties/ responsibilities, he had felt that earlier drafts had underplayed some of the health challenges facing the City and the contribution of planning in helping to address such challenges. However, it was felt that initial concerns had been addressed and the current draft strategy included all the contributions that planning can make towards improving health across the City.

Reference was also made to an additional document produced by Marmot (The Marmot Review: Implications for Spatial Planning), which provided evidence on the relationship between aspects of spatial planning, the built environment, health and health inequalities.

In terms of implementation of the strategy/ framework, the Joint Director of Public Health welcomed the proposal to establish a health and planning reference group, to ensure the contribution and consideration of health issues much earlier in the planning process than had historically been the case.

A number of specific issues were highlighted and discussed, including the following matters:

- The general complexities associated with health and well-being and its relationship with inter-dependencies such as employment, income, housing, education and the built environment and consideration of how specific areas of the City that had historically had higher levels of deprivation, for example Burley, Chapeltown, Harehills, Beeston and other outer areas, would benefit from the development of the LDF Core Strategy
- Concerns about the rapid Health Impact Assessment process adopted to consider the health implications / considerations of planning. There was a general view that this perhaps reinforced and reflected the position that, historically, health implications were not considered early enough within the planning/ development processes. Assurances were given by the Joint Director of Public Health that a much closer working relationship between City Development and Public Health had developed over recent months and that he was confident this would continue
- Queries regarding the accuracy of the population growth projections (approx. 200,000 by 2033 (20 years), as this represented more than double the current health dynamic in the City (i.e. the difference between births and deaths)
- Implications of the population growth projections on infrastructure across the City and the availability of affordable housing across the City. It was outlined that changes to the affordable housing policy

were proposed, which would make the policy applicable to all residential developments (from 1 property upwards)

- Subjectivity around the term 'sustainable development' and the need to maximise the development of brownfield (previously developed) sites to help control the expansion of urban areas
- The anticipated guidance from the National Institute for Health and Clinical Excellence (NICE) regarding the relationship between planning and health. Specifically, members queried how this and future guidance / best practice evidence would be taken into as part of specific future planning considerations/ proposals. The Joint Director of Public Health highlighted the importance of the ongoing involvement of Public Health professionals within the planning process. It was also stated that ensuring the most up-to-date guidance / evidence was considered would be a key role for Public Health professionals and would be a key responsibility of the Joint Director of Public Health
- The general availability and/or provision of green space. It was highlighted that this would form part of the 'site allocation process', which would consider where the different elements of the Local Development Framework (including green space, housing etc.) would be provided across the City. There was a recognition of the difficulties associated with creating additional open/ green spaces in existing highly populated urban areas, however the Core Strategy aimed to help improve access to walking, cycling and green infrastructure across the City
- The protection of playing pitches and where issues of re-provision elsewhere in the City were considered, the 'elsewhere' was key to those communities where the original provision may be lost
- Securing job opportunities for local people through S106 employment agreements. It was highlighted that provision for such agreements was available within the LDF policy framework, however it was suggested that issues remained regarding the application and implementation of the policy

Members also raised some issues relating to specific development's and planning applications. The Head of Forward Planning and Implementation responded in general terms but advised he was unable to address specific queries related to individual planning applications/ developments.

Members of the Board were also advised that, as the Leeds Local Development Framework Core Strategy forms part of the council's budget and policy framework, the Scrutiny Board (Sustainable Economy and Culture) – as the relevant Scrutiny Board – would be invited to make any formal comments at its meeting on 1 November 2012, before the final draft was submitted to the Executive Board for recommendation to Full Council.

RESOLVED-

a) That the contents of the report and appendices be noted.
b) That the Principal Scrutiny Adviser ensure the points raised by the Scrutiny Board (Heath and Wellbeing and Adult Social Care) were

reported to the Scrutiny Board (Sustainable Economy and Culture) – as the relevant Scrutiny Board – for consideration ahead of the final draft of the Core Strategy being submitted to the Executive Board for recommendation to Full Council.

53 Better Lives Explained - Leeds draft Local Account of Adult Social Care 2012/13

The Head of Scrutiny and Member Development submitted a report in relation to 'Better Lives Explained' – Leeds' draft Local Account of Adult Social Care 2012/13.

Appended to the report was a copy of the following document for the information/comment of the meeting:-

- Better Lives Explained – Our local account of Adult Social Care 2012/13 – October 2012/13

The following representatives were in attendance and responded to Members' queries and comments:-

- Mick Ward (Head of Commissioning) – Leeds City Council, Adult Social Services
- Stuart Cameron–Strickland (Head of Policy, Performance and Improvement) – Adult Social Services, Leeds City Council

At the request of the Chair, the Head of Policy, Performance and Improvement outlined the background information and informed the meeting that the document was still draft and subject to amendment.

Members discussed the context of service delivery over recent years, including the projected £60m savings against a background of increase demand for services over the last five years.

Members welcomed the overall style and format of the draft report. Some specific issues were discussed and a number of potential improvements / amendments to the current draft were highlighted, including:

- Confirmed accuracy of some of the information presented
- Improvements to charts, diagrams and the associated legends throughout the documents, to ensure they were readable
- Consideration be given to including a specific section on complaints
- Confirmation that the contact numbers provided were correct
- Inclusion of contact numbers for 'one stop shops'
- Where possible, improved clarity within the performance data around what was being measured

Members also sought clarification in relation to Neighbourhood Networks and the level of engagement with BME communities. It was agreed that this information would be provided and disseminated to the Board.

Members discussed more detailed consideration of the personalisation agenda and issues associated with personal budgets, and agreed to consider this under the work schedule item (Minute 54 refers).

RESOLVED –

a) That the contents of the report and appendices be noted and welcomed.
b) That the Head of Policy, Performance and Improvement use the comments made by the Scrutiny Board to make the necessary improvements to the current draft.
c) That progress against the plans identified in Leeds' Local Account of Adult Social Care 2012/13 be linked into the quarterly performance monitoring cycle and a progress report to be submitted to the Board meeting in March 2013.

(Councillor G Hussain left the meeting at 12.05pm during discussions of the above item)

(Councillor M Harland left the meeting at 12.15pm during discussions of the above item)

(Councillor S Bentley left the meeting at 12.20pm at the conclusion of the above item)

54 Work Schedule

The Head of Scrutiny and Member Development submitted a report which presented the Scrutiny Board's outline work schedule for the remainder of the current municipal year.

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

- Scrutiny Board (Health and Wellbeing and Adult Social Care) 2012/13 Municipal Year – Work Schedule (Appendix 1 refers)
- Executive Board minutes of meetings held on 18th July 2012 and 5th September 2012 (Appendix 2 refers)

The Principal Scrutiny Adviser, Scrutiny Support presented the report and a number of specific issues, including the following matters, were highlighted and discussed:

- Consideration of the personalisation agenda, including national and local requirements within the work schedule (likely to be scheduled for March/April 2013)
- Inclusion of a report on the transfer of public health responsibilities, progress and associated timescales within the work schedule
- The workshop/ seminar on Loneliness and Social Isolation being held in Sheffield on 15 November 2012 (details previous e-mailed to all members of the Scrutiny Board)

- The Leeds Transformation Programme event being organised for Wednesday 7th November 2012 at 5.00pm. This would help prepare the Board for formal consideration of a series of reports regarding 'transformation' at its November meeting
- The possibility of convening an additional Board meeting in November 2012 to consider the report to support the referral to the Secretary of State for Health regarding the Joint Committee of Primary Care Trusts' decision following the review of Children's Congenial Cardiac Services
- A report to Executive Board likely to presented in the near future on the implications (and associated progress) relating to The Health and Social Care Act (2012). This was likely to include implications for scrutiny. While any detailed regulations and guidance was still awaited, the Scrutiny Board agreed it was difficult to foresee how Council could discharge its powers relating to the scrutiny of health other than through the existing overview and scrutiny function/ arrangements
- The need to convene a meeting of the Health Service Development Working Group in the near future
- Consideration be given to the potential input of Mr J Pritlove at the Mental Health working group meeting scheduled for December 2012. The specific purpose being to discuss issues around Out of Area Placements

RESOLVED –

a) That the contents of the report and appendices, alongside the issues discussed at the meeting, be noted.
b) That the Executive Board minutes presented be noted.
c) That, with the inclusion of the areas identified at the meeting, the work schedule as presented be approved.

55 Date and Time of the Next Meeting

Wednesday 21st November 2012 at 10.00am – Pre- meeting for all Board Members at 9.30am

(The meeting concluded at 12.30pm)

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Well-Being and Adult Social Care)

Date: 21 November 2012

Subject: Transformation of Health and Social Care Services in Leeds

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. In June 2012, the Scrutiny Board (Health and Wellbeing and Adult Social Care) agreed its inquiry report and recommendations associated with the Transformation of Health and Social Care Services in Leeds.

2. The purpose of this report is to present an update against a number of the Scrutiny Board's previous recommendations. A summary of the recommendations from that report is attached at Annex 1 for information.

3. Updates covering the following areas are attached to this report:

   Governance arrangements for integrated working with Adult Social Care and Health (Recommendation 10)

4. The report presented to Executive Board on 17 October 2012, is attached for consideration. The minutes from that meeting are presented elsewhere on this agenda for consideration. However, the Scrutiny Board is asked to note the following Executive Board resolutions in this regard:

   (a) That the approach to Section 75, Section 76 and Section 256 agreements for the governance and pooling of Health and Social Care resources be endorsed.

   (b) That the process for the Director of Adult Social Services to approve future agreements under the delegations afforded to her within the Council's Constitution, Officer Delegation Scheme (Executive Functions), be noted.

(c) That it be noted that the agreements will be subject to formal review every 3 years, but monitored annually during this time in order to assure their continuing relevance and effectiveness.

Partnership arrangements between Adult Social Care and Leeds and York Partnership Foundation Trust (LYPFT) (Recommendation 9)

5. The Director of Adult Social Services approved the Section 75 Agreement between LYPFT and Leeds City Council for the integration of council Mental Health Assessment and Care Management Teams with LYPFT Community Health Teams on 28 September 2012. The associated report is attached at Annex 3 or members consideration.

Integrated health and social care teams (including lessons from demonstrator sites (Recommendation 8) and Risk stratification (Recommendation 7)

6. An update report is attached at Annex 4.

Progress report on developing Harry Booth House (Recommendation 11)

7. An update report is attached at Annex 5.

8. To assist the Scrutiny Board's consideration of the various aspects presented in this report, appropriate officers from Adult Social Care and local NHS organisations have been invited to attend the meeting.

Recommendations

9. Members are asked to consider the information presented and determine any further action that may be required.

Background documents [1]

Scrutiny Inquiry Report: The Transformation of Health and Social Care Services in Leeds (July 2012).

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

ANNEX 1

Scrutiny Inquiry Report: Transformation of Health and Social Care Services in Leeds (June 2012)

Summary of recommendations

Recommendation 1

During consideration of its work schedule for 2012/13, the successor Scrutiny Board (Health and Wellbeing and Adult Social Care) includes maintaining an overview of the Leeds Health and Social Care Transformation Programme and Programme Board within its work schedule.

Recommendation 2

That, by August 2012, the Chair of Leeds Health and Social Care Transformation Board reviews the membership of the Board and considers expanding the membership to include a Third Sector Leeds representative.

Recommendation 3

By August 2012, NHS Leeds provides a further report to the successor Scrutiny Board that clearly outlines the savings (in terms of both 'cash releasing' and increased productivity) achieved through the work of the Transformation Board and the associated projects / supporting workstreams.

Recommendation 4

Following the operation of the local 111 service for a period not exceeding 18-months, that the Clinical Commissioning Groups review the provision of local urgent care services to ensure they continue to meet the needs of the people of Leeds.

Recommendation 5

That the Chief Executive of NHS Airedale, Bradford and Leeds ensures that:

(a) The Scrutiny Board comments aimed at improving access to Leeds Urgent Care Services are considered and taken forward appropriately.

(b) Future public consultation exercises should, as a minimum gather partial postcode information to facilitate better interrogation and analysis of responses.

Recommendation 6

That the Chief Executive of NHS Airedale, Bradford and Leeds ensures that Clinical Commissioning Groups are encouraged to agree and adopt consistent approaches to consultation, including the collection and analysis of postcode information.

Recommendation 7

By December 2012, the Director of Adult Social Services, the Chief Executive of NHS Airedale, Bradford and Leeds and the three Clinical Commissioning Groups provide a joint report to the successor Scrutiny Board (Health and Wellbeing and Adult Social Care), on the work around risk stratification and its impact on services across the local health and social care economy.

Recommendation 8

By August 2012, the Director of Adult Social Services and the Chief Executive of Leeds Community Healthcare NHS Trust provide the successor Scrutiny Board (Health and Wellbeing and Adult Social Care) with a progress report on the development of integrated health and social care teams – with a particular focus on the relative success of new ways of working trialled at each of the three demonstrator sites.

Recommendation 9

By September 2012, the Director of Adult Social Services and the Chief Executive of Leeds and York Partnership NHS Foundation Trust provide a joint progress report to the successor Scrutiny Board on the development of the formal partnership arrangements between Adult Social Services and Leeds and York Partnership NHS Foundation Trust, with a particular emphasis on the areas of potential risk, including governance arrangements, finance, human resources and performance.

Recommendation 10

During the municipal year 2012/13, the Shadow Health and Wellbeing Board considers the governance arrangements associated with service integration, with the aim of developing some guiding principals and agreeing an overarching framework.

Recommendation 11

By September 2012, the Director of Adult Social Services and the Chief Executive of Leeds Community Healthcare NHS Trust provide a joint report to the successor Scrutiny Board on the progress of the Harry Booth House project.

Recommendation 12

That, following a suitable period of operation and in discussion with the successor Scrutiny Board, the Director of Adult Social Services provides a further report on Harry Booth House that reviews its operation, achievements and outlines the benefits realised across the local health and social care economy.

Leeds CITY COUNCIL

Report author: Dennis Holmes
Tel: 2474959

Report of the Director of Adult Social Services

Report to Executive Board

Date: 17th October 2012

Subject: Strategy for governance in integrated working with Health

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☒ Yes	☐ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. This report deals with the means by which more integrated commissioning and providing arrangements between NHS commissioners and providers of services and their Local Authority counterparts will be encouraged and supported in the future. The report sets out the intention to use the powers contained in the 2006 Health Act, principally sections 75, 76[1] and 256[2], to use the legal flexibities contained within those sections to ensure good governance and accountability for the use of public funds in the pursuit of joint improvement .

2. This sets out the intention to have one overall Section 75 Agreement to cover all joint commissioning arrangements between Leeds City Council Adult Social Care and NHS Leeds or its sucessors in title.

3. The report also sets out how other dedicated Section 75 agreements will be used to ensure good governance and accountability between providers of NHS care for specific services and their Local Authority counterparts, principally between Leeds Community Healthcare, Leeds and York Partnership Foundation Trust and Adult Social Care provided services.

[1] S76 allows the local authority to transfer money etc to a CCG etc and is the mirror opposite of s256. Leeds City Council has never used it but it is available to us.
[2] The overarching agreement will not cover ss76 and 256

4. The adoption of robust legal agreements for joint working in the provision of care and support ensures a consistency of approach within the terms of the constitution of the Local Authority and makes efficient use of officer and legal services time. It also ensures we have a robust approach to the governance of services provided by both health and social care staff working as part of joint team arrangements.

5. The basis for the agreement centres upon promoting effective partnership working with the aim of the more effective and efficient use of resources in order to meet the health and social care needs of the citizens of Leeds.

Recommendations

That the approach to Section 75, S76 and Section 256 agreements for the governance and pooling of Health and Social Care resources be endorsed.

That the process for the Director of Adult Social Services to approve future agreements under the delegations afforded to her within the Council's Constitution, Officer Delegation Scheme (Executive Functions) be noted.

That the agreements will be subject to formal review every three years and monitored annually during this time to assure their continuing relevance and effectiveness be noted.

1. Purpose of This Report

1.1 The purpose of the report is to seek the endorsement of Executive Board to the direction of travel in our approach to partnership arrangements with NHS bodies in Leeds.

1.2 Recent years have seen a healthcare system emerging in the City that has expanded in size and in complexity. The NHS 'Family' of organisations has effectively split into essentially two types, Commissioners of care on the one hand, three Clinical Commissioning Groups responsible for the effective planning and purchase of healthcare services. On the other hand NHS organisations who are principally concerned with the actual provision of care, these include; Leeds and York Partnership Foundation Trust, Leeds Community Healthcare and Leeds Teaching Hospital Trust.

1.3 There are a significant number of overlaps between that which the NHS and local Authority commissions (or wishes to commission) and that which is directly provided to people with health and social care needs. In order to provide a cogent governance structure for the oversight of joint initiatives and to ensure that financial and organisational risks are identified and addressed, officers from NHS organisations and the local authority have developed a suite of agreements which it is intended will be used into the future to manage all joint commissioned or jointly provided endeavors[3].

[3] There are a number of joint commissioning programmes where the local authority and the PCT work jointly and draw down contracts from the same framework arrangement but these are not caught by the s75 agreement.

2. Background Information

2.1 S256 of the National Health Service Act 2006 (NHSA 2006) permits a PCT to transfer to the local authority sums of money or resources which, in the view of the NHS, furthers their staturory objectives to provide better and more efficient health services or prevent ill-health. The local authority will then procure services along side their own which helps to meet that objective. There is no transfer of statutory functions.

2.2 S76 is a mirror image of S256 in that it permits a local authorities to transfer monies or resources to a PCT (or CCG as of 1 April 2013) towards expenditure incured by the NHS in relation to their staturory functions. Again there is no transfer of statutory functions.

2.3 However, unlike a S256 and S76 agreements, a s75 agreement allows one of the partners to delegate its statutory duties to the other. In Leeds the PCT, for example, has delegated its statutory duty to ASC for the assessment and provision of services to people with a learninng disability who are in need of a care package which would be funded by the NHS under the continuing health care legislation. The local authority assessment and commisioning teams have developed specialist knowledge and expertise in identifying needs and how those can best be met, most cost effectively. The delegation of NHS statutory functions to the Council allows the statutory partners to better intergrate their services, cost effectively to achieve a seemless and client focused service.

2.4 Section 75 of the NHSA 2006 provides that health bodies and health related Local Authority services can pool money and integrate resources and management structures. These powers are intended to support partnership working and result in service improvements through the joining up of existing services or the development of new initiatives.

2.5 These agreements can be pooled budget arrangements for the commissioning of services, lead commissioning by one organisation on behalf of another or integrated provider agreements. The agreement to be used depends on whether we are commissioning the service e.g. Learning Disability services and Joint Equipment services or working together to provide a service, for example Mental Health Assessment services, and the intermediate care service to be provided from Harry Booth House.

2.6 In Leeds we have a number of partnership arrangements already in place between Health and Social Care and through the Transformation Programme we have been looking at how to progress further opportunities for joint working going forward. It should also be noted that the development of further opportunities will be a key responsibility of the Health and Wellbeing Board in the future.

2.7 In the past we have had a number of separate agreements in place governing jointly commissioned services. Moving forward we are proposing to implement new agreements which provides a legal framework and a more robust approach to governance.

3. Main Issues

3.1 Leeds has a very long history of using 'Health Act Flexibilities' primarily in Learning Disability services where a joint commissioning service has commissioned care using a budget pooled between the NHS and Local Authority for the past 12 years. However, in recognising the rapidly changing organisational landscape for NHS organisations and the significantly harsher financial climate, officers had determined that the agreements that had served well in the past were unlikely to do so in the future.

3.2 The revised agreements have the benefit of a contemporary overview of current (rather than historic) national policy and guidance, providing a clear rationale and governance for our partnerships. The design of an overall S75 agreement to be adopted by commissioners for joint commissions of service is that this provides a written, formalised and robust baseline from which to develop partnership relationships on the context of ongoing organisational change.

3.3 The documents which are specific to the joint commissioning terms and conditions (including the management of pooled fund agreements) have been drafted by Adult Social Care officers working with legal advice and in co-operation with the three emerging Clinical Commissioning Groups who will be counter-signatories to the agreements.

3.4 The overall commissioning agreement under Section 75 of the National Health Service Act 2006 sets out the arrangements in particular: to establish the lead commissioner; establishing and maintaining the pooled budgets within the agreement; establishing and maintaining a charging policy and protocol ensuring that the Council retains the power to charge eligible service users for certain functions whilst ensuring that the delivery of health care through NHS functions remain free at the point of delivery; gives detailed arrangement for financial contributions from both parties and the arrangements for the management of the fund; the governance arrangements for the oversight of the partnership arrangements and the standards of service and monitoring.

3.5 With the overall S75 agreement having taken care of overall governance and risk sharing arrangements, all that remains is the addition of a service schedule specific to the particular activity under commission, for example, one schedule specific to the Learning Disability service, one for the intermediate care service.

3.6 Each service schedule requires (for consistency) a minimum data set. This will contain a descriptor of the partnership including the aims and objectives, specific governance and reporting arrangements (including terms of reference for partnership boards and reference groups), details of financial contributions, which will include any pooled budget arrangements and staff or other resources which are committed against the agreement. Performance management arrangements will also be included within the specific schedules as will functions of staff that support the delivery of the partnership.

3.7 Section 75 agreements between the Local Authority in its role as a provider of support and care services and their NHS counterparts, will operate in precisely the same way covering the specifics of day to day operation and risk sharing and in

particular covering: the governance, monitoring and strategic planning arrangements; inspection arrangements; financial arrangements ensuring that whilst there is no Pooled Fund arrrangement both parties agree to adhere to reporting on expenditure and that financial officers attend relevant meetings of the Partnership Board; staffing roles for the staff managed under the agreement; dispute and complaints processes.

3.8 This process toward greater integration of both commissioning and provided services will continue to run alongside the lesser used Section 256 of the 2006 Health Act. There are some circumstances in which NHS commissioners will wish the local authority to commission services on their behalf and, rather than enter into a pooled fund arrangement, will simply transfer the value of the service under commission for the local authority to administer. These arrangements will continue where appropriate as part of this developing approach. These types of agreement cover in particular: the conditions of transfer of monies; ensuring that the annual sum shall be used for the specified purpose; the arrangements for authenticating, accounting and auditing; the governance and meeting arrangements to discuss the provision of services.

3.9 The establishment of agreements with our Health partners under the National Health Service Act 2006 provides a good practice framework for future working by ensuring a consistent approach across the city and providing stability in the transitional timescale from PCT to Clinical Commissioning Groups (CCGs) under the 2012 Health and Social Care Act. Under this legislation NHS commissioning responsibilities will be overseen by the NHS Commissioning Board (NHSCB). Some acute and most community based commissioning will be delegated to the CCGs by the Board. Working relationships with the NHSCB will be developed through the Health and Wellbeing Board.

4. Corporate Considerations

4.1 Consultation and Engagement

4.1.1. The work of these agreements has been led by Adult Social Care and the three emerging Clinical Commissioning Groups (CCGs) and rigorous reporting procedures have been followed including consultation and communication with the Executive Member for Adult Social Care, Partnership Boards, the voluntary sector, Learning Disability Commissioning Executive and the Clinical Commissioning Group Collaborative. The agreements could be modified for application to other services in the authority in due course.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1. An Equality Impact screening assessment will be carried out on each individual agreement as it is prepared and processed prior to approval. Following the screening, a full assessment will be carried out as required.

4.3 Council Policies and City Priorities

4.3.1. The direction of integration is in line with current City Council and Adult Social Care priorities and the NHS drivers for Partnership and Change. The Vision for Leeds

2011-2030 states that 'Leeds will be the best city for Health and Wellbeing, Leeds will be a healthy and caring city for all ages where people are supported by high quality services to live full, active and independent lives'. On a more specific level a formal approach to partnership agreements will strengthen partnership arrangements, increase the optimum use of resources and will support increased personalisation.

4.3.2. This initiative contributes to National Indicator 142, the percentage of vulnerable people supported to achieve independent living.

4.3.3. This contributes to the City Priority Plan 2015 by supporting people to live safely in their own homes and increases the opportunities for more significant choice and control in relation to health and social care services.

4.3.4. This contributes to the Council Business Plan 2011-2015, Adult Social Care Directorate Priorities and Performance Measures by ensuring more people with poor health remain living at home longer.

4.3.5. This initiative supports adults whose circumstances make them vulnerable to live safe and independent lives.

4.3.6. This further provides easier access to joined up health and social care services underpinned by Valuing People principles amongst other substantial policy drivers and Self Directed Support.

4.4 Resources and Value for Money

4.4.1. The extension of joint commissioning and joint provision of services between the Local Authority and NHS organisations presents significant opportunity to deliver more effective and efficient public services in the City in which outcomes are maximized for Leeds citizens by better use of the 'Leeds £'. However, all organisations need to be assured, through good governance, that their resource contribution generates the anticipated benefits and efficiencies required by their own sponsors.

4.4.2. An example of this working in practice is the pooled budget for people with Learning Disability which is managed by the Local Authority on behalf of all commissioners and is valued at £63M in this financial year. Over the past 2 years more than £3M of efficiencies have been made by more effective contract negotiation and management, these have enabled both the Local Authority and their Health commissioning partners to manage demand for services within their existing resources and provide a regular and detailed account of the outcomes achieved for people using this budget.

4.4.3. The recent Winterbourne View Hospital Serious Case Review significantly highlighted the need for responsible commissioners to take a much more proactive stance in the promotion of good governance and accountability to protect people whose circumstances make them especially vulnerable. It can be seen that the quality assurance, contract monitoring and compliance measures deployed under

the pooled fund arrangement offers enhanced protection to those people whose care is funded through the pool.

4.5 Legal Implications, Access to Information and Call In

4.5.1. The process for formulating the agreements (S75 Commissioner/ Provider & S256) has been undertaken with detailed advice, support and assurance from the Council in house legal services team and their NHS lawyer colleagues to ensure full compliance with the requirements of the Health Act 2006.

4.5.2. All agreements are subject to approval by the Director of Adult Social Services, Leeds City Council, under her powers of Delegated Decision making after appropriate consultation with the Executive Lead Member. The first tranche of agreements will be the overall S75 Commissioning agreement (which will have attached as schedules the updated agreements around the Learning Disability joint commissioning service, Leeds Equipment Service and the arrangements governing the joint commission of the South Leeds Intermediate Care Centre (formerly Harry Booth House). In addition, the provider S75 agreements for the provision of care in relation to the former Harry Booth House and the joint provision of a range of mental health services will also be approved by this means. A S256 agreement will also be made to enable £340K to be transferred to the Local Authority for the administration of some services to carers on behalf of the NHS.

4.5.3. It is proposed that all such decisions to produce new schedules for the overall commissioning agreement or to produce new agreements between provider functions will be made by the means highlighted above. However, because the scale and nature of agreements will vary into the future some may not be subject to call-in. The agreements highlighted at 4.5.2, by virtue of their value will be subject to call-in.

4.5.4. We have assessed the Partnership agreements against the 'Advisory note for Directors - Partnerships Governance' tool and can confirm that it meets the requirements stated within.

4.5.5. In terms of elected members, governance and scrutiny, The Director of Adult Social Services via the Executive Lead Member will continue to remain statutorily accountable for both the commission and provision of service and the constitution of the Council needs no amendment by the approach set out in this report. However, Members will be aware of the potential for significantly more extensive integration of Council and NHS services, taken to their fullest this would require further reports to the executive seeking authorisation to proceed.

4.5.6. Colleagues in Internal Audit have confirmed that they are satisfied that the Section 75 agreement meets their requirements around governance.

4.6 Risk Management

4.6.1. In many respects S75/256 agreements are mechanisms for identifying, mitigating and sharing risks between Health and Local Authority bodies. By having such agreements in place, whether between providers or commissioners, organisations

are making explicit in a legally binding agreement between them, how they will improve outcomes for people.

4.6.2. At the same time the agreements articulate how risks and benefits are to be shared between the organisations and how statutory duties are to be discharged. The agreements seek to limit organisational and reputational risk alongside legal and, of course, financial. Members can be be assured that the content of the agreements as described at point 3 above ensure due diligence for the Council.

4.6.3. Operating or commissioning services jointly in the absence of such agreements is therefore inherently risky, potentially exposing one of the partners to the endeavor to greater than acceptable financial or organisational exposure.

5. Conclusions

5.1 This report has set out the intent that Section 75 and Section 256 agreements will be used to ensure good governance and accountability between commissioners and providers of NHS care and their Local Authority counterparts. The adoption of robust legal agreements for joint working in the commission and provision of care and support ensures a consistency of approach and makes efficient use of officer and legal services time. It also ensures we have a robust approach to the governance of services provided by both health and social care staff working as part of joint team arrangements and financially efficient effective arrangements for demonstrating improved outcomes for people.

6. Recommendations

6.1 That the approach to Section 75, S76 and Section 256 agreements for the governance and pooling of Health and Social Care resources be endorsed

6.2 That the process for the Director of Adult Social Services to approve future agreements under the delegations afforded to her within the Council's Constitution, Officer Delegation Scheme (Executive Functions) be noted.

6.3 That the agreements will to be subject to formal review every 3 years but monitored annually during this time to assure their continuing relevance and effectiveness be noted.

7. Background Documents[4]

None

[4] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Leeds CITY COUNCIL

Report author: Maxine Naismith
Tel: 50449

Chief Officer, Learning Disabilities

Report to Director Adult Social Care for Delegated Decision

Date: September 2012

Subject: Section 75 Agreement for Integrated Mental Health Teams under the National Health Service Act 2006

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. This report brings forward our intention to have a formal Section 75 Agreement, attached as Appendix 1 to this report, in place between Leeds City Council and Leeds and York Partnership Foundation Trust (LYPFT) with regards to the integration of Adult Social Care's Health Assessment and Care Management Teams with LYPFT Community Health Teams.

2. The adoption of robust legal agreements for joint working ensures a consistency of approach and makes efficient use of officer time from both organisations. It also ensures that we have a co-ordinated approach to the governance of integrated teams overseen by a Partnership Board

3. The agreement follows a clear rationale thereby promoting effective partnership working with the aim of effective and optimum use of resources. This will allow both Health and Social Care to meet the assessed health and social care needs of the citizens of Leeds who are eligible to access secondary mental health provision.

Recommendations

4. The Director of Adult Social Services (DASS) is asked to approve the Section 75 agreement between Leeds City Council and LYPFT for the integration of council Mental Health Assessment and Care Management Teams with LYPFT Community Health Teams.

1 Purpose of This Report

1.1 The purpose of the report is to recommend that the DASS approves the partnership arrangements between Adult Social Care and LYPFT under the auspices of Section 75, National Health Service Act 2006.

2 Background Information

2.1 Section 75 of the National Health Service Act 2006 provides that health bodies and Local Authority services can pool money and integrate resources and management structures. These powers are intended to support partnership working and result in service improvements through the joining up of existing services or the development of new initiatives.

2.2 These agreements can be either pooled budget arrangements commissioner led services or integrated provider agreements. This agreement is in relation to integrated provider arrangements.

2.3 In Leeds we have enjoyed an informal partnership arrangement with the provider trust and teams have been co-located in Health bases for a number of years. The implementation of the Section 75 agreement enables us to have a more streamlined approach to meeting the needs of people who are mentally ill on a formal, performance managed basis with a number of key drivers. Significantly for Adult Social Care these will be focussed around an increase in Self Directed Support (SDS) uptake and more robust and enhanced safeguarding of vulnerable adults.

3 Main Issues

3.1 This agreement will have the benefit of both organisations being at the forefront of implementing national policy and local guidelines by having a shared strategic and operational vision.

3.2 This document has been drafted by Adult Social Care and LYPFT working in co-operation. Both organisations will be counter signatories to the agreement.

3.3 The establishment of a Section 75 agreement with LYPFT provides a good practice framework for future working by ensuring a consistent approach across the city and providing stability for this particular service user group at a time of Health and Social Care reform.

3.4 This agreement will serve to improve services, maximise efficiencies and deliver more effective and efficient services in order to meet assessed need. The aim of the agreement is to enable both partners to integrate services including staff, resources and management structures to design and deliver products around the needs of clients and carers. This agreement will provide arrangements to eliminate unnecessary gaps and duplications between services thus providing more positive outcomes for clients, carers and the workforce.

3.5 The Section 75 agreement clarifies the role and responsibilities of the Director of Adult Social Services and describes in detail the statutory function of Social

Workers and more specifically illustrates the role and function of the Approved Mental Health Professional Service. In addition the agreement clearly describes the core business functions of Health and Social Care within secondary mental health provision.

3.6 The governance of the agreement will be overseen by a Partnership Board, co-chaired by the Chief Officer for the Adult Social Care Directorate and the Deputy Chief Executive for the Trust. The board responsibilities are comprehensively set out in the agreement and its business will centre around performance data, financial allocation including pressures and efficiencies. In addition the board will have a clear overview of the risks and benefits on a quarterly basis in relation to both organisations within this agreement.

4 Corporate Considerations

4.0.1 We have assessed the Partnership agreements against the 'Advisory note for Directors – Partnerships Governance' tool and can confirm that it meets the requirements stated within.

4.0.2 In terms of Elected Members governance and scrutiny, the same procedures will be in force under the Section 75 agreement as apply now. The Director of Adult Social Services will continue to remain statutorily responsible for the Assessment and Care Management Mental Health function and therefore it sits within the constitution of the Council as it stands. Following the first year of the agreement should changes be made to the delegation of responsibility, the DASS and the Council still remain accountable for the social care element of the Mental Health service as outlined in the partnership agreement.

4.0.3 Colleagues in Internal Audit have confirmed that they are satisfied that the Section 75 agreement meets their requirements around governance.

4.1 Consultation and Engagement

4.1.1 The work of this agreement has been led jointly by Adult Social Care and LYPFT, rigorous reporting procedures have been followed including consultation and communication with the Executive Member for Adult Social Care, Transformation Board, Transformation Project Board, user representative on the Transformation Board, extensive utilisation of the Trust's Transformation Newsletter, Local Authority Trade Unions, NHS Leeds and quarterly Adult Social Care staff sessions.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 An Equality Impact Assessment was carried out prior to a report to Executive Board in December 2011. For good practice another Screening Assessment has been recently carried out to confirm that there is not any deviation from the work carried out in 2011. This is attached as Appendix 2 to this report.

4.3 Council Policies and City Priorities

4.3.1 The direction of integration is in line with current City Council and Adult Social Care priorities and the NHS drivers for Partnership and Change. The Vision for

Leeds 2011-2030 states that 'Leeds will be the best city for Health and Wellbeing, Leeds will be a healthy and caring city for all ages where people are supported by high quality services to live full, active and independent lives'. On a more specific level a formal approach to partnership agreements will strengthen partnership arrangements, increase the optimum use of resources and will support increased personalisation.

4.3.2 This initiative contributes to National Indicator 142, the percentage of vulnerable people supported to achieve independent living.

4.3.3 This contributes to the City Priority Plan 2015 by supporting people to live safely in their own homes and increases the opportunities for more significant choice and control in relation to health and social care services.

4.3.4 This contributes to the Council Business Plan 2011-2015, Adult Social Care Directorate Priorities and Performance Measures by ensuring more people with poor health remain living at home longer.

4.3.5 This initiative supports adults whose circumstances make them vulnerable to live safe and independent lives.

4.4 Resources and Value for Money

4.4.6 No significant financial risks are forecast, in the first year of this agreement there will be no pooling of budgets therefore the Community Care Budget responsibility will be retained by Adult Social Care. The Section 75 agreement has the flexibility to look at and analyse benefits for further alignment of budgets overseen by the Partnership Board. A focus of the integration is to achieve greater efficiencies and whilst none are forecast for Adult Social Care in the first year of the agreement this will be a priority for years 2 and 3.

4.5 Legal Implications, Access to Information and Call In

4.5.1 The process of formulating this agreement has been undertaken with detailed advice and support from the Council in house legal services team and Beachcrofts (LYPFT lawyers) to ensure full compliance with Section 75 procedures.

4.5.2 The agreement is subject to approval and signoff by the Director of Adult Social Services, Leeds City Council under her powers of Delegated Decision making.

4.5.3 This Section 75 agreement is reported as a significant operational decision and therefore not subject to call-in.

4.6 Risk Management

4.6.1 The risks of not implementing a formal Section 75 agreement are as follows;

- The process of obtaining increased efficiencies across the Health and Social Care Pathways will be affected.

- There will be an increased risk of continued, informal co-location arrangements remaining in place by not having a formal, consistent approach to the integration of teams which may result in tensions across both organisations without a clear strategic direction.

4.6.2 Failure to implement a formal, legal partnership agreement will have a detrimental impact upon the plans to further develop and integrate Health and Social Care Services in Leeds.

4.6.3 As the agreement does not have a stated 'duration' i.e. end date contained within, advice has been sought from legal services as to whether this is acceptable with a Section 75 agreement.

Their advice is that the termination clause at paragraph 17 of the agreement allows for the termination on a number of grounds - default by one party, convenience, force majeure, ultra vires, budgetary reasons and therefore it is robust enough to effectively end the agreement with appropriate notice.

5 Conclusions

5.1 The partnership between the Council and LYPFT is positive and has been successful in delivering some positive outcomes for clients and carers to date. This agreement envisages the possibility of a delegation of statutory functions being transferred in coming years and therefore it is appropriate to use this format. To implement a formal arrangement would strengthen this relationship further and would have the benefit of planning and supporting the future direction of travel and would put Leeds at the forefront of challenging initiatives.

6 Recommendations

6.1 The Director of Adult Social Services (DASS) is asked to approve the Section 75 agreement between Leeds City Council and LYPFT for the integration of council Mental Health Assessment and Care Management Teams with LYPFT Community Health Teams.

7 Background documents[1]

None

[1] The background documents listed in this section are available for inspection on request for a period of four years following the date of the relevant meeting. Accordingly this list does not include documents containing exempt or confidential information, or any published works. Requests to inspect any background documents should be submitted to the report author.

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Leeds CITY COUNCIL

Leeds and York Partnership NHS
NHS Foundation Trust

Dated 28th September 2012

(1) **LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST**

- and -

(2) **LEEDS CITY COUNCIL**

Agreement under Section 75 of the National Health Service Act 2006

for the integrated provision of adult mental health services

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FORM OF NOTIFICATION TO THE DEPARTMENT OF HEALTH 76

THIS AGREEMENT is made the 28th day of September 2012

BETWEEN:

(1) **Leeds and York Partnership NHS Foundation Trust** of 2150 Century Way, Thorpe Park, Leeds West Yorkshire LS15 8ZB (the **"Trust"**); and

(2) **Leeds City Council** of Civic Hall, Calverley Street, Leeds, LS1 1UR (the **"Council"**),

together, the **"Parties"**.

RECITALS:

(A) The Trust and the Council have agreed to enter into a partnership arrangement pursuant to section 75 of the National Health Service Act 2006, in respect of health and social care services for the Service Users as further described in this Agreement.

(B) As part of the partnership arrangement referred to at Recital (A) above, the Parties have agreed that the Trust shall exercise certain of the Council's health related functions on behalf of the Council under an integrated provision arrangement.

NOW IT IS HEREBY AGREED as follows:

1. **DEFINITIONS AND INTERPRETATION**

1.1 In this Agreement unless the context otherwise requires the following words and expressions shall have the following meanings:

"Act"	the National Health Service Act 2006;
"Agreement"	this agreement between the Trust and the Council comprising these terms and conditions, together with all Schedules attached hereto;
"AMHP Service"	Approved Mental Health Professional service provided by the Council;
"Arrangements"	has the meaning ascribed to it in clause 4.1;
"ASC"	Adult Social Care;
"BIA"	Best Interests Assessments provided by the relevant staff managed under this Agreement;
"Care Package Escalation Procedure"	the procedure set out in Schedule 5, Appendix i of this Agreement.
"Client Group"	the collection of Service Users either receiving or eligible to receive the Services and living within the administrative area of the City of Leeds because of their enhanced care needs, adult mental health or as otherwise agreed between the Parties;
"Commencement Date"	30 September 2012
"Community Care Assessments"	Community Care Assessments provided by the Council pursuant to s47 on the National Health Service and Community

	Care Act 1990;
"Contributions"	the respective financial contributions of the Parties (as set out in Schedule 6 (Resources)), for use by the Trust in connection with the Integrated Provision of the Services in fulfilment of the Functions and in accordance with the terms of this Agreement;
"Council Functions"	the health related functions of the Council listed in Regulation 6 of the Regulations (and further described in Schedule 3 (Council Functions) of this Agreement) in relation to the provision of, or making arrangements for the provision of, the Services, but excluding the Excluded Functions;
"Council Staff"	any employee or employees of or persons engaged by the Council carrying out the Functions;
"DASS"	the Council's Director of Adult Social Services;
"DASS Responsibilities"	the responsibilities of the DASS as far as they relate to this Agreement to: • act within the Officer Delegation Scheme of the Leeds City Council Constitution (Executive functions) (Part 3 Section 3E) in relation to the Director of Adult Social Services; • account directly to the Chief Executive of the Council; • advise the Council and the management team of the Council in respect of mental health issues; • provide professional leadership to social care staff matrix managed under this agreement; • take responsibility for the quality of social care provided to local people, whether directly or through delegation, contracting or commissioning; • act as principle point of contact , beneath the Chief Executive of the Council for the conduct of business; and • provide information as requested by the Care Quality Commission (CQC).
"Demand"	any action, award, claim or other legal resource, complaint, cost (including professional fees), debt, demand, expense, fine, liability, loss, outgoing, penalty or proceeding
"Department"	the Department of Health;
"DoLS"	deprivation of liberty safeguards service;
"DPA"	the Data Protection Act 1998, as amended from time to time;
"ESCR"	Electronic Social Care Records – the Council's ASC electronic case management system;
"Event of Force Majeure"	an event or circumstance which is beyond the reasonable control of the Party claiming relief under clause 22 (Force

	Majeure), including without limitation war, civil war, armed conflict or terrorism, strikes or lock outs, riot, fire, flood or earthquake, and which directly causes that Party to be unable to comply with all or a material part of its obligations under this Agreement;
"Excluded Functions"	such Functions contained in Schedule 4 (Excluded Functions) of this Agreement and/or such Functions as the Parties may agree from time to time are excluded from the Arrangements, together with any exclusions set out in the Regulations;
"Financial Year"	the financial year running from 1 April of one year to 31 March in the next year;
"FOIA"	the Freedom of Information Act 2000, as amended from time to time;
"Functions"	the Trust Functions and the Council Functions in relation to the provision of, or making arrangements for the provision of, the Services to meet the needs of the Client Group, but excluding the Excluded Functions as set out in Schedule 4 (Excluded Functions);
"HMRC"	Her Majesty's Revenue and Customs;
"Integrated Provision"	the arrangements agreed by the Parties for the integrated provision of the Services in accordance with the terms of this Agreement and as further detailed in clause 5 (Services);
"Partnership Board"	the Partnership Board made up of representatives from both the Trust and the Council (as further described at clause 10 (Governance and Monitoring Arrangements) and Schedule 7 (Partnership Board));
"NHS"	National Health Service;
"PARIS"	the Trust's electronic case management system;
"Premises"	the premises used or occupied from time to time by the Council in connection with the provision of the Services as of the date of this Agreement;
"Quarter"	each of the following periods in the Financial Year: (i) 1 April to 30 June; (ii) 1 July to 30 September; (iii) 1 October to 31 December; (iv) 1 January to 31 March, and **"Quarterly"** shall be construed accordingly;
"Regulations"	the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (SI 617) as amended from time to time;

"Relevant Transfer"	a transfer for the purposes of TUPE;
"Section 75 Flexibility"	any of the powers set out in section 75 of the Act, developed to give NHS bodies and local authorities the flexibility to be able to respond effectively to improve services, either by joining up existing services, or developing new, co-ordinated services, and to work with other organisations to fulfil this, which include: (i) a pooled fund arrangement; (ii) a lead commissioning arrangement; and (iii) an integrated provision arrangement;
"Services"	the Services described in clause 5 (Services) and Schedule 5 (The Services) and which the Parties have agreed will come within the Arrangements and will be provided by the Trust;
"Service Users"	any individual for whose benefit the Services are provided, as further described at Schedule 5 (The Services);
"Staff"	any employee or employees or persons engaged by the Council and/ or the Trust who are carrying out the Services under this Agreement;
"Staff Emoluments"	all employment related outgoings including salaries, wages, bonus or commission, holiday pay, expenses, national insurance and pension contributions and any taxation liabilities
"Transferred Council Staff"	any Council Staff who, as a consequence of there having been a Relevant Transfer, are deemed to have had their contract of employment transferred to the Trust on the Transfer Date
"Transfer Date"	the date of the Relevant Transfer
"TUPE"	the Transfer of Undertakings (Protection of Employment) Regulations 2006;
"Trust Functions"	those of the functions of the Trust set out in Regulation 5 of the Regulations (and further described in Schedule 2 (Trust Functions) of this Agreement) as are exercised in the provision of the Services, excluding the Excluded Functions;
"Trust Staff	any employee or employees of or persons engaged by the Trust carrying out the Functions;
"Variation"	an addition, deletion or amendment in the clauses of or Schedules to this Agreement, agreed to be made by the Parties in accordance with clause 15 (Review and Variation) or clause 16 (Change in Law);
"VAT Guidance"	the guidance entitled "Guidance on the Health Act 1999 Section 31 partnership Agreements" and "VAT Arrangements for Joint NHS/Local Authority Initiatives - Section 31 Health Act (Department of Health/Customs and Excise, March 2003)";

"Working Day"	any day other than Saturday, Sunday, a public or bank holiday in England and Wales.

1.2 References to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted (whether before or after the Commencement Date) from time to time.

1.3 The headings of the Clauses in this Agreement are for reference purposes only and shall not be construed as part of this Agreement or deemed to indicate the meaning of the relevant clauses to which they relate. Reference to Clauses are clauses in this Agreement.

1.4 References to Schedules are references to the schedules to this Agreement and a reference to a Paragraph is a reference to the paragraph in the Schedule containing such reference.

1.5 References to a person or body shall not be restricted to natural persons and shall include a company, corporation or organisation.

1.6 Words importing the one gender shall include the other genders and words importing the singular number only shall include the plural.

1.7 Where anything in this Agreement requires the mutual agreement of the Parties, then unless the context otherwise provides, such agreement must be in writing.

2. BACKGROUND

2.1 The Trust is a foundation trust authorised under its Terms of Authorisation dated 1 August 2007 pursuant to Section 35 of the National Health Service Act 2006. The Trust provides mental health services for the Client group in the area.

2.2 The Council is a local authority established under the Local Government Act 1972 (as amended) and has a social care department responsible for the mental health elements of social care and more particularly the AMHP role. The Council provides mental health and AMHP services for the Client Group in the City of Leeds.

2.3 The Trust and the Council have duties and powers to provide care to the Client Group and section 82 of the Act requires both local authorities and NHS bodies when exercising their respective functions to co-operate to secure and advance the health and welfare of the people of England and Wales. Furthermore, under relevant guidance, local authorities and NHS bodies are encouraged to consider partnership working, including Integrated Provision under the Act. Section 75 of the Act and the Regulations have introduced powers for local authorities and NHS Bodies to set up joint working arrangements.

2.4 The Parties are entering into this Agreement (which includes Integrated Provision) in exercise of the powers under section 75 of the Act and pursuant to the Regulations.

2.5 As at the Commencement Date, the Arrangements do not include a pooled fund arrangement under section 75 of the Act and pursuant to the Regulations, but the Parties may elect to pool their funds (by way of a Variation to this Agreement) at any time after the Commencement Date and during the term of this Agreement.

2.6 The Trust and the Council have jointly consulted and communicated with such persons as appear to them to be affected by the Arrangements.

2.7 The Trust and the Council are satisfied that the arrangements are likely to lead to an improvement in the way that the Functions are exercised.

2.8 The arrangements fulfil objectives set out in the relevant health improvement plan of the Leeds Primary Care Trust in whose area these arrangements operate.

2.9 The Trust has obtained the consent of Leeds Primary Care Trust with which it has a contract for the provision of services for the Client Group to enter into the arrangements described in this Agreement with the Council.

2.10 On entering into this Agreement, the Parties shall jointly give notification of this Agreement to the Health and Social Care Joint Unit of the Department. The notification shall be in the form annexed hereto as Schedule 14 (Form of Notification to the Department of Health), subject to such amendments as may be agreed in writing between the Parties. The Parties shall arrange for such notification to be updated on an annual basis, so as to reflect any Variations.

2.11 The Trust and the Council have approved the terms of this Agreement and agree to work together in accordance with the terms of the Agreement.

3. DURATION OF THE AGREEMENT

3.1 This Agreement shall take effect on the Commencement Date and shall continue until it is terminated in accordance with the provisions of clause 17 (Termination).

4. SUMMARY OF THE ARRANGEMENTS

4.1 The Parties have agreed that, with effect from the Commencement Date, the partnership arrangements are to comprise:

4.1.1 the Integrated Provision arrangements set out in this Agreement (and more particularly described at Clause 5 (The Services));

4.1.2 the provision of the Contributions by each Party, insofar as is required for the exercise of the Functions (as set out in Schedule 6 (Resources));

4.1.3 the performance of the Functions specified in Schedule 2 (Trust Functions) and Schedule 3 (Council Functions) in accordance with this Agreement; and

4.1.4 the establishment of the Partnership Board and the monitoring of the Functions and the Services by the Partnership Board (as set out and described in clause 7 (Governance and Monitoring Arrangements) and Schedule 7 (Partnership Board)),

the **"Arrangements"**.

4.2 Without prejudice to the other provisions of this Agreement, the primary objective of the Parties in entering into this Agreement is to improve the Integrated Provision of the Services in accordance with the aims and objectives outlined in Schedule 1 (Aims and Objectives).

4.3 The Parties hereby represent that they have obtained all necessary consents sufficient to ensure the delegation of Functions provided for by this Agreement.

4.4 It is the Parties' intention that the Arrangements shall be the mechanism through which the Functions shall be fulfilled.

4.5 The Parties wish to use this Agreement to enable the Trust to exercise the Functions on behalf of the Council and the Trust for the Integrated Provision of the Services to the Service Users.

4.6 The Trust shall (without limitation) be responsible for ensuring that there is integrated Service provision (pursuant to Clause 5 (Services);

5. SERVICES

The Trust shall ensure the Integrated Provision of the Services.

6. SERVICE STANDARDS AND PERFORMANCE MANAGEMENT

6.1 The Services under this Agreement must be carried out in accordance with:

6.1.1 Care Quality Commission requirements;

6.1.2 Monitor Requirements; and

6.1.3 each Party's respective standing orders and standing financial instructions.

6.2 The Services under this Agreement shall be monitored by the Care Quality Commission and Monitor.

6.3 Without prejudice to clauses 6.1 and 6.2 above, the Trust shall exercise its duties, obligations and functions arising out of or in relation to this Agreement effectively, efficiently, fairly and in good faith.

6.4 The Trust shall report to the Partnership Board both bi-monthly and annually, on the operation of the Arrangements (which, to avoid doubt, shall include but not be limited to, the operation of the Services) and the exercise of the Functions by the Trust.

6.5 The Parties shall agree the format of, and the content to be included in, the Quarterly and annual reports to the Partnership Board referred to at clause 6.4 above. Any disagreement as to the format of the content to be included in the Quarterly and annual reports may be referred to the Partnership Board for its determination and/or instruction.

7. GOVERNANCE, MONITORING AND STRATEGIC PLANNING ARRANGEMENTS

7.1 The Parties shall jointly monitor the effectiveness of the Arrangements.

7.2 The Parties agree that they shall establish and maintain the Partnership Board, whose members, framework and terms of reference shall be as described at Schedule 7 (the Partnership Board). The Partnership Board's Terms of Reference shall be reviewed by the Parties on an annual basis and, if necessary, amended to ensure that the Partnership Board continues to assist the Parties to meet the aims and objectives of the Arrangements.

7.3 The role of the Partnership Board is to manage and monitor the Trust's role as the Provider of the Services, the exercise of the Functions and the application of the Contributions, together with supporting the implementation of any strategic plan or variation to the Services as provided for in Clause 5 (Services).

Clinical and Corporate Governance

7.4 The Trust is subject to a duty of clinical governance, which (for the purposes of this Agreement) shall be defined as "*a framework through which it is accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish*".

7.5 The Council acknowledges that clinical governance (as described at clause 7.4 above) applies to the treatment of NHS patients. Such patients are entitled to expect to receive services which are part of a clinical governance system irrespective of where they are treated.

7.6 The Arrangements will therefore be subject to clinical governance obligations so far as they relate to the provision of NHS services and the Council shall use reasonable endeavours to co-operate with all reasonable requests from the Trust, which the Trust considers necessary in order to fulfil its obligations.

7.7 The Trust shall comply with the principles and standards of corporate governance relevant to NHS bodies.

Social Care Governance and Performance Reporting

7.8 The Council has a duty to report on performance in order to ensure that targets are being met and that the social care economy is effective in its delivery with regards to policy drivers and improved outcomes to individuals. The Arrangements will be subject to these obligations as set out in Schedule 5, Annex 5.

Strategic Planning

7.9 The Partnership Board shall consider the risks and benefits of a transition to a fully integrated model of service delivery which may include: -

7.9.1 the Trust assuming responsibility for the DoLS BIA, Community Care Assessments and for the ASC adult placement budget;

7.9.2 streamlining management structures and staff models to ensure that they best meet Service User needs;

7.9.3 improving staffing arrangements which align human resource practices with line management and professional responsibility;

7.9.4 the alignment of ASC management with the Trust Transformation Project and the development of integrated care pathways;

7.9.5 build and maintain professional social care expertise and capacity at all levels;

7.9.6 ensure that financial opportunities are maximised and the risks to both Parties are minimised;

7.9.7 development of IT systems to allow greater integration including a bolt on social care module for PARIS and a data warehousing solution where both PARIS and ESCR (or future replacement systems) can be accessed through a single screen; and

7.9.8 longer term development of integrated IT systems.

7.10 It is the parties intention that further integration in accordance with Clause 7.8 would align with complete Financial Years and will require the agreement of both Parties and a variation to this Agreement in accordance with clause 15 (Variation) prior to implementation.

8. INSPECTION

The Parties shall co-operate with any investigation undertaken by the Care Quality Commission and/or the Audit Commission or any regulatory authority/body.

9. FINANCIAL ARRANGEMENTS

9.1 Subject to Clause 2.5 above, the Parties acknowledge that they are not entering into a Pooled Fund arrangement pursuant to section 75(2)(a) of the Act and Regulation 7 of the Regulations.

9.2 The Parties agree to adhere to the financial arrangements more fully set out in Schedule 6 (Resources) Part 1 (Financial Resources) of this Agreement.

10. **NOT USED**

11. **STAFFING ROLES**

11.1 The Parties have agreed that the Arrangements shall be facilitated by the Staff listed at Schedule 13 (Human Resources).

11.2 The Trust shall make available those Staff listed at Schedule 13 (Human Resources) to carry out the Trust Functions.

11.3 The Council shall make available those of its Staff listed at Schedule 13 (Human Resources) to carry out the Council Functions.

11.4 The Parties do not consider that, as a consequence of clause 11.3 above, there is a Relevant Transfer under TUPE in relation to those Council Staff listed in Schedule 13 (Human Resources).

11.5 If, as a consequence of clause 11.3 above, there is a Relevant Transfer of Council Staff under TUPE on the Commencement Date, or in the event that there is a Relevant Transfer under TUPE in relation to any Council Staff (whether listed in Schedule 13 [Human Resources] or not) at any time or for any reason after the Commencement Date, so that, in either case, with effect from the Transfer Date contracts of employment of any Council Staff took effect as if originally made between that individual and the Trust, then:

11.5.1 the Council shall indemnify the Trust and shall keep the Trust indemnified from and against all Demands suffered or incurred by the Trust arising out of or in relation to any Transferred Council Staff, including but not limited to:

(a) any breach by the Trust of its failure to pay Staff Emoluments in relation to any Transferred Council Staff;

(b) any breach by the Trust of its failure to comply with its obligations under regulations 13 or 14 of TUPE;

(c) the employment or engagement or termination of employment or engagement of any Transferred Council Staff by the Council and/or arising out of any act or omission of the Council (including, for the avoidance of doubt, any claim under the Equal Pay Act 1970) before, on, or after the Transfer Date;

(d) any breach by the Trust of its failure to comply with the pension obligations under the Cabinet Office: Staff Transfers in the Public Sector Statement of Practice 2000 (as revised), including A Fair Deal for Staff Pensions;

(e) complying with the pension obligations under the Cabinet Office: Staff Transfers in the Public Sector Statement of Practice 2000 (as revised), including A Fair Deal for Staff Pensions; and

(f) any liability to provide pension benefits which are not old age, invalidity or survivors benefits,

11.5.2 the Trust shall agree not to bring any claim against the Council in relation to its failure to comply with its obligations under Regulation 11 of TUPE.

12. PREMISES

12.1 The Services will be provided from the Premises.

12.2 The Parties shall comply with the obligations set out at Schedule 6 Part 4 in relation to the Premises.

13. EQUIPMENT AND OTHER RESOURCES

13.1 Lists of Trust Equipment and Council Equipment are set out at Schedule 6 (Resources) Part 5 (Equipment).

13.2 The Trust shall use the Trust Equipment in accordance with the provisions of Schedule 6 (Resources) Part 5 (Equipment).

14. INDEMNITIES, LIABILITY AND INSURANCE

14.1 Nothing in this Agreement shall affect:

14.1.1 the liability of the Trust to the Service Users in respect of the Trust Functions; or

14.1.2 the liability of the Council to the Service Users in respect of the Council Functions.

14.2 Each Party (the "First Party") shall indemnify and keep indemnified the other Party (the "Second Party") and its officers, employees and agents against any damages, costs, liabilities, losses, claims or proceedings whatsoever, arising in respect of:

14.2.1 any damage to property (real or personal) including, but not limited to, any infringement of third party intellectual property, including patents, copyrights and registered designs;

14.2.2 any death or personal injury;

14.2.3 any fraudulent or dishonest act of employees;

14.2.4 any Service User complaint or investigation by the Parliamentary Health Service Ombudsman or the Local Government Ombudsman or any similar entity,

arising out of or in connection with the Agreement, to the extent that such damages, costs, liabilities, losses, claims or proceedings shall be due directly or indirectly to any negligent act or omission, any breach of this Agreement or any breach of statutory duty by the First Party, its officers employees or agents. Where the Parties are unable to agree any such apportionment of liability and consequential indemnity under this Clause 14, the disputes procedure in clause 23 (Dispute Resolution) shall apply.

14.3 For the avoidance of doubt, the Second Party shall be under a duty to mitigate its losses in accordance with general principles of common law and the indemnity on the part of the First Party shall not extend to damage, cost, liability, loss, claim or proceedings incurred by reason of or in consequence of any negligent act or omission, misconduct or breach of this Agreement by the Second Party.

14.4 Each Party shall ensure that it maintains appropriate insurance arrangements in respect of employer's liability, liability to third parties and all other potential liability under this Agreement.

15. REVIEW AND VARIATION

15.1 If at any time during the term of this Agreement the Council or the Trust requests in writing any change to the Services described or the manner in which the Services are provided, then the provisions outlined in this clause 15 shall apply.

15.2 The Party proposing the Variation ("the Proposer") shall provide a report in writing to the other Party (the "Report") setting out:

15.2.1 the Variation proposed;

15.2.2 the date upon which the Proposer requires it to take effect;

15.2.3 a statement of whether the Variation will result in any increase or decrease in Contributions by reference to the relevant component elements of the Service or Services the subject of change;

15.2.4 a statement on the individual responsibilities of the Trust and the Council for any implementation of the Variation;

15.2.5 a timetable for implementation of the Variation;

15.2.6 a statement of any impact on, and any changes required to the Services;

15.2.7 details of any proposed staff and employment implications; and

15.2.8 the date for expiry of the Report.

15.3 Following receipt by the receiving Party ("the Recipient") of the Report and allowing the Recipient a reasonable period of time in which to consider the Report, the Parties shall meet to discuss the proposed Variation and acting reasonably and in good faith shall use reasonable endeavours to agree the Variation.

15.4 Where the Parties are unable to agree on the terms of the Variation then the Agreement may terminate in accordance with clause 17.3.4.

15.5 If agreement in principle is reached then the Parties shall confirm in writing their decision to proceed with the proposed Variation and shall agree a formal Variation to this Agreement.

15.6 All Variations made to this Agreement pursuant to this clause 15 or otherwise shall be agreed between the Parties and made in writing.

15.7 The Parties shall review this Agreement within two months of each anniversary of the Commencement Date. Any changes agreed between the Parties to the Agreement shall be effected in accordance with this clause 15.

16. CHANGE OF LAW

16.1 If at any time during the term of this Agreement a change to the manner in which a Service or the Services are provided is required by operation of NHS or Local Government law through statutes, orders, regulations, instruments and directions made by the Secretaries of State for Health and Local Government respectively or others duly authorised pursuant to statute or other changes in the law which relate to the powers, duties and responsibilities of the Parties and which have to

be complied with, implemented or otherwise observed by the Parties in connection with the Functions for the time being, then the provisions outlined in this Clause 16 shall apply.

16.2 The Parties shall jointly investigate the likely impact of the required change on the Services and any other aspect of the Agreement and shall prepare a Report in writing, setting out:

16.2.1 the Variation proposed;

16.2.2 the date upon which it should take effect;

16.2.3 a statement of whether the Variation will result in any increase or decrease in Contributions by reference to the relevant component elements of the Service or Services the subject of change;

16.2.4 a statement on the individual responsibilities of the Trust and the Council for any implementation of the Variation;

16.2.5 a timetable for implementation of the Variation;

16.2.6 a statement of any impact on, and any changes required to the Services;

16.2.7 details of any proposed staff and employment implications; and

16.2.8 the date for expiry of the Report.

16.3 Where the Parties are unable to agree on the terms of the Variation then the Agreement may terminate in accordance with clause 17.3.3.

16.4 The Parties shall confirm in writing their decision to proceed with the proposed Variation and shall agree a formal Variation, in writing, to this Agreement.

17. TERMINATION

17.1 Either Party ("**the First Party**") may, at any time by notice in writing to the other Party, terminate this Agreement if the other Party is in default of its obligations under this Agreement (the **"Defaulting Party"**) and:

17.1.1 if such default is capable of remedy, fails to comply with a written notice from the First Party to remedy such default within a reasonable period (which shall be specified in such written notice), such termination notice to take effect two (2) weeks from its date of receipt; or

17.1.2 if such default is not capable of remedy, such termination notice shall take effect upon receipt.

17.2 Either Party may terminate this Agreement:

17.2.1 for convenience, by giving twelve (12) months' notice in writing to the other Party;

17.2.2 immediately on written notice, if the other Party suffers an Event of Force Majeure and such event persists for more than twenty (20) Working Days following the service of the notice referred to at clause 22.4.2 or;

17.2.3 the fulfilment of the Arrangements would be ultra vires.

17.3 Either Party ("**the First Party**") may terminate this Agreement by giving the other Party 6 months' notice in writing if:

17.3.1 for budgetary reasons:

(a) the First Party is no longer able to contribute sufficient resources to the Arrangements (or any part of them); or

(b) the First Party is of the reasonable opinion that in light of the other's proposed Contribution the Arrangements (or any part of them) are no longer viable;

17.3.2 the First Party's fulfilment of its obligations hereunder would be in contravention of any guidance from any Secretary of State issued after the date hereof; or

17.3.3 the Parties are unable to agree a Variation to this Agreement in accordance with clause 15 and/or clause 16 so as to enable either/ both Parties to fulfil its/ their obligations in accordance with law and guidance.

18. EFFECTS OF TERMINATION

18.1 Upon termination of this Agreement for any reason whatsoever, the following shall apply:

18.1.1 termination of this Agreement shall have no effect on the liability of either Party to make payment of any sums due under this Agreement, nor any rights or remedies of either Party already accrued, prior to the date upon which such termination takes effect;

18.1.2 upon termination of this Agreement, the Parties agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities is carried out smoothly and with as little disruption as possible to Service Users, the Client Group as a whole, Staff, the Parties and third parties, in accordance with Schedule 11 (Winding Down Protocol); and

18.1.3 the Parties shall ensure that payment of the Contributions, including the handling of any potential or actual remaining overspend or underspend, is carried out in accordance with the procedures set out in Schedule 11 (Winding Down Protocol).

18.2 Upon termination, and subject to the provisions of Schedule 11 (Winding Down Protocol), the Contributions shall continue, notwithstanding termination, to be used by the Trust to pay for any of the Services delivered by third parties under contracts approved by the Partnership Board.

19. CONFIDENTIALITY

19.1 Except as required by law and specifically pursuant to clause 21 (Freedom of Information), each Party agrees at all times during the continuance of this Agreement and after its termination or expiry to keep confidential any and all information, data and material of any nature which either Party may receive or obtain in connection with the operation of this Agreement or otherwise relating in any way to the business, operations and activities of the other Party, its employees, agents and/or any other person with whom it has dealings including any Service User of either Party. For the avoidance of doubt this Clause shall not affect the rights of any workers under section 43 A-L of the Employment Rights Act 1996.

19.2 The Parties agree to provide or make available to each other sufficient information concerning their own operations and actions and concerning Service User information (including material affected by the DPA in force at the relevant time) to enable efficient operation of the Arrangements (which to avoid doubt shall include the Services).

20. DATA PROTECTION

20.1 The Parties acknowledge their respective duties under the DPA and shall give all reasonable assistance to each other where appropriate or necessary to comply with such duties.

20.2 To the extent that the Trust is acting as a Data Processor (as such term is defined in the DPA) on behalf of the Council, the Trust shall, in particular, but without limitation:

20.2.1 only process such Personal Data as is necessary to perform its obligations under this Agreement, and only in accordance with any instruction given by the Council under this Agreement;

20.2.2 put in place appropriate technical and organisational measures against any unauthorised or unlawful processing of such Personal Data, and against the accidental loss or destruction of or damage to such Personal Data having regard to the specific requirements in clause 20.3.3 below, the state of technical development and the level of damages that may be suffered by a Data Subject (as such term is defined in the DPA) whose Personal Data is affected by such unauthorised or unlawful processing or by its loss, damage or destruction;

20.2.3 take reasonable steps to ensure the reliability of employees who will have access to such Personal Data, and ensure that such employees are aware of and trained in the policies and procedures identified in clauses 20.3.4, 20.3.5 and 20.3.6 below; and

20.2.4 not cause or allow such Personal Data to be transferred outside the European Economic Area without the prior consent of the Council.

20.3 The Trust shall ensure that Personal Data is safeguarded at all times in accordance with the DPA and other relevant data protection legislation, which shall include without limitation the obligation to:

20.3.1 perform an annual information governance self-assessment;

20.3.2 have an information guardian able to communicate with the Partnership Board, who will take the lead for information governance and from whom the Partnership Board shall receive regular reports on information governance matters including details of all data loss and confidentiality breaches;

20.3.3 (where transferred electronically) only transfer essential data that is (i) necessary for direct Service User care; and (ii) encrypted to the higher of the international data encryption standards for healthcare and the National Standards (this includes, but is not limited to, data transferred over wireless or wired networks, held on laptops, CDs, memory sticks and tapes);

20.3.4 have appropriate policies which are rigorously applied that describe individual personal responsibilities for handling Personal Data;

20.3.5 have agreed protocols for sharing Personal Data with other NHS organisations and non-NHS organisations; and

20.3.6 have a system in place and a policy for the recording of any telephone calls, where appropriate, in relation to the Services, including the retention and disposal of such recordings.

21. FREEDOM OF INFORMATION

21.1 Each Party acknowledges that the other Party is subject to the requirements of the FOIA and each Party shall assist and co-operate with the other (at their own expense) to enable the other Party to comply with its information disclosure obligations.

21.2 Where a Party receives a "request for information" (as defined in the FOIA) in relation to information which it is holding on behalf of the other Party, it shall (and shall procure that its sub-contractors shall):

21.2.1 transfer the request for information to the other Party as soon as practicable after receipt and in any event within two (2) Working Days of receiving the request for information;

21.2.2 provide the other Party with a copy of all information in its possession or power in the form that the other Party requires within five (5) Working Days (or such other period as may be agreed) of the other Party requesting that information; and

21.2.3 provide all necessary assistance as reasonably requested to enable the other Party to respond to the request for information within the time for compliance set out in section 10 of the FOIA.

21.3 Where a Party receives a request for information which relates to the Agreement, it shall inform the other Party of the request for information as soon as practicable after receipt and in any event within two (2) Working Days of receiving the request for information.

21.4 If either Party determines that information must be disclosed pursuant to Clause 21.3, it shall notify the other Party of that decision at least two (2) Working Days before disclosure.

21.5 Each Party shall be responsible for determining at its absolute discretion whether the relevant information is exempt from disclosure or is to be disclosed in response to a request for information.

21.6 Each Party acknowledges that the other Party may be obliged under the FOIA to disclose information:

21.6.1 without consulting with the other Party; or

21.6.2 following consultation with the other Party and having taken its views into account.

22. FORCE MAJEURE

22.1 Where a Party is (or claims to be) affected by an Event of Force Majeure, it shall take all reasonable steps to mitigate the consequences of it, resume performance of its obligations as soon as practicable and use all reasonable efforts to remedy its failure to perform.

22.2 Subject to clause 22.1, the Party claiming relief shall be relieved from liability under this Agreement to the extent that because of the Event of Force Majeure it is not able to perform its obligations under this Agreement.

22.3 The Party claiming relief shall serve initial written notice on the other Party immediately it becomes aware of the Event of Force Majeure. This initial notice shall give sufficient details to identify the particular event.

22.4 The Party claiming relief shall then either:

22.4.1 serve a detailed written notice within a further five (5) Working Days. This detailed notice shall contain all relevant available information relating to the failure to perform as is available, including the effect of the Event of Force Majeure, the mitigating action being taken and an estimate of the period of time required to overcome it; or

22.4.2 in the event it reasonably believes that the effects of the Event of Force Majeure will make it impossible for the Arrangements to continue, serve notice of this to the other Party and the Agreement will terminate in accordance with clause 17.2.2 of this Agreement.

23. DISPUTE RESOLUTION

23.1 The Parties shall use their best efforts to negotiate in good faith and settle any dispute that may arise out of or relate to this Agreement. If any dispute cannot be settled amicably through ordinary negotiations, then it shall be referred to the Chief Executive of the Council and the Chief Executive of the Trust for discussion and resolution.

23.2 Each Party shall use all reasonable endeavours to reach a negotiated resolution to the dispute through the above dispute resolution procedure. If the dispute is not resolved, the Parties will use reasonable endeavours to settle it by mediation in accordance with the Centre for Effective Dispute Resolution (**"CEDR"**) Model Mediation Procedure (**"the Model Procedure"**).

23.3 To initiate the mediation, a Party must give notice in writing (**"ADR notice"**) to the other Party requesting a mediation in accordance with clause 23.2.

23.4 The procedure in the Model Procedure will be amended to take account of:

23.4.1 any relevant provisions in this Agreement;

23.4.2 any other agreement which the Parties may enter into in relation to the conduct of the mediation (**"Mediation Agreement"**).

23.5 The costs of the mediation shall be met in equal shares by the Parties and will not be paid from the Contributions.

24. NOTICES

24.1 Any notice or communication in relation to this Agreement shall be in writing.

24.2 Any notice or communication to the Council shall be deemed effectively served if sent by registered post or delivered by hand to the Council at the address set out

above and marked for the Chief Executive or to such other addressee and address notified from time to time to the Partnership Board for service on the Council.

24.3 Any notice or communication to the Trust shall be deemed effectively served if sent by registered post or delivered by hand to the address set out above and marked for the attention of the Chief Executive or to such other addressee and address notified from time to time to the Partnership Board for service on the Trust.

24.4 Any notice served by hand delivery shall be deemed to have been served on the date it is delivered to the addressee. Where notice is posted, it shall be sufficient to prove that the notice was properly addressed and posted and the addressee shall be deemed to have been served with the notice forty-eight (48) hours after the time it was posted.

25. EXCLUSION OF PARTNERSHIP AND AGENCY

25.1 Nothing in this Agreement shall create or be deemed to create a legal partnership under the Partnership Act 1890 or the relationship of employer and employee between the Parties or render either Party directly liable to any third party for the debts, liabilities or obligations of the other Party.

25.2 Save as specifically authorised under the terms of this Agreement, neither Party shall hold itself out as the agent of the other Party.

26. ASSIGNMENT AND SUB-CONTRACTING

This Agreement, and any right and conditions contained in it, may not be assigned or transferred by either Party without the prior written consent of the other Party, except to any statutory successor to the relevant function.

27. THIRD PARTY RIGHTS

The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly the Parties to this Agreement do not intend that any third party should have any rights in respect of this Agreement by virtue of that act.

28. COMPLAINTS

28.1 Any complaints relating to Council Functions shall be dealt with in accordance with the statutory complaints procedure of the Council.

28.2 Any complaints relating to the Trust Functions shall be dealt with in accordance with the statutory complaints procedure of the Trust.

28.3 Insofar as any complaint may relate to the content of this Agreement or to the operation of the Arrangements, such complaints shall be referred to the Partnership Board or such Partnership Board member or sub-committee made up of Partnership Board members as it nominates for the procedure adopted by it for the handling of complaints to be carried through.

28.4 All complaints shall be reported by the Parties to the Partnership Board.

29. ENTIRE AGREEMENT

This Agreement constitutes the entire agreement and understanding of the Parties and supersedes any previous agreement between the Parties relating to the subject matter of this Agreement.

30. SEVERABILITY

If any term, condition or provision contained in this Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision shall not affect the validity, legality or enforceability of the remaining parts of this Agreement.

31. WAIVER

31.1 The failure of any Party to enforce at any time or for any period of time any of the provisions of this Agreement shall not be construed to be a waiver of any such provision and shall in no matter affect the right of that Party thereafter to enforce such provision.

31.2 No waiver in any one or more instances of a breach of any provision hereof shall be deemed to be a further or continuing waiver of such provision in other instances.

32. COSTS AND EXPENSES

Each Party shall be responsible for paying its own costs and expenses incurred in connection with the negotiation, preparation and execution of this Agreement.

33. GOVERNING LAW AND JURISDICTION

Subject to the provisions of clause 23 (Dispute Resolution) this Agreement shall be governed by and construed in accordance with English Law, and the Parties irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

34. FAIR DEALINGS

The parties recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of either of them and that if in the course of the performance of this Agreement, unfairness to either of them does or may result then the other shall use its reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

SIGNATURE PAGE

SIGNED by CHRISTOPHER BUTLER

for and on behalf of **LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST**

.....

(Signature)

28/9/12

.....

(Date)

SIGNED by Sandie Keene

for and on behalf of **LEEDS CITY COUNCIL**

.....

(Signature)

28/9/12

.....

(Date)

SCHEDULE 1

AIMS AND OBJECTIVES

1. The Parties wish to use this Agreement to enable the Trust to act as Integrated Provider of the Services to the Service Users.

2. Without prejudice to the other provisions of this Agreement, the primary objective of the Parties in entering into this Agreement is to improve the provision of the Services to Service Users by:

   2.1 providing integrated Services and seamless care pathways, which will improve outcomes and Service User/carer experience of the Services;

   2.2 delivering value for money and positive outcomes for Service Users in ways that are compatible with national strategic drivers for change;

   2.3 improved team working and joint priority setting;

   2.4 analysing local needs, gaps in current service provision and capacity and demand issues, so as to ensure investment is targeted and cost effective;

   2.5 synergising business planning, reporting procedures and other administrative and reporting requirements between the Parties; and

   2.6 formalising the agreed level of integration of Council mental health assessment and Trust care management functions and provide a framework through which further integration and service improvement can be delivered in future.

3. The Parties have consulted with the following stakeholder organisations on the proposals for the Arrangements:

   3.1 Leeds Primary Care Trust Service Users workshop to capture experiences of health and social care and to share what is important to Service Users when accessing services – July 2010;

   3.2 Service Users event linked to the Trust Building Your Trust event and focussing on exploring the impact of the integration of mental health and social care pathways – December 2010; and

   3.3 Trust and Council Staff.

SCHEDULE 2

TRUST FUNCTIONS

The NHS functions are, in so far as they may be delegated under regulation 5(1) of the Regulations:

1. the function of providing, or making arrangements for the provision of, services:

   1.1 under sections 2 and 3(1) of the Act, including rehabilitation services and services intended to avoid admission to hospital but excluding surgery, radiotherapy, termination of pregnancies, endoscopy, the use of Class 4 laser treatments and other invasive treatments and emergency ambulance services; and

   1.2 under paragraphs 1 to 8 of Schedule 1 to the Act;

2. the functions under sections 117 and 130A of the Mental Health Act 1983;

3. the functions of making direct payments under:

   3.1 section 12A(1) of the National Health Service Act 2006 (direct payments for health care); and

   3.2 regulation 2(7) of the National Health Service (Direct Payments) Regulations 2010; and

   3.3 the functions under Schedule A1 of the Mental Capacity Act 2005.

The foregoing functions set out all NHS functions that could be managed under this Agreement. It does not necessarily follow that all such functions will be managed under this Agreement. A detailed descriptions of those functions managed under this Agreement can be found in the service description in Schedule 5.

SCHEDULE 3

COUNCIL FUNCTIONS

The health-related functions are all those services provided under the following legislation which relate to persons aged 18 or over, in so far as they may be delegated under regulation 6(1) of the Regulations:

1. the functions under sections 21, 22, 23(1), 23(2), 24 and 26 of the National Assistance Act 1948;

2. the functions under section 45 of the Health Services and Public Health Act 1968;

3. the functions under Schedule 20 of the 2006 Act;

4. the functions under section 46 of the National Health Services and Community Care Act 1990;

5. the functions under section 117 of the Mental Health Act 1983; and

6. the functions under s2 of the Chronically Sick and Disabled Persons Act 1970.

SCHEDULE 4

EXCLUDED FUNCTIONS

1.1 Trust Functions shall not include the following:

1.1.1 surgery;

1.1.2 radiotherapy;

1.1.3 termination of pregnancies;

1.1.4 endoscopy;

1.1.5 the use of Class 4 laser treatments and other invasive treatments; and

1.1.6 emergency ambulance services; and

1.2 the Council Functions shall not include any functions pursuant to the following:

1.2.1 subject to Regulation 6(k) of the Regulations, sections 22, 23(3), 26(2) to (4), 43, 45 and 49 of the National Assistance Act 1948;

1.2.2 sections 6 and 7B of the Local Authorities Social Services Act 1970;

1.2.3 section 3 of the Adoption and Children Act 2002;

1.2.4 sections 114 and 115 of the Mental Health Act 1983;

1.2.5 section 17 of the 1983 Act;

1.2.6 the Registered Homes Act 1984; and

1.2.7 Parts VII to X and section 86 of the Children Act 1989,

or any other functions that are specified in the Regulations as amended from time to time as being excluded from section 75 arrangements.

2. To avoid doubt:

2.1 all functions that are not specified as either Council Functions in Schedule 3 or Trust Functions in Schedule 4 of this Agreement shall be Excluded Functions; and

2.2 any Functions of either Party that do not relate to or benefit any individual falling within the Client Group shall be excluded from this Agreement.

SCHEDULE 5

THE SERVICES

Part 1: The Services

The services managed under this agreement fall into three categories, which are as follows:

1. NHS Case Management Functions within integrated teams.

2. The Approved Mental Health Professional (AMHP) function – this is principally the management of the AMHP rota across the city of Leeds. However, it should be noted that the training and approval of AMHPs will remain a responsibility of the Director of Adult Social Services (DASS). The Trust shall through the performance of the Services assist the DASS in the execution of these responsibilities.

3. The operation of the specialist social work function of the Mental Health Unit (MHU). Although this service supports all relevant persons over the age of 18 the community care budget for persons of age 65 or over is located and managed within a separate area of the Council ASC function.

Part 2: Service Users

1. The Service Users shall be the adult population of the City of Leeds with secondary care mental health needs, excluding care packages for older people.

Service Specification:

The following is a description of those Trust and Council functions and responsibilities managed under this agreement. On an operational basis these functions will be managed holistically across the integrated services in order to balance competing priorities. Individual team members will contribute to multiple elements of these functions in conjunction with line management and the overarching management of the integrated services to ensure effective performance across all services.

1. NHS case management functions within integrated teams:

The Trust and the Council work within common geographical boundaries (with the exception of Wetherby in East North East locality) within the City of Leeds, as per appendix iii of this agreement. These localities are named as:

- West North West – managed by a nominated Trust Locality Team Manager (LTM)
- East North East – managed by a nominated Trust LTM
- South – managed by a nominated Trust LTM

Council staff are embedded into all of these teams, as set out in the staffing schedule of the Matrix Management Agreement (schedule 13).

In addition to these services there are embedded social workers in the:

- Crisis Assessment Service (CAS) – currently based at the Becklin Centre – managed by a nominated Trust manager.

In addition, AMHPs provide ad hoc support to the:

- Section136 Assessment suite – currently based at the Becklin Centre, which is located alongside the CAS – managed by a nominated Trust manager.

The single point of access is currently based at the Becklin Centre and this provides a coordinating and gate keeping services to Trust mental health resources across the localities.

Crisis Assessment Service (CAS)

There are four full time Social Workers (AMHPs) based within the CAS to provide a service which covers a 24 hour 7 day a week period. The AMHPs operate as key workers alongside other workers from different disciplines.

Operational issues are managed by Clinical Leads within CAS on a daily basis. A Clinical Lead usually equates to a Band 7 (NHS Agenda for Change pays scales) level clinician; the AMHPs are aligned to one of the Band 7 clinical leads. Currently, in agreement with the Clinical Lead, each CAS AMHP contributes two days per month to the Council ASC AMHP rota coinciding with their duty for the CAS.

Each CAS AMHP is supervised by a MHU Team Manager in order to meet their AMHP supervision requirements. Ongoing social work related issues are discussed in conjunction with the relevant Trust manager.

Integrated Locality Teams

Council Staff embedded in the above teams operate within a single line management structure hosted by the Trust in accordance with the Matrix Management Agreement (Schedule 13).

Council Staff have a requirement for ongoing professional supervision, training and development so to support this each team will appoint a Lead Social Work Professional to provide professional supervision. These leads will in turn link into the Service Delivery Manager (SDM) who will be the senior social work professional within the integrated services and will be the primary link into the Council ASC function in relation to social workers and AMHPs' professional and statutory responsibilities. The AMHP and MHU functions are described in more detail in sections 2 and 3 of this document.

It is acknowledged that Council Staff managed under this agreement have a duty to deliver specific ASC responsibilities beyond the Trust teams listed above. However, they are expected to make a significant contribution to the functioning of the integrated, multi disciplinary teams in which they are embedded. Moreover, given that the management of the functions of the MHU and that the AMHP rotation all fall under this agreement, the management of each individual resource will be determined by the LTM in consultation with the individual Social Care Professional concerned and the SDM. The intention of this is to facilitate the Trust in managing a limited resource across a number of potentially competing responsibilities.

Staff Supervision/Personal Development

Day to day management of embedded Council staff will fall under the line management of the host organisation (the Trust) and will therefore be subject to local determination by the LTM. Input in relation to professional social work matters will be sought from the local professional social work lead and/or the SDM. The process of personal development planning will be in accordance with Council policy but will be mindful of Trust processes in order to ensure that Council staff have access to opportunities available within the Trust.

Contribution to Trust NHS Functions

Insofar as is possible and in accordance with the individual work plan agreed with the LTM, embedded Council staff will play a vital role in the integrated team structures and will:

- Contribute directly to the care of service users in the integrated teams; carrying a case load for which they will be the case coordinator, where there is a predominance of social care need.
- Contribute towards a holistic assessment process to assist in the provision of a team wide, multidisciplinary assessment of referrals; in particular **formulation meetings** which are designed as a fundamentally important to the mental health transformation programme underway in the Trust.
- Contribution to the triage function.
- Contribute to Continuing Care Assessments.
- Use the FACE assessment tool – for which the Trust will provide relevant training and support.

- Contribute to the ongoing management of the integrated locality team by participating in the on call duty rota.

Information Systems

It is an agreed ambition of the partnership to work towards an integrated information reporting system; it is accepted that in the interim it will be necessary for Council Staff to access both Trust and Council information technology systems. In this regard the Trust will provide all embedded Council Staff with access and training in PARIS which will be used in accordance with Trust policies and procedures for the input of all data relating to the health functions covered by this agreement.

2. The AMHP Function:

The Mental Health Unit has responsibilities to locality based AMHPs regarding both supervision and training. The current Council localities are defined as (see map at appendix iii):

- Leeds - West North West
- Leeds - East North East
- Leeds - South

As mental health needs change over time there will be cases that will be transferred from area teams to the MHU and vice versa.

APPROVED MENTAL HEALTH PRACTITIONERS

1.0 AMHPs are professionals who have been approved by the Local Social Services Authority (LSSA), in this case Leeds City Council (the Council), to carry out key statutory functions under the Mental Health Act 1983.

These duties are outlined in detail within the Act itself, the Mental Health Code of Practice and the Reference Guide (2008). The regulations for AMHPs is contained within The Mental Health (Approved Mental Health Professionals) (Approval) (England) Regulations 2008 (Statutory Instrument 2008 No 1206). The key competencies are contained within Schedule 2 to the AMHP Regulations.

1.1 Whilst there are a number of disciplines of mental health professionals that can fulfil the role of the AMHP it is the Council which ensures that they are competent and approved to carry out the duties and functions as laid down. AMHPs are approved for a five year period.

2.0 The Trust will adhere to AMHP policies and procedures as laid out by statute and the Council for whom they are acting.

3.0 Workforce and Capacity (AMHPs)

3.1 The Trust will make reasonable endeavours to manage the available AMHP resource across the localities efficiently in order to ensure that there are a sufficient number of AMHPs in each locality to carry out the duties and responsibilities laid out by the government for that professional role.

3.2 If in its reasonable opinion the Trust believes that there are insufficient AMHP resources to fulfil the AMHP function or those other functions managed under this agreement as prescribed in law it should report the issues to the Partnership Board.

3.3 AMHPs will also be required to evidence their continued professional development and competence to act in this role over a prescribed timescale.

3.4 The AMHP has the ability to make an independent decision as an AMHP is personally liable for their actions when deciding whether to make an application to detain a person under the Act. They exercise their judgement based upon the social and medical evidence provided and do not act at the behest of their employer, medical practitioner or other persons who might be involved with the person's care. The judgement made applies not only to the decision on whether an application should be made in respect of the person it also applies to the question of what section of the Act to invoke.

3.5 An AMHP requires the professional experience to respect an individual's right to freedom of choice whilst being prepared to intervene decisively where the level of mental disorder and risk requires it. The AMHP also demonstrates a sound understanding of all relevant legislation.

4.0 Management and Supervision of AMHPs

4.1 AMHPs are approved by the Council irrespective of who their employer is; which could be the Trust, for example.

4.2 AMHPs are required to go through a re-approval process every five years.

4.3 AMHPs require a clear pathway to obtain legal advice from the Council. Access arrangements are described under "Council legal services" below.

4.4 AMHPs must have access to;

- Professional supervision from an experienced AMHP.
- Information about AMHP practice in general.
- Advice on any practice problems they may encounter (e.g. access to beds, the police or ambulance services).
- Advice and support on how to work to resolve issues with partner organisations.
- Relevant, continual professional development training of a minimum of 18 hours per annum.

4.5 AMHPs will operate as team members in a variety of community and hospital settings. Whilst they will receive a caseload commensurate with their experience they will also require the time and capacity to fulfil their statutory role as AMHPs. This will normally be planned on a rota basis.

4.6 AMHPs also require a 'duty release' to undertake mandatory training with national portfolio guidelines.

5.0 Governance Issues

5.1 The appropriate collation of AMHP activity data will be required at key intervals by the Local Authority. Council information reporting requirements will continue to be met by the Council and performance reports will be received by the Partnership Board and will include:

- Section 117 details
- Section 2/3/4 and Community Treatment Orders
- Section 135/136
- Guardianship Section 7

As detailed in the Matrix Management Agreement at Schedule 13 Council Staff shall use specific policies and procedures of the Trust in order to avoid duplication with other processes.

6.0 Charging and Financial Assessments

6.1 Users of some social care services are liable to pay charges towards the costs of providing these; NHS patients receive services free at the point of demand.

6.2 People discharged from hospital following a compulsory admission under various sections are entitled under Section 117 of the Mental Health Act 1983 to receive free after care services in order to meet their mental health needs from health and social care. These services will be identified within a care plan.

6.3 Regular reviews of Section 117 cases will be undertaken on a multi-disciplinary basis through the Care Programme Approach to determine their continued appropriateness.

6.4 For clarity the Trust will not be liable for any Section 117 aftercare costs relating Council responsibilities under the Act and the Council will not be liable for meeting healthcare costs under said section of the act.

6.5 Charges set by the Council may be varied on an annual basis. The Trust will ensure that service users and carers (where appropriate) are aware of any such changes. The Council will ensure that the Trust is made aware of any changes through bringing them to the attention of the Partnership Board in advance.

6.6 The Financial Assessment Section of the Council will liaise with the Trust to ensure that an appropriate financial assessment is completed and that fairer charging is applied.

The AMHP Rota

The AMHP rota is managed under this agreement by the SDM.

The majority of AMHPs in the City of Leeds are managed under this Agreement. It is expected that social workers engaged under this Agreement will train as AMHPs and provide capacity to the AMHP rota within Leeds. The AMHPs managed under this Agreement provide the "backbone" of the AMHP capacity within the city as a whole; however, a significant cohort of AMHPs remain under the direct management of the Council ASC department in other areas e.g. Learning Disability. Therefore depending upon demand for the AMHP function the effective delivery of the service will depend on AMHPs outside the direct control of the SDM.

The SDM will manage the AMHP rota within available resources. This will involve utilising other AMHPs outside of the Agreement by working flexibly with others. This is accepted to be a sufficient method to manage short term issues such as sickness absence, training requirements and modest fluctuations in demand. It is the responsibility of the SDM under this Agreement to monitor and record demand on the AMHP rota and to bring to the attention of the Partnership Board details of demand on the system to allow resourcing to be reviewed and amended appropriately. Similarly, if the availability of AMHPS outside this Agreement is reduced for any reason, and this results in a detrimental effect on the delivery of any of the functions managed under the Agreement, then the SDM will bring this to the attention of the Partnership Board for a steer as to a way forward.

It is established under this Agreement that the Trust will only provide services to a level possible through the utilisation of the resources made available to it within this Agreement. The Trust is only responsible to manage these resources in a reasonable manner and agree to bring to the attention of the Council via the Partnership Board any demand issues that may weaken any or all elements of the service. Should the Council determine that it cannot provide any additional Social Care resources and the Partnership Board cannot agree any alternative remedy the Trust cannot be held accountable for any detrimental effect on Social Care service delivery.

3. The Mental Health Unit (MHU)

The MHU provides the assessment and care management function for adults with secondary care mental health needs within the City of Leeds. This includes a number of people who will have a dual diagnosis of mental health issues and other co-morbidities. The unit accesses the community care budget for adults aged between 18 and 65 with secondary care mental health needs which is held and managed by the Council.

A detailed specification of the MHU is appended to this agreement in appendix iv. This document is intended to detail the operational responsibilities of the MHU rather than describe the manner in which they are delivered. All of the functions of the Council (ASC) and the Trust described under this Agreement are delivered in an integrated rather than isolated form as laid out in the Matrix Management Agreement appended in Schedule 13.

Care Packages – Gatekeeping Function

Care packages are funded by the Council (ASC) and are defined under the Department of Health document Prioritising need in the context of *Putting People First: A whole system approach to eligibility for social care (2010)*. This is further clarified under the Leeds City Council leaflet: *Eligibility for Social Care for People in Leeds (SS38A)*. Currently funded packages of care will only be allocated to those service users meeting the following definitions:

- Critical - The risk of major harm / danger to a person or major risks to independence.
- Substantial - The risk of significant impairment to the health and well being of a person or significant risk to independence.

Any proposed change to the eligibility criteria must be formally notified to the Trust via the Partnership Board in order that any resourcing implications may be considered.

The SDM holds the Community Care budget for service users who present with an eligible, unmet social care assessed need up to the age of 65. This budget is accessible to service users with a secondary mental health need, including those with a co-existing condition such as Asperger's syndrome, Learning Disability, substance misuse or personality disorders.

Requests for funding for community and/or residential packages are submitted to the SDM using ESCR. The process usually involves the Social Worker/Care Manager initially submitting the care option to their immediate Line Manager/Team Manager. The submission is scrutinised (along with administration checks) prior to being submitted to the SDM. Those requests come from either Social Workers within the MHU or from other areas of the Council's ASC directorate, provided the service user meets the criteria as previously defined.

The SDM, in discussion with the relevant Team Manager or directly with the responsible Social Worker will review all aspects of the care option to seek clarification on the rationale for seeking funding. Approval limits and processes are described in Appendix i of this Agreement.

As part of the scrutiny process all care options must have essential information outlined clearly in the support plan such as Mental Capacity, Financial Assessment, Continuing Health Care Assessment, exploration of Self Directed Support and the options appraisals. It is essential that the care option highlights all components having had due regard to the above otherwise the SDM will reject or defer the approval process pending additional information being supplied.

At present, the gatekeeping functions are done on a daily basis subject to their urgency and needs as they arise. It is important to point out that the SDM spends a considerable amount of time deferring care options that are inappropriate. This information is then fed back to Social Workers and Team Managers to explore alternatives.

Part of the role of the Social Worker is to source suitable support packages for Service Users. This can happen in two ways:

- the Service User is entitled to self directed support. In this case a support plan will be put in place and the service user will either opt for a Personal Budget (where the user manages the money themselves) or a Council Managed Budget (where the social worker as case worker manages the care package budget under delegated authority from the DASS and directs the Council finance to pay the support providers);

- the Service User is not entitled to a budget (either because they are entering residential or nursing care or in a very few specific cases where people are not entitled for legal reasons). In this instance support is purchased directly for them from the placement budget usually from a source on the Council's approved providers list.

Commissioning of care packages remains within the Council in conjunction with a Contracts Section which manages and monitors contracts with providers. Service User requirements are identified by social workers within defined criteria (as per schedule id) and recommendations are made to the SDM who can approve certain packages of care within their approval limit or refer upwards, as appropriate, within the escalation process defined in schedule ib.

In order that the Trust can gain a greater understanding of the approvals process and determine the value of any future transfer of function to the Trust, relevant financial reporting information will be provided to the Trust via the Partnership Board. This is described in appendix 1b of this Agreement (summary report).

Care Packages for Persons Aged 65 Or Over

The MHU passes all care plans for persons aged 65 or over to area gate keeping (a retained Council function) for approval. The same rules apply depending on the proposed costs of care packages. The money for these care options come from the individual areas and not the MHU community care budget lines.

The area panels operating across the three localities are all slightly varied with their panels considering more care options than just those from Mental Health. Generally the Area Service Delivery Manager (a retained Council function not delegated under this Agreement), sometimes supported by colleagues from Joint Care Management (a retained Council function) along with administrative support, will scrutinise submitted care options with reference to Council policies and procedures. Trust managed social workers submit care options appraisals to the MHU Team Manager for scrutiny before these are forwarded to the respective SDM for each area.

Safeguarding Adults

In matters relating to Council functions Council Staff managed under this Agreement will work to Council Safeguarding Adults policies and procedures, signed up to by the Trust as a key member of the Leeds Safeguarding Adults Board.

Safeguarding Adults procedures require qualified professionals (having received appropriate post qualification specialist training) to investigate Adult Safeguarding cases. In Leeds, Social Work Team Managers oversee and sign off the process. Many of these practitioners are highly skilled and experienced and are also trained as Best Interest Assessors to meet Mental Capacity Act (MCA) and DoLS statutory requirements.

Legal Proceedings

Following the admission of individuals to psychiatric hospitals, the Mental Health Unit is also called upon to provide Mental Health Review Tribunal reports and attend Court Hearings. Mental Health Review Tribunals are managed and coordinated by the Trust's mental health legislation department.

Council Legal Services

The Council Staff managed under this Agreement require and shall enjoy the ongoing advice and support of the Council legal services team so far as it relates to a Council function. This service includes:

- Council legal services will keep the Partnership Board apprised of any legal issues that might affect the Services delivered under this Agreement.
- They will advise the Partnership Board of any training requirements in relation to the staff managed under this Agreement that they believe are required so that this can be factored into business planning.
- Council legal services will facilitate such training either by providing training directly or by sourcing it externally.
- The cost of any such training will be borne by the Council.

Emergency Duty Team (EDT)

Where appropriate Council Staff managed under this Agreement will make referral to the Council Emergency Duty Team (EDT), which is described as follows:

The EDT comprises 1 Team Manager, 7 AMHPs and Business Support. The service is based at;

Westgate, 6th Floor
6 Grace Street
Leeds
LS21 2RP.

The hours of business are Monday to Thursday 17:00 - 08:00. Friday 16:30 – Monday 08:00. EDT provides cover for all Bank Holidays from 17:00 – 08:00 the day following the Bank Holiday.

The core business of the team is to meet the Council's statutory obligations in relation to Child Protection and Mental Health Act Assessments. In addition the service has a remit for Adult Safeguarding and provides emergency intervention in terms of placement allocation usually resulting from carer breakdown. The EDT prioritises referrals on the basis of the urgency of the request, clear and full information is imperative in order to enable the staff to appropriately prioritise actions and responses to ensure the safety of the most vulnerable children and adults within Leeds.

Other Social Work Functions

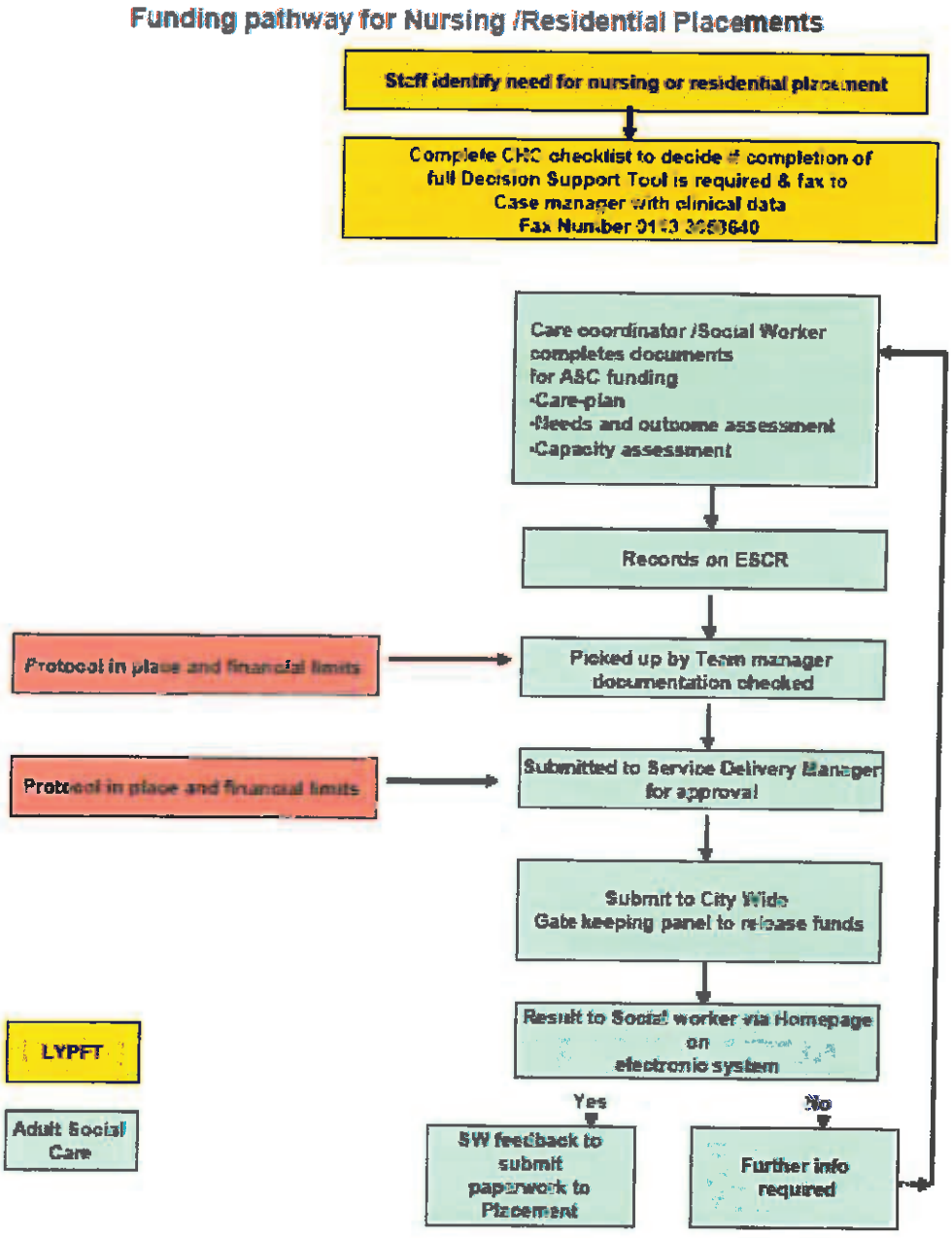
It is noted that Council (Social Care) Staff may, on occasion, be required to fulfil other Council functions outside of the general remit of this Agreement. It is not anticipated that these functions will create a substantial drain on the resources available to fulfil the Council and NHS responsibilities managed under this Agreement. Should such issues arise this should be brought to the attention of the Partnership Board. These other functions include:

- Appropriate Adult in relation to Police and Criminal Evidence Act (PACE)

- Guardianship panel involvement (Section 7 Mental Health Act 1983)

Annex 1
Care packages

Part 1
Funding pathway for nursing and residential placements



ib – Approval of Care Packages (age 18-65 service users)

The ability to authorise/approve **new** packages of care is limited to the following.

- Individual packages up to an annual value of £50,000 can be approved by the Council nominated SDM
- Individual packages up to an annual value of £100,000 can be approved by the Council nominated Head of Service.
- Individual packages with an annual value in excess of £100,000 can only be approved by the Council nominated Chief Officer

Any proposed increase in an **existing** package that moves it from a lower to a higher-level approval requirement must be approved by the appropriate higher-level officer. For example, an existing package costed at £45,000 per annum which requires an increase of £10,000 per annum must have the approval of the Head of Service or the Chief Officer.

The present Council nominated officers are:

- Service Delivery Manager - managed under Matrix Management Agreement by the Trust
- Head of Service - managed and employed by the Council
- Chief Officer - managed and employed by the Council

Details of approved packages will be recorded on the Council ESCR system to ensure payments are processed promptly.

Community Care Finance Team
Leeds City Council
3rd Floor East
Merrion House
Leeds
LS2 8QB

E-mail: contacts_ccf@leeds.gov.uk

A summary report will be produced detailing:

- Number of packages submitted for approval
- Number of packages approved estimated value
- Number of packages deferred
- Number of packages rejected

For those **accepted** the report should include:

ESCR reference number
Cost
Effective date
Estimated period of package (measured in the following time markers - 0–3 months, 4-6 months, 6–12 months, 12 months plus)

The report will be produced as a minimum monthly although more frequently when appropriate. The report will be produced for the Council nominated Chief Officer within 5 working days of the end of the calendar month.

To facilitate the effective management of this agreement reports should be copied to:

- The SDM
- The Trust officer responsible for the operational delivery of services under this agreement
- The nominated Trust finance manager

Part 4
Packages of care – definitions

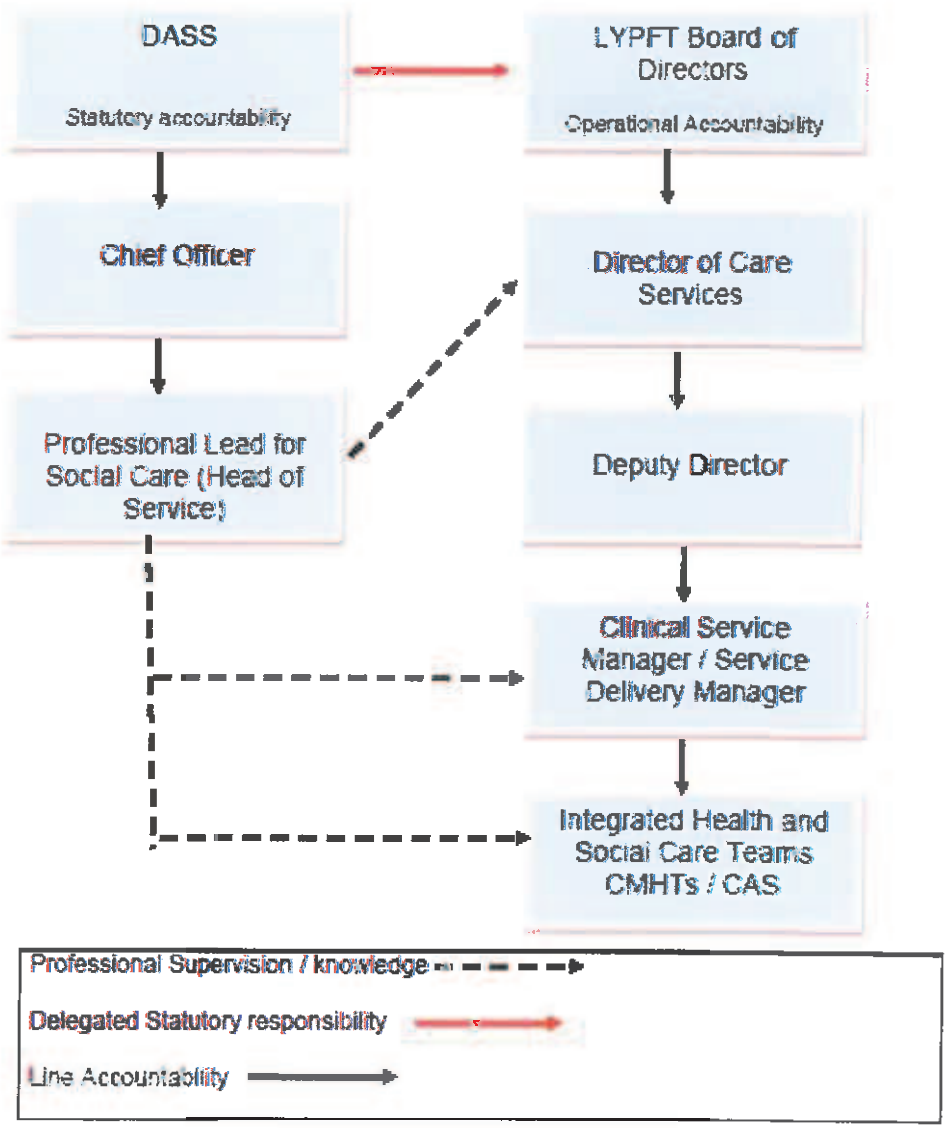
Putting People First: A whole system approach to eligibility for social care (DH 2010):

DH Prioretising Needs.pdf

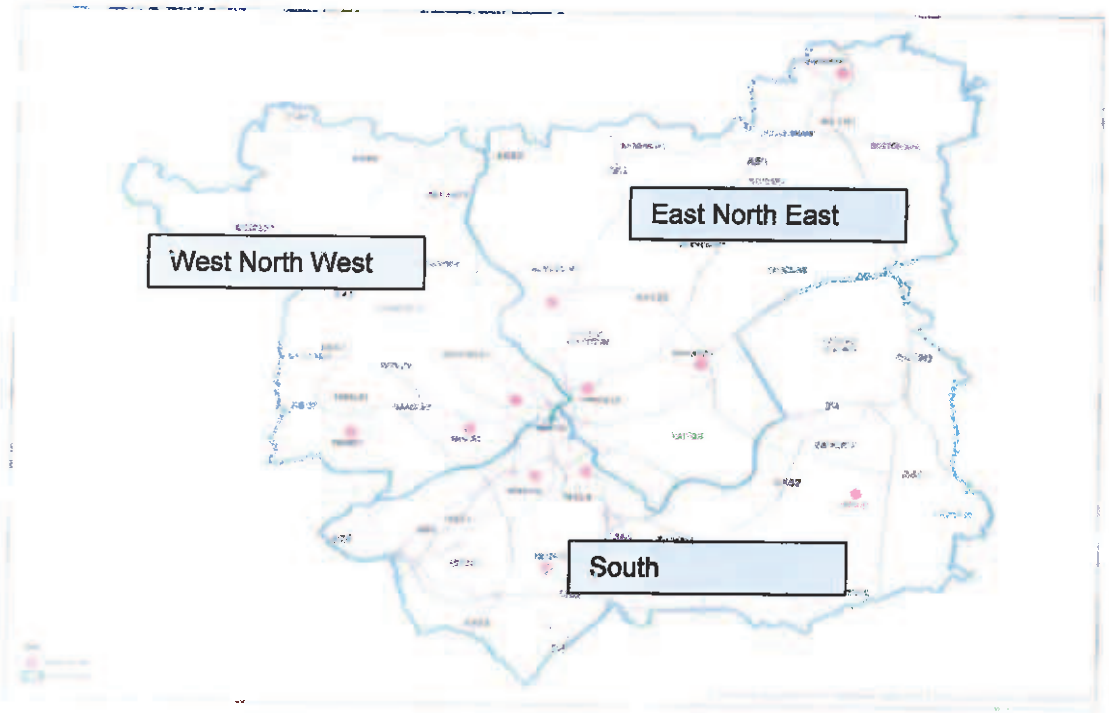
Eligibility for Social Care for People in Leeds (SS38A, February 2008):

Eligibility for social care for people of Lee

Annex 2
Lines of responsibility



Annex 3
The Localities



Wetherby

Although the vast majority of Council and Trust services are geographically coterminous, it is acknowledged that the Trust is not commissioned to provide services in the town of Wetherby, which is within the metropolitan boundaries of the City of Leeds.

Team Protocols

The specialist Social Work function in the Mental Health Unit

Prepared for: Adult Social Care
Service Area:
Version: 1.00
Date: 23rd May 2012

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DOCUMENT CONTROL AND ADMINISTRATION

1. DOCUMENT REVISION INFORMATION

Version	Date	Authors	Description of Changes
0.01	8th May 2012	Kwai Mo, Keith Williamson, Ann Sikorska, Richard Poll, Gary Burns, Clive Rudman, Iola Shaw	Initial draft following template developed for the REAP, Care Manament and DST prepared at managers meeting.
0.02	9th May	Keith Williamson, Ann Sikorska, Richard Poll, Gary Burns, Clive Rudman, Iola Shaw	Updates to draft
0.03	16th May	Keith Williamson, Ann Sikorska, Richard Poll, Gary Burns, Clive Rudman, Iola Shaw	Updates to draft based on feedback from MHU social work staff
1.0	23rd May	Max Naismith	Uadates and HoS approval

1.1 Signatories

Name
Signature

1.2 Distribution List

Name	Job Title/Role
Kwai Mo, SDM	MHU
Team managers	MHU
Iola Shaw	Project Leader
MHU SWs	All staff reporting to MHU TMs
Max Naismith	Head of Service MH, EDT and LD services

1.3 Background

Over the years since some MH social workers have been co-located with LYPFT staff within CMHT the focus has been on delivering an increasingly generic service. Focused work has been ongoing regarding the increased integration of adult social care mental health unit staff and LYPFT since 2010. A clear need to identify the specialist role of social workers within these teams has been identified to ensure that the new care pathway includes all that is required.

The LYPFT transformation programme, established in 2011, has developed a new community care pathway to be implemented during 2012. This will deliver a recovery based model of support to all service users. The new model represents a significant restructuring of working practice, with changes to management structures. It incorporates a removal of the boundary between "working age" and "retired" adults, and other areas where there have been a significant variation in team structures.

The new model incorporates a model of management where line management and professional supervision are separated. To ensure the specialist and statutory requirements of the social work function are met and fully supported a clear social care model has been developed following the same template as that used by other social work teams across the city such as the REAP, and Care management teams.

2. MENTAL HEALTH UNIT SOCIAL WORK TEAM

2.1 Purpose

The Adult Social Care Mental Health Unit (MHU) is a city wide specialist service offering an assessment and care management function to individuals and families with, or affected by, mental health problems. The MHU is closely allied to Leeds and York Partnership Foundation Trust (LYPFT) as many of the services are co-located in LYPFT accommodation. Social care staff from the MHU provide a range of services to adults who are ordinarily resident within Leeds metropolitan area presenting with secondary mental health needs. Within the mental health unit we maintain the specialisms required to deliver a comprehensive service.

As a key function the MHU is the host and provides the majority of Approved Mental Health Professionals (AMHP) to meet the statutory responsibilities of the Local Authority under the Mental health Act 1983. The Unit also holds the central administrative and triaging roles in managing the safeguarding enquiries and assessments as appropriate under legislation such as the Mental Health Act (1983), Mental Capacity Act (2005) and related legislation.

The function of the MHU necessitates working jointly in a multi-disciplinary team environment with health colleagues and those of other partner agencies (such as Aspire) in both the voluntary and independent sector regarding support to citizens of Leeds with secondary mental health issues.

The service provides a screening, assessment and care management function, with the following outcomes:

- establishing the most appropriate response to referrals which might include advice and sign-posting and/or referral to another part of the health and social care system (e.g. a specialist service),
- identifying referrals requiring the application of safeguarding processes,
- the preliminary establishment of FACS eligibility,
- the completion of assessments for both new and existing customers within its remit,
- the development of support plans/care plans and the commissioning services as appropriate for those with eligible needs,
- entry to the appropriate reablement pathway

2.2 Entry Criteria

For individuals with specialist mental health needs who are in need of the following support and are:

1. Age 18 upwards for assessment and care management and any age for MH Act related tasks.
2. The service user has ordinary residence in Leeds (as defined in regulations) other than where there is a duty to cooperate with another authority. This is in keeping with reciprocal arrangements outlined in legislation. This details that host authorities will provide a service under the MH Act to undertake AMHP assessment in the location of the person to be assessed.
3. Service User (SU) appears to be a vulnerable adult in need of community care services (NHS & CC Act 1990).
4. SU requires an intervention from ASC and integrated MH services in fulfillment of other

statutory duties (MH Act 1983; NA Act 1948; CS&DPA 1970; Carers legislation; Mental Capacity Act, 2005, etc.)

5. SU is a vulnerable adult who is subject to an allegation of harm requiring investigation and protection under safeguarding procedures.
6. Current case episode is not active to another worker in the City, i.e. they are new or open-passive.
7. Younger adults in transition.

2.3 Channels into MHU Function

1. Referrals via the Corporate Contact Centre, transferred by ESCR; (this would included referrals received from Councillors and MPs.)
2. Referrals via One Stop Centres, transferred by ESCR.
3. Direct contact from a Service User who is open-passive, either by letter or telephone call.
4. Service request made directly from members of a Multi-Disciplinary Team
5. Direct contact from appropriately qualified professionals, organizations or the criminal justice system (written or verbal)
6. Allocation within the MH integrated processes regarding formulation
7. Referral for MH Act related functions diverted from SPA or direct from Referrer to MH Act administration (including nearest relative request).

2.4 MHU Function

1. Referral Screening.
2. Referral Advice and Assistance.
3. Referral Signposting (for example, Drug and alcohol, rehabilitation assessments)
4. Urgent response re AMHP assessment and duties, safeguarding,
5. MH Act and Mental Capacity Act related duties (including, but not exclusively, Mental Health Tribunal reports, S20 Hearing reports, and attendance at the hearings, statutory supervision visits for clients on Conditional Discharge, and reports to the Ministry of Justice, Best Interest Assessment and decisions, assessment of capacity, interface with Mental Health Act)
6. Full Assessment - new case episode,
7. Re-assessments - scheduled and unscheduled reviews.
8. Safeguarding screening unless existing open-active to a different CM team or service.
9. Within 3 month reviews on cases open-active.
10. Maintaining responsibilities for statutory duties such as S117 reviews.
11. Transfers to/from other Authorities
12. Appropriate adult (serious crime and/or open case to the MHU)
13. Offer specialist MH advice guidance and co-working to other professionals and agencies.

2.5 Exit Criteria

1. The assessment process identifies that the service user does not meet the Department's eligibility criteria. They may be offered information or advice including sign-posting to other services that may meet their needs prior to exit.
2. The assessment process identifies that the service user does not meet the entry criteria for a specialist MH team
3. at review it is identified that there are no unmet FACS eligible needs
4. they no longer require input from specialist MH services
5. at the conclusion of the MH Act assessment or other related duties
6. when the statutory responsibilities under MH Act transfer to another authority
7. The 'within 3 month review' undertaken at 6 weeks following approval of the care option identifies that the service user no longer requires support from the Department or is no longer eligible. The case will be closed and involvement with the MHU Team will cease (see point 1 above).
8. On completion of the provision of statutory responses under the National Assistance Act (Section 50 Burials, Section 48 Protection of Property, etc) where no other social care needs are indicated.
9. The service user's condition has deteriorated making them eligible for Fully Health funded (CHC) provision and there are no other ASC needs
10. The service user no longer requires longer term care management or on-going professional support and whilst in continued receipt of services (open-passive cases) can be monitored and reviewed by the Adult Review Team ***(Process and team protocols for ART will be reviewed over the next 12 months***). For example, the existing support plan is meeting all the care needs including 12 month placement reviews where the resident 's ordinary residence prior to placement was Leeds.

2.6 Roles within the MHU function

The roles within MHU functions include

1. Assessment and care management of adults with primary mental health needs, who may also have physical and sensory impairment and learning disabilities for all unmet FACS eligible needs.
2. Access to universal information and signposted services
3. Personalisation and self directed support
4. Safeguarding people
5. To provide services that are inclusive, recovery focused and meet the needs of the community
6. To provide statutory functions relating to all relevant legislation such as the NHS community care Act, Mental Health Act, Mental Capacity Act, National Assistance Act.
7. To support other colleagues in providing a specialist/statutory MH review.
8. Ensuring work required under the sections 48 and 50 of the National Assistance Act are fulfilled when applicable.
9. Coordination of the MH related legislation around mental capacity and deprivation of liberty safeguards.
10. To contribute relevant duty systems

11. To contribute to CPA care coordination
12. To ensure that the statutory functions of the DASS with respect to secondary mental health service users are discharged

Annex 5
Mental Health Assessment and Care Management Performance Framework

1. Introduction

This paper was commissioned in March 2012 by the Council (Adult Social Care Directorate) as part of the Budget Planning Finance Calendar programme. Meetings have been held with senior operational managers, data analyst and administrative staff to identify available and required data.

2. Currently produced and regularly reported mental health activity data

At the date of this Agreement the following information is captured in quarterly team reports about work carried out by the Council's mental health staff:

2.1 attendance;

2.2 referral numbers;

2.3 assessment numbers, timescales and outcomes;

2.4 reviews;

2.5 safeguarding referrals and investigations;

2.6 Carers Assessments/Reviews;

2.7 numbers of Open Active Cases;

2.8 Residential Admissions;

2.9 timeliness of the delivery of care packages; and

2.10 Self Directed Support.

3. Currently available and occasionally reported activity data

3.1 Mental Health Act Assessments;

3.2 Mental Health Act capacity assessment work;

3.3 Deprivation of Liberty assessments; and

3.4 Guardianship.

4. Other key areas of activity, where reporting is still to be developed

4.1 Time spent on tribunals/appeals; and

4.2 Work of Crisis Resolution staff.

5. Reporting process

From August 2012 it has been agreed that reports relating to the key issues identified in paragraph 3 above will be included in the Quarterly Team reports.

6. Adult Social Care (Council) data requirements

In order to provide these reports and to meet the current requirements for adult social care statutory reporting, activity data will need to be provided for the periods April 1st to March 31st.

6.1 Safeguarding Data Required:

6.1.1 number of safeguarding alerts, referrals, repeat referrals and completed referrals by age, primary client group and gender of alleged victim;

6.1.2 number of safeguarding alerts, referrals, repeat referrals and completed referrals by ethnicity and age of alleged victim;

6.1.3 number of safeguarding referrals by source of referral, by age and primary client group of alleged victim;

6.1.4 number of safeguarding referrals by nature of alleged abuse, age and gender of alleged victim;

6.1.5 number of safeguarding referrals by nature of alleged abuse, primary client group and age of alleged victim;

6.1.6 number safeguarding of referrals by location alleged abuse took place and age group of vulnerable adult;

6.1.7 number safeguarding of referrals by location alleged abuse took place and by type of service;

6.1.8 number of safeguarding referrals by relationship of alleged perpetrator, by age and gender of vulnerable adult;

6.1.9 number of safeguarding referrals by relationship of alleged perpetrator, by primary client type and age of vulnerable adult;

6.1.10 number of completed safeguarding referrals by case conclusion, primary client group and age of vulnerable adult;

6.1.11 number of completed safeguarding referrals by case conclusion, and ethnicity of vulnerable adult;

6.1.12 outcome of completed safeguarding referral by age group and primary client group of vulnerable adult;

6.1.13 number of completed safeguarding referrals Leading to Serious Case Review by age group and primary client group of vulnerable adult;

6.1.14 acceptance of Safeguarding Protection Plan by age group and primary client group of vulnerable adult; and

6.1.15 outcome of completed safeguarding referral for Alleged Perpetrator/Organisation/Service by age group and primary client group of vulnerable adult.

6.2 Referrals for Adult Social Care:

6.2.1 Referral Sources used in the RAP return, showing which Agents link to which source;

6.2.2 RAP Referral Source:

(a) family / friend / neighbour;

(b) internal (i.e. own CSSR);

(c) local authority housing department or housing association;

(d) legal agency (police, court, probation, immigration);

(e) other departments of the Council or other local authority;

(f) primary health / community health (GP, Community-based PAM, etc.);

(g) secondary health (A+E, hospital OT, Ward hospice, etc.);

(h) self referral;

(i) not known; or

(j) other;

6.2.3 Referral outcome:

(a) dealt with at referral stage; or

(b) passed on for further action.

6.3 Assessments:

6.3.1 number of people receiving a community care assessment - by ethnicity, age, gender;

6.3.2 number of people receiving a community care assessment and the outcome - no services provided, services declined or services provided, other;

6.3.3 the length of time from first contact to completed assessment - split by 18 - 64 and over 65, and by number of days;

6.3.4 assessments completed for people who are - health funded, self funded, section 117; and

6.3.5 time from completion of assessment to provision of a service;

6.4 Service Provision:

6.4.1 people receiving adult social care service provision - split by day care, homecare, meals, professional support, equipment and adaptations, short term residential, direct payments, reablement, telecare, extra care housing, supported housing;

6.4.2 people receiving adult social care service Provision as above and broken down by gender, age group, ethnicity, mental health, dementia, substance abuse, 18 -64 and over 65;

6.4.3 people receiving adult social care service provision as above in the year and at the year end;

6.4.4 people receiving self directed support split by council controlled budgets, self controlled budgets, mixed budgets; and

6.4.5 the costs of services provided;

6.5 Residential and Nursing Care:

6.5.1 number of residents supported by your local authority in residential and nursing placements as at 31 March 2011, - by type of residence, local authority and independent residential care, primary client type, age group, split by permanent and temporary placements;

6.5.2 number of residents supported by your local authority in adult placements as at 31 March 2011, by age group and permanent and temporary;

6.5.3 number of local authority supported permanent admissions to residential and nursing care during 1 April 2010 to 31 March 2011 (excluding admissions to group homes), by type of residence, and age group;

6.5.4 please include those clients who transfer from temporary to permanent care during the year by type of placement - nursing or residential and local authority provided or independent sector;

6.5.5 number of local authority supported permanent residents transferring between residential and nursing care during 1 April 2010 to 31 March 2011 (excluding admissions to group homes), by age group; and

6.5.6 the costs of residential and nursing care placements;

6.6 Carers:

6.6.1 number of carers reviewed and assessed or reviewed by age; and

6.6.2 number of carers receiving services by age and ethnicity - carer specific services, information and advice only; and

6.7 Ad hoc - by age, ethnicity, gender:

6.7.1 total number of people receiving FACs eligible services;

6.7.2 number of people receiving an annual review in the financial year by age;

6.7.3 people supported to leave hospital and still at home 90 days later;

6.7.4 provision of details of people to enable inclusion in annual surveys for DOH;

6.7.5 the proportion of adults in contact with secondary mental health services in paid employment; and

6.7.6 the proportion of adults in contact with secondary mental health who love independently with or without support.

6.8 The data requirements for Adult Social Care change over time and any collection of activity will require the flexibility to provide a range of information and to meet changing needs for management information and statutory returns and collections.

SCHEDULE 6

RESOURCES

Part 1: Financial Resources

1. The Parties' Contributions shall be managed by the Partnership Board, which will monitor and review the effective utilisation of the collective resources.

2. Each Party's Contributions for the first Financial Year shall be as set out in Annex A to this Schedule 6 Part 1.

3. It is acknowledged that a number support functions provided by both parties (Human Resources, Information Technology, estates and facilities etc) have a financial value. However, it is not deemed necessary to itemise their value within this Agreement.

Contributions Monitoring

4. For each Financial Year subsequent to the initial Financial Year, the Parties' respective Contributions shall be discussed and agreed by the Partnership Board no later than 31 March in the preceding Financial Year.

5. Once the Contributions for a Financial Year have been agreed, they may only be varied in accordance with Clauses 15 and/or 16.

6. Notwithstanding any other provision of this Agreement, the Parties shall act in good faith and in a reasonable manner but in the event that agreement on the level of Contributions is not reached by 31 May in the relevant Financial Year then either Party may terminate this Agreement by giving the other Party not less than 6 months' written notice in accordance with Clause 17.3 (Termination).

7. Each Party shall ensure that their respective financial officers attend relevant meetings of the Partnership Board (with relevant papers to be circulated at least five Working Days before such meetings) and have all support and resources necessary to negotiate and agree the budgets described in this Schedule 6 Part 1.

8. For the avoidance of doubt any means tested personal financial contributions in relation to the Services received from any Service User in respect of any Services will be the responsibility of the Council and will be collected and administered by the Council.

No Pooled Fund

9. This Agreement does not create any pooling of funds and the funds of the Parties shall be kept and recorded separately at all times.

Reporting

10. Each party shall report Quarterly to the Partnership Board on expenditure against Contributions.

Annex A

Contributions for the Financial Year 2012/13

Staffing budgets

- **LCC employed staff – funded by LCC:**
  - 2012/13 budget = £1,813,220

- **LCC employed staff – funded by LYPFT:**
  - 2012/13 budget £438,894

- **LYPFT employed staff – funded by LYPFT:**
  - 2012/13 budget £109,452

Part 2

Premises

1. The Services shall be provided from the Premises.

2. The Trust shall ensure that the Premises are maintained to a satisfactory level which is fit for their intended purpose and in line with NHS Estates Code. For the avoidance of doubt the Premises will be adequately fitted out with desks, chairs office equipment, toilet facilities etc sufficient to maintain a comfortable working environment for those staff managed under this Agreement.

3. It is agreed that in support of the Trust's transformation programme that Services will be reconfigured over time and the locations of Services delivered under this Agreement will change over time. Such changes will be determined through the transformation programme board (on which the Council is represented) but will be reported to the Partnership Board to support effective management of the integrated services.

Locations	Whose property?
Aire Court	Trust
Asket Croft	Trust
Becklin Centre	Trust
Brook House	Trust
Holly House	Trust
Linden House	Trust
Malham House	Trust
Millfield House	Trust
Millside	Trust
Moresdale Lane	Leased from the Council
Moresdale Lane	Trust
Newsam Centre	Trust
Newsam Centre	Trust
Newsam Centre	Trust
Newsam Centre	Trust
Newsam Centre	Trust
Newsam Centre	Trust
St Mary's Hospital	Trust
St Mary's Hospital	Trust
St Mary's Hospital	Trust
St Mary's Hospital	Trust
St Mary's Hospital	Trust
St Mary's House	Trust
St Mary's House	Trust
St Mary's House	Trust
St Mary's House	Trust
St Mary's House	Trust
St Mary's House	Trust
St Mary's House	Trust
St Mary's House	Trust
St Mary's House	Trust

St Mary's House	Trust
St Mary's House	Trust
St Mary's House	Trust
St Mary's House	Trust
The Cottage, St Mary's House	Trust
Towngate House	Trust
Towngate House	Trust

Part 3

Equipment

1. The Trust shall ensure that any Equipment being used for the provision of the Services is:

   1.1.1 suitable for the delivery of the Services;

   1.1.2 sufficient to meet the reasonable needs of Service Users; and

   1.1.3 where required by Law, shall meet any and all regulatory standards (as appropriate) including but not limited to the Disability Discrimination Act 1995, the Care Standards Act 2000 and the Private and Voluntary Healthcare (England) Regulations 2001, together with any applicable NHS standards in force from time to time.

2. The Trust shall:

   2.1 maintain in good and serviceable repair all Trust Equipment;

   2.2 In general all equipment relevant to the services belongs to the Trust and will be maintained within Trust premises with the exception of Information and Communications Technology (ICT) equipment.

3. ICT – at the commencement of operations under this agreement it will be necessary for both parties to maintain and support separate ICT equipment and systems. The Partnership Board shall:

   3.1 determine which of the integrated staff require ongoing access to Council and/or Trust ICT systems; specifically

      3.1.1 ESCR (Council)

      3.1.2 PARIS (Trust); and, in accordance with this determination:

   3.2 each Party's ICT department will provide any equipment, systems access, software and support required to fulfil their obligations under this Agreement.

SCHEDULE 7

PARTNERSHIP BOARD

The purpose of the Partnership Board is to act as a contract monitoring forum to review the effectiveness of the services managed under this Agreement with a particular emphasis on quality, safety and financial sustainability.

1. The particular responsibilities of the Partnership Board are (without limitation) as follows:

   1.1 to receive feedback and reports from the Parties on the Services provided;

   1.2 to monitor, advise and agree resource allocation and highlight cost pressures to the Parties through reporting lines to be agreed between the Parties;

   1.3 to approve changes to the provision of the Services, within the terms of this Agreement; noting that the development of changes under this Agreement may be progressed by the Partnership Board to the Transformation Board of the Trust.

   1.4 The Partnership Board shall consider the risks and benefits of a transition to a fully integrated model of service delivery which may include:

      1.4.1 the Trust assuming responsibility for the AMHP service, DoLS BIA, Community Care Assessments and for the ASC adult placement budget;

      1.4.2 streamlining management structures and staff models to ensure that they best meet Service User needs;

      1.4.3 improving staffing arrangements which align human resource practices with line management and professional responsibility;

      1.4.4 consideration to providing Trust staff with the opportunity to train as AMHPs under the authority and professional supervision of the Council;

      1.4.5 the alignment of Council management with the Trust Transformation Project and the development of integrated care pathways;

      1.4.6 build and maintain professional social services expertise and capacity at all levels;

      1.4.7 ensure that financial opportunities are maximised and the risks to both Parties are minimised;

      1.4.8 development of IT systems to allow greater integration including a bolt on social care module for PARIS and a data warehousing solution where both PARIS and ESCR can be accessed through a single screen; and

      1.4.9 longer term development of integrated IT systems;

   1.5 to ensure the Parties comply with this Agreement;

   1.6 to measure performance and quality of the provision of the Services against the standards; and

   1.7 to pursue the intended aims and objectives as specified in Schedule 1 (Aims and Objectives).

2. The Parties may agree in writing from time to time to modify, extend or restrict the remit of the Partnership Board.

3. The Partnership Board will be constituted by the following members:

   3.1 Chief Operating officer and Chief Nurse/Deputy Chief Executive of the Trust;

   3.2 Chief Officer, Adult Social Care of the Council;

   3.3 Operational Lead (Deputy Director) of the Trust;

   3.4 Commissioner Representative of the Council;

   3.5 Finance Lead of the Trust; and

   3.6 Finance Lead of the Council.

4. The Partnership Board will be co-chaired by the Trust's Chief Operating Officer and the Council's Chief Officer of Adult Social Care, or nominated representatives.

5. Partnership Board meetings will be held quarterly or by exception.

6. Partnership Board meetings will be deemed quorate if the Trust's Chief Operating Officer and the Council's Chief Officer of Adult Social Care are present.

7. Decisions made by the Partnership Board will be by consensus. Should the parties not be in agreement on any issue then the dispute resolution procedure defined under this Agreement shall apply.

8. Some changes to this Agreement are not within the gift of the Partnership Board to approve and would need the separate approvals of each Party's senior management. These include:

   3.7 increases in the respective Parties' contributions.

   3.8 determination to change the employment status of staff performing functions under this Agreement; or

   3.9 any proposal deemed by either Party to be novel or contentions, as defined by their respective governance structures.

SCHEDULE 8

INFORMATION SHARING PROTOCOL (Leeds Interagency Protocol for Sharing Information; NHS Leeds (Leeds PCT) 2008)

Pan Leeds
information sharing pl

SCHEDULE 11

WINDING DOWN PROTOCOL

In the event that this Agreement is terminated the Parties agree to co-operate to ensure an orderly wind down of their joint activities as set out in this Agreement and the following provisions shall (unless agreed otherwise by the Parties) have effect:

1. the Council shall ensure or procure the continued provision of the Services related to the Council Functions;

2. the Trust shall ensure or procure the continued provision of the Services related to the Trust Functions;

3. each Party shall use its reasonable endeavours to arrange and ensure the novation of the contracts (if any) which were novated by the other Party (or other contracts either substituted or entered into solely in connection with other Party's Functions) back to that other Party, who shall accept such novation;

4. the Equipment and any other assets transferred from a Party to the other under these Arrangements shall transfer back to the originating Party subject to agreed terms;

5. each party's rights of occupation of Premises owned or controlled by the other Party shall cease insofar as applicable to the provision of the Services related to the Functions of that other Party;

6. the Parties will not, following service or receipt of a valid notice to terminate this Agreement:

   6.1 increase or decrease the number of persons employed or engaged by in connection with the provision of the Functions without obtaining the consent of the other (such consent not to be unreasonably withheld); or

   6.2 significantly alter the terms and conditions of employment of persons employed or engaged in connection with the provision of the Functions without obtaining the consent of the other (such consent not to be unreasonably withheld).

7. The Trust and the Council shall work together to ensure an orderly handover in relation to all aspects of the Functions and shall at all times act in such a manner as not to adversely affect the delivery of the Services and in particular the Parties shall, as soon as reasonably practicable provide to the other details of the terms and conditions of employment of all employees engaged in providing the Functions.

8. Both Parties agree that all such information as may be provided to the other may be passed on to any prospective or new service providers (in confidence) for the purposes of future provision of the Functions and obtaining advice only.

9. Both Parties shall transfer ownership, to the originating Party, the records and information relating to the Functions, including any relevant records that were transferred to the other at the Commencement Date.

SCHEDULE 13

HUMAN RESOURCES

1. STAFFING LIST

The Staff who will be managed under this agreement are listed within the Matrix Management Agreement (below). This list represents the staffing at the commencement date of services and will naturally change over time.

2. MATRIX MANAGEMENT

Staff employed by the Council and the Trust as at the Commencement Date will be subject to management in accordance with the Matrix Management Agreement set out below.

Any new staff employed by the Council and the Trust subsequent to the Commencement Date but relevant to the Services managed under this Agreement will also be subject to management in accordance with the Matrix Management Agreement, unless otherwise agreed through the Partnership Board.

The Partnership Board will keep a live version of the Matrix Management Agreement and commit to maintaining an agreed and accurate staff list. This agreement will be updated with a refreshed Matrix Management Agreement periodically; unless no changes have taken place then at least annually.

For the avoidance of doubt the staff list is not intended for publication. It is therefore agreed that unless there is any overriding legal requirement then in the event of publication the staff list will be redacted to remove any personally identifiable information.

Leeds CITY COUNCIL

Leeds and York Partnership NHS
NHS Foundation Trust

MATRIX MANAGEMENT AGREEMENT

BETWEEN

**MENTAL HEALTH SERVICES,
LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST (LYPFT/ "The Trust")**

AND

**MENTAL HEALTH ADULT SOCIAL CARE,
LEEDS CITY COUNCIL (LCC/ "The Council")**

30th September 2012 – 30th September 2013

1. SCOPE

This Agreement outlines the Human Resource and operational / managerial issues of Adult Social Care (ASC) Mental Health Staff who are employed by the Council. These Council staff are based with, and operate as part of the Integrated Mental Health Service hosted by the Trust (LYPFT).

The agreement outlines the responsibilities of the employees and Trust Managers for Mental Health Services and provides guidance regarding specific circumstances which may arise.

The basis of the agreement is that Council ASC Professional Leads will be responsible to the Trust (LYPFT) Locality Managers on a day to day basis. The Professional Leads will be accountable as employees of the Council to the ASC Service Delivery Manager (SDM).

The ASC Professional Leads and SDM will be responsible for ensuring that the Council statutory functions are fulfilled (this will also include the provision of an AMHP service and associated responsibilities).

The agreement also clarifies liabilities of each organisation in relation to the Council ASC employees.

2. PARTIES

1. Mental Health Services, Leeds & York Partnership NHS Foundation Trust (The Trust)
2. Mental Health Adult Social Care, Leeds City Council (The Council)

3. AGREEMENT PERIOD

This agreement shall commence on 30th September 2012 – 30th September 2013 and will be reviewed annually.

4. PERFORMANCE MONITORING

Trust Managers will provide assurances to the Council that compliance with ASC requirements are maintained. It is also acknowledges that the employees of the Council have a personal responsibility to comply with the requirements of the Council.

A quarterly review will take place between the ASC SDM and the Locality Managers in order to address any issues with this Matrix Management Agreement in relation to operational issues. Escalation meetings can be organised to include the Council ASC Head of Service and the Trust Deputy Director should the need arise.

An annual review of the Matrix Management Agreement and arrangements will take place and will include the Deputy Director of the Trust and the Council Head of Service, ASC.

Performance will be reported to the Partnership Board of the Section 75 Partnership Agreement on a quarterly basis and any issues with the Matrix Management arrangements will be addressed by the Trust Deputy Director and Council Head of Service and updates will then be fed into the governance framework to the board. In addition the Trade Unions (Council) and Trust staff side representatives will also have the opportunity to feed issues to the Council Head of Service and Trust Deputy Director in order to address issues arising as a result of members liaising with their respective representatives.

5. SERVICE DESCRIPTION AND RESPONSIBILITIES

5.1 CURRENT STAFF EMPLOYED BY LCC

Post Reference	Funded WTE	Job Title
50016640	Full time	Service Delivery Manager
50016643	35.5	Team Manager

50016644	22	Team Manager
50016642	Full time	Team Manager
50016646	Full time	Team Manager
50016641	Full time	Team Manager
50016646	22.5	Social Worker
50015878	32.5	AMHP
50016661	29.5	AMHP
50016669	22	AMHP
50154743	Full time	AMHP
50017495	Full time	AMHP
50016667 TEMPORARY VACANCY	21	AMHP Maternity leave from June 12
50017628	Full time	AMHP/DoLS Coordinator
50016687	29.6	AMHP
50016684	22.5	AMHP
50016650	35	AMHP
50296046	Full time	AMHP Career Break
50016651	Full time	AMHP
50017777	Full time	AMHP
50016678	Full time	Social Worker
50017968	Full time	AMHP
50016675	Full time	AMHP
VACANCY	Full time	AMHP Finished end of June Early Leavers
50016660	Full time	Social Worker
50017577	Full time	Social Worker
50016657	Full time	AMHP
50016664	Full time	AMHP
50294701	Full time	AMHP
50016674	18.5	Social Worker
50016654	Full time	Social Worker
50016240	Full time	AMHP
50016671	Full time	AMHP
50017852	30	AMHP
50016676	Full time	AMHP
50016668	Full time	AMHP
50016652	Full time	AMHP
50016656	Full time	AMHP
50017496	Full time	Social Worker

50016682	Full time	AMHP
50016681	Full time	Social Worker
50017497	30	AMHP
VACANCY	Finished	Social Work Assistant – convert to SW post
50095293	37	Social Worker
50016649	Full time	Social Worker
50016662	18.5	AMHP
50016658	32	AMHP
VACANCY	22	Social Worker – Left 16.5.12.
50016672	Full time	Social Worker
50016648	Full time	Social Worker
50296046 VACANCY – 1 YEAR BACKFILL FOR SECONDMENT	35	AMHP – Seconded to CAS from 22.6.12.
50076315	Full time	AMHP
50099155	23	AMHP
50016679	Full time	Social Worker
50016655 TEMPORARY VACANCY	Full time	Social Worker Maternity leave from June 12.
50017716	Full time	AMHP
50016659	22.5	AMHP

5.2 EMPLOYEE RESPONSIBILITIES

The Council shall procure that Council Employees shall:

- abide by Council Policies and Procedures (see Appendix 1 for a list of essential Employment Procedures) To attend and comply with Council Statutory/Mandatory Training requirements (see Appendix 2 for the Council's Mandatory Training Schedule)
- participate in an appraisal and Personal Development Plan utilising Council procedures and documentation
- To complete statutory documentation and tasks within specified timescales when required by the Council e.g:
    - CRB (Criminal Records Bureau)
    - Monthly Flexi Sheets where applicable
    - Vehicle documentation
    - Leave requests and authorisation – e.g. annual leave, special leave, study leave
- To have personal responsibility as stipulated in the Council's Supervision Policy.
- To complete Council audits and performance data as and when required.
- To keep abreast of Council Communications via their own professional responsibilities and to read relevant information distributed via the Head of Service.

- To ensure professional registration is maintained.

- To attend training as and when required.

Where there is no adherence and compliance to these requirements the Council SDM will inform the employee and the Trust manager so that this can be rectified as soon as possible.

5.3 TRUST (LYPFT) LOCALITY MANAGER RESPONSIBILITIES

The functions provided by the Council Social Care staff is within the remit of the Section 75 agreement signed between the parties and as a result the Trust Locality Managers have line management responsibility for the Council Social Care Team Managers.

As specified in the scope of agreement the Council SDM will retain accountability for the Professional Leads who will be managed by the Trust Locality Mangers. The Council SDM will provide professional leadership and practice supervision and will also work alongside the Trust Locality Managers to ensure a partnership approach.

Examples of what this entails include:

- Monitoring that the Council Social Care staff are aware of the requirement to comply with Council Policies and Procedures

- Support & facilitate the Council Social Care staff fulfil the Council Statutory / Mandatory training requirements.

- Monitor day to day attendance issues, approve annual leave and time owing and be responsible for monitoring this

- Sickness and Performance monitoring – to be fully conversant with the Council's Managing Attendance Policy and Improving Performance and take appropriate action in accordance with relevant policy. Ensure that the SDM is kept informed and is involved if there is a requirement to progress to a more formal stage. All Trust managers who will be responsible for the management of Council social care staff will be trained in line with relevant policies to ensure a quality standard. Professional advice will be sought from the SDM or Council Human Resources advisor where relevant and necessary.

- To provide monthly managerial supervision to Council ASC Professional Leads.

- To ensure that complaints are dealt with in accordance with the Council's Complaints Procedure. If appropriate the Council SDM will become directly involved.

- To undertake Council ASC Professional Lead staff appraisals, agree objectives and Personal Development Plans in conjunction with the Council SDM as a three way process. With regards to the SDM an annual appraisal will be undertaken again as a three way process with the Trust Deputy Director and Council Head of Service.

- To ensure the lone worker and risk management requirements are adhered to and monitored utilising Council local procedures.

- To ensure that the working arrangements of the Council Social Care staff are compliant with the Working Time Directive. If there are concerns with time keeping the Locality Manager has a duty to initially address this and also to inform the SDM.

- To discuss any potential changes/amendments to individual working hours and/or arrangements with the Council SDM upon receipt of any request.

- To resolve grievances at the informal stage; if a formal grievance is submitted this will dealt with by Human Resources as part of a formal process.

- To inform the Council SDM when there are any proposed and/or planned Trust organisational changes which may affect the Council Social Care staff

- To release Council Social Care staff to attend Council training / meetings as required

- To participate in recruitment processes for posts. The appointing officer will be relevant managers employed by the Council (ASC), dependent upon the grade of the vacancy.

5.4 SERVICE DELIVERY MANAGER RESPONSIBILITIES

- Ensuring that the Locality Managers are aware of the requirement to comply with Council Policies and Procedures and has access to them

- To complete any BSC documentation as appropriate

- To act as Appointing Officer for any recruitment processes from PO6

- To manage all formal absence/performance issues relating to Professional Leads from Stage 2 of the Council Procedures

- To appoint investigating officers to deal with disciplinary investigations

- To refer to HR in relation to possible suspensions from duty.

- To respond to formal grievances utilising Council procedures, informal resolution is sought ideally and these matters will involve Council managers.

- To contribute to Appraisals, agree objectives and Personal Development Plans for the Professional Leads in accordance with Council documentation.

- To provide the Council Social Care staff with ASC communications and all relevant information Re: policy / procedures, mandatory training course dates

- To arrange and hold formal and regular quarterly meetings with Council Social Care staff in partnership with Trust Locality Managers

5.5 RESPONSIBILITIES IN RELATION TO SPECIFIED CIRCUMSTANCES

This section outlines the process to be adopted in accordance with Council Employment Policies and Procedures in relation to specific circumstances:

Absence

- Short term / long term sickness will be monitored and managed by Council ASC Professional Leads and the Council SDM.

- Short term cover requirements needed as a result of absence for any reason will be managed by Council ASC Professional Leads in conjunction with the Locality Managers. Long term cover requests will be discussed with the Council SDM.

Staff movement / changes from substantive post and funded hours

The Council Social Care staff posts are assigned as detailed in section 5.1. Any changes in relation to the staffing structure identified in section 5.1 must be agreed in writing with the Council Head of Service, ASC. This includes secondment opportunities within both organisations.

This is to ensure that the service provided is still being delivered and complies with Council requirements in accordance with the duties of the Director of Adult Social Services (DASS).

The Council SDM will complete relevant documentation to ensure that agreed changes are actioned appropriately.

Vacated Positions

Council ASC Professional Leads and Trust Locality Managers will inform the Council SDM as soon as they become aware that an employee may resign from their post. The employee's resignation letter must be submitted formally to the SDM to be progressed. Council notice periods will be adhered to and any variation from this must be agreed with the SDM.

Any vacant post will be subject to the Council's recruitment procedures.

Any recruitment process will be conducted in partnership with the respective Locality Manager.

The Council Lead Professionals will act as Appointing Officer for any recruitment processes up to PO6.

Disciplinary and Grievance

The Council Social Care staff are employees of the Council and as such will adhere to the Council's Disciplinary Procedure and Grievance Procedures.

If a disciplinary incident occurs then an investigating officer will be assigned by the Council. If it is felt necessary to suspend an employee from duty this decision will be the responsibility of the Council.

If a member of the Council Social Care workforce raises a grievance, this will be dealt with through the Council's Grievance Procedure. Grievances should be resolved informally where possible, but any formal grievance will be dealt with through the Council's Grievance Procedure

6. STANDARD TERMS AND CONDITIONS

6.1 STATUTORY AND OTHER REQUIREMENTS

All parties must recognise their respective obligations as stipulated from Section 5.2 to 5.5 to comply with the requirements of all current legislation in relation to employment law. As the Council Social Care workforce are employees of the Council, the Council requires Trust Managers to facilitate and support the Council Social Care staff to meet their obligations.

6.2 EMPLOYER LIABILITY

The Council is the legal employer of the Council Social Care workforce, detailed within 5.1 of this agreement.

It is acknowledged and accepted that the Trust has responsibility for coordinating and ensuring the acceptable working environment of the Council employees detailed in section 5.1 and as such the Trust acknowledges its liability and responsibilities in relation to these employees.

The Council will seek to recover any costs associated with this agreement where it believes the responsibility for those costs rests with the Trust e.g. Industrial Injury, locum/agency costs.

With regard to the Council's indemnity and insurance it requires **all** Council staff to follow Council Procedures and Mandatory / Statutory training and to fulfil their professional registration requirements.

6.3 REPRESENTATIVES

At the time of establishing this agreement the representatives are:

Deputy Director – Leeds and York Partnership Foundation Trust (the Trust)

Head of Service - Learning Disabilities, Transitions, EDT and Mental Health, Leeds City Council (The Council)

6.4 COMPLAINTS

Any complaints received regarding the service provision will be investigated by the Council SDM in conjunction with the Trust Locality Managers. The SDM will keep the Locality Managers informed of complaints that are received and the outcome of those complaints. If the complaint necessitates a change in procedure, this will be negotiated between the parties including the Trade Unions. Complaints will be handled in accordance with the Council's Complaints Procedure.

Any complaints/concerns regarding this agreement will be dealt with informally where possible. The Quarterly/ Annual Review process can also be used to raise complaints/concerns. If deemed appropriate complaints or concerns can be raised, in writing with the Council Head of Service, Adult Social Care.

6.6 AMENDMENTS

This agreement may be amended by written agreement from both parties via the Partnership Board with appropriate consultation with relevant Council staff and trade union representatives.

Appendix 1

Leeds City Council HR Procedures

All of the procedures below must be used for all staff substantively or temporarily employed by LCC:

- Access to Employee Medical Records
- Alcohol and Drug Misuse Policy
- Appointment and Promotion
- Appraisals in LCC
- Assisted Car Purchase Scheme
- Bullying at Work Policy
- Employee Code of Conduct
- Corporate Information Technology Security Policy
- Corporate Safeguarding
- Disciplinary Policy
- Domestic Violence Policy
- Employee Payments during Emergency Incidents
- Equality and Diversity Policy
- Eye test for Display Screen Equipment User
- Flexible Working Hours
- Grievance Policy
- GSCC Registration
- Health and Safety Policy
- HIV and AIDS Policy
- Hours and Leave
- Improving Performance Policy
- Job Sharing Scheme
- Managing Attendance Policy
- Managing Workforce Change
- Maternity, Birth (including Paternity) and Adoption Leave
- Politically restricted posts
- Pre-employment Health Declaration Policy
- Probationary Period Policy
- Provision of First Aid Facilities Policy
- Recruitment and Selection Policy
- Sexuality in the Workplace Policy
- Smoking Policy
- Travelling and Subsistence
- Use of Communication Equipment whilst Driving Policy
- Whistle Blowing Policy

In addition to the terms and conditions outlined in this document, other terms and conditions of employment will be in accordance with those prescribed by the National Joint Council for Local Government Services as set out in the Conditions of Service as varied or supplemented by the City Council's Local Conditions of Service.

Appendix 2

The Council's Mandatory Training Schedule

Development Need	Driver for Change	Outcome for staff	Outcome for customer	Tier of staff the training is aimed at				
				SWA	NQSW	SW	SSG Pract	TM
Welcome to LCC	Mandatory Requirement	Will help new staff put their role in context with the council	Improved Service	✓	✓	✓	✓	✓
Adult Social Care Induction (Provider Services)	Mandatory Requirement	Staff working to appropriate standards, understanding of job role and working to guidelines, policies and procedures	Skilled and qualified workforce to deliver the service	✓				
NQSW Programme	Mandatory Requirement	Confident and competent practice based on a firm foundation of skills and knowledge	Skilled and qualified workforce to deliver the service		✓			
Induction workshops for SW new to Leeds	Mandatory Requirement	Confident and competent practice for staff coming to work in Leeds	Skilled and qualified workforce to deliver the service			✓		
MCA/DoLS (A Practice Perspective for Fieldworkers)	Mandatory Requirement	Skills and knowledge is consistent with relevant legislation	Improved health, safety and wellbeing	✓	✓	✓	✓	✓
Keeping up to date with policy changes	To meet with new legislation	Confident and competent practice	Improved Service	✓	✓	✓	✓	✓
Capacity and Tenancies	To meet new and existing legislation	Confident and competent practice	Improved Service	✓	✓	✓	✓	✓
Safeguarding 'It's Everybody's Job'	Mandatory Requirement	Staff trained at relevant level to support customers safely	Improved health, safety and wellbeing	✓	✓	✓	✓	✓
Safeguarding Concerns and How to Refer Appropriately	Mandatory Requirement	Staff trained at relevant level to support customers safely	Improved health, safety and wellbeing	✓	✓	✓		
Safeguarding Adults – The Process for SW and JCM	Mandatory Requirement	Staff trained at relevant level to support customers safely	Improved health, safety and wellbeing	✓	✓	✓	✓	✓
Investigating Disclosures and Allegations	Mandatory Requirement	Staff trained at relevant level to support customers safely	Improved health, safety and wellbeing		✓	✓		
Writing the Investigating Officers Report	Mandatory Requirement	Staff trained at relevant level to support customers safely	Improved health, safety and wellbeing		✓	✓	✓	

Development Need	Driver for Change	Outcome for staff	Outcome for customer	Tier of staff the training is aimed at				
				SWA	NQSW	SW	SSG Pract	TM
Safeguarding Policy, Procedure and Practice	To meet new and existing legislation	Staff trained at relevant level to support customers safely	Improved health, safety and wellbeing	✓	✓	✓		✓
Risk Assessment and Risk Management	To meet new and existing legislation	Staff trained at relevant level to support customers safely	Improved health, safety and wellbeing	✓	✓	✓		✓
MCA including Assessments of Capacity & Best Interest Decision Making	To meet new and existing legislation	Staff trained at relevant level to support customers safely	Improved health, safety and wellbeing	✓	✓	✓		✓
What is a good Assessment and What is a good Review	Service Transformation	Confident and competent practice	Improved Service	✓	✓	✓		
DoLS & Courts role and Court Craft	To meet new and existing legislation	Staff trained at relevant level to support customers safely	Improved health, safety and wellbeing	✓	✓	✓	✓	✓
Equality and Diversity	Mandatory Requirement	Confident and competent practice around the Equality Act 2010	Improved Service	✓	✓	✓	✓	✓
Introduction and awareness raising of Autistic Spectrum Disorders	To meet the Autism Strategy	Staff trained at relevant level to support customers who are on the Autistic Spectrum	Improved Service	✓				
Specialist training in Autistic Spectrum Disorder	To meet the Autism Strategy	Staff trained at relevant level to support customers who are on the Autistic Spectrum	Improved Service	✓	✓	✓	✓	✓
IRT Function and Implementation	Service Transformation	Confident and competent practice	Improved Service	✓	✓	✓		
Step by step Care Options	Service Transformation	Confident and competent practice	Improved Service		✓	✓	✓	
What to take to Nominations Panel	Service Transformation	Confident and competent practice	Improved Service		✓	✓		
ESCR – Reporting and Recording	Service Transformation	Confident and competent practice	Improved Service	✓	✓	✓	✓	✓
Self Directed Support	Mandatory Requirement	Confident and competent practice	Improved Service	✓	✓	✓	✓	✓
Person Centred Approaches and tools	Service Transformation	Staff are open and receptive to new ways of working	Improved service for customers	✓	✓	✓	✓	✓

Development Need	Driver for Change	Outcome for staff	Outcome for customer	Tier of staff the training is aimed at				
				SWA	NQSW	SW	SSG Pract	TM
Continuing Health Care	Service Transformation	Confident and competent practice	Improved Service		✓	✓		
Leadership and Management standards	Mandatory Requirement	Confident and competent practice	Improved Service				✓	✓
Involving and Engaging Carers	Service Transformation	Staff and Carer engagement	Improved Service	✓	✓	✓	✓	✓
Information Governance training	Mandatory Requirement	Understand the use and control of information	Information id protected	✓	✓	✓	✓	✓

Appendix 3

Information Governance Policies

Clear Desk and Clear Screen Policy
The overall purpose of this policy is to ensure you have an awareness of the importance of keeping both paper and electronic documents and records safe when they are working at their desk/workstation or on their screen and that you have knowledge of how to protect them.

Data Protection Policy
This policy aims to make it clear how the council responds to its duties in respect of processing "personal data" under the Data Protection Act 1998, and "private" information under Article 8 of the Human Rights Act 1998.

Freedom of Information Act Policy
This policy aims to make it clear how the council responds to its duties under the Freedom of Information Act 200 and the Environmental Information Regulations 2004 in relation to dealing with information requests, and in relation to the positive duty under the Regulations to disseminate certain types of environmental information.

Information and Data Quality Policy
This policy sets out the council's approach to data and information quality. The quality of data and information can impact on efficiency, effectiveness, decision making and service delivery in general. This policy outlines the requirements that must be met to ensure that colleagues have access to timely, accurate and relevant information.

Information Security Policy
This policy aims to ensure that all information and information systems upon which the council depends are adequately protected to the appropriate level, and that all staff have a proper awareness, concern and an adequate appreciation of their responsibility for information security.

Information Security Incident Management and Reporting Policy
The aim of this policy is to ensure that the council's incident reporting systems are robust in managing, reporting and learning from adverse events; thereby minimising the potential impact of any security incidents. The council also recognises the importance of reporting 'near misses' to promote a learning culture within the organisation.

Information Sharing Policy
The aim of this policy is to support good practice in information sharing by offering clarity on when and how information can be shared legally and professionally.

Information Systems Acceptable Use Policy
The overall purpose of this policy is to provide protection for information assets and information systems owned and used by the council from the risks posed by inappropriate use. It relates to the acceptable use of information and information systems, including future technologies. A supporting electronic communications code of practice (currently in draft format) has also been published to support this policy.

Protective Marking and Asset Control Policy
This policy sets out appropriate measures through which the council will classify its information, using the Government Protective Marking Scheme, to facilitate the secure handling, storage and disposal of its information assets. The policy also underpins the more effective and efficient information sharing with other public authorities who already apply protective marking.

Records Management Policy
This policy outlines the requirements that must be met for the council to ensure that its records are created, captured, and managed appropriately, to recognised standards, in order to meet legal and

operational needs.

Removable Media and Mobile Computing Policy
This policy establishes the principles and working practices that are to be adopted by all staff in order for information to be safely stored and transferred on removable media and mobile computing devices.

Retention and Disposal Policy
The retention and disposal policy sets out the principles to be followed to ensure that council records are kept and then disposed of appropriately, in line with a corporately agreed retention and disposal schedule. This will clearly state the requirements for reviewing, retaining, disposing of, or transferring the council's records to the council's archive service provider.

SCHEDULE 14

FORM OF NOTIFICATION TO THE DEPARTMENT OF HEALTH

ROCR/OR/0226 **Licence Expiry Date:**

The use of this collection has been approved by the Review of Central Returns Steering Committee – ROCR.

This is a Mandatory collection from Primary Care Trusts and NHS Trusts. Monitor, Independent Regulator of Foundations Trusts has provided approval for a voluntary collection.

NOTIFICATION FORM
SECTION 75 PARTNERSHIP ARRANGEMENTS

To be completed for each partnership arrangement and updated annually for amendment of a partnership arrangement.

This form below should be sent to the Health and Social Care Joint Unit, c/o CSIP ICN, Department of Health, Room 304 Wellington House, Waterloo Road, London SE1 8UJ.

Email: MB-HSD-SCJU@dh.gsi.gov.uk

1. NAMES OF THE STATUTORY PARTNERS **(Officers & Organisations)**	
2. DATE OF AGREEMENT	
3. DATE WHEN PARTNERSHIP IS INTENDED TO START OR DATE OF ANNUAL UPDATE FOR DH IF THIS HAS BEEN PREVIOUSLY NOTIFIED	
4. TITLE OF OFFICER RESPONSIBLE FOR THE PARTNERSHIP	
5. CONTACT NAME	
6. CONTACT TEL. NO.	
6. WHICH FLEXIBILITIES ARE BEING USED? • **LEAD COMMISSIONING (LC)** • **POOLED FUNDS (PF)** • **INTEGRATED PROVISION (IP)**	

8. WHICH CARE GROUP OR CATEGORY DOES THE PARTNERSHIP SERVE?	
9. SUMMARY OF KEY OBJECTIVES **(DO NOT COMPLETE AGAIN IF PREVIOUSLY NOTIFIED AND THESE REMAIN UNCHANGED AT THE TIME OF ANY ANNUAL UPDATE)**	
10. CONTRIBUTIONS **IDENTIFY THE FINANCIAL CONTRIBUTION OF EACH PARTNER SEPARATELY** **(To be updated by notification annually)**	

SEE OVERLEAF FOR PARTNERSHIP CHECKLIST (FOR LOCAL USE)

PARTNERSHIP CHECKLIST (FOR LOCAL USE):

	Yes	No
1. Are you clear how the partnership will lead to improvement?		
2. Have you clearly defined objectives and how you will measure their success?		
3. Have you decided when the partnership arrangement will be formally reviewed?		
4. What the Governance arrangements will be for: • **Review** • **Renewal** • **Variation** • **Reporting** • **Monitoring** • **Accounting and auditing,** • **Operational management**		
5. Do the named people in these roles have formal delegated authority?		
6. Have you addressed where relevant: • **Human resources, including staffing** • **Terms and conditions** • **Necessary policies and agreements**		
7. Have you defined adequately for local use: • **Scope and nature of service**		

• How it is be accessed • Eligibility criteria and assessment processes • Any necessary delegation • Performance requirements and reporting at this level • Put the systems in place		
8. How are Complaints to be dealt with?		
9. Have you studied the VAT guidance and chosen a preferred option?		
10. Are you clear how disputes will be resolved?		
11. Have you agreed how you will manage continuing liability in the event of any future termination e.g. for contracts and care agreements previously entered into during the partnership period?		
12. Have you consulted with those affected by this agreement, and is it clear how has this been done?		
13. If there is to be a movement of staff, have staff and their unions been consulted?		
14. Are elected members and Non Executives clear on the nature of S75 and how it will operate locally?		

Equality, Diversity, Cohesion and Integration Screening

As a public authority we need to ensure that all our strategies, policies, service and functions, both current and proposed have given proper consideration to equality, diversity, cohesion and integration.

A **screening** process can help judge relevance and provides a record of both the **process** and **decision.** Screening should be a short, sharp exercise that determines relevance for all new and revised strategies, policies, services and functions. Completed at the earliest opportunity it will help to determine:

- the relevance of proposals and decisions to equality, diversity, cohesion and integration.
- whether or not equality, diversity, cohesion and integration is being/has already been considered, and
- whether or not it is necessary to carry out an impact assessment.

Directorate: Adult Social Care	**Service area: Mental Health**
Lead person: Max Naismith	**Contact number:**

1. Title: Agreement between Leeds and York Partnership Foundation Trust and Leeds City Council Adult Social Care under Section 75 of the National Health Service Act 2006, for the integrated provision of adult mental health services

Is this a:

	Strategy / Policy		**Service / Function**	x	**Other**

If other, please specify: Agreement under Section 75 of the National Health Service Act 2006, for the integrated provision of adult health and social services

2. Please provide a brief description of what you are screening

The Agreement under Section 75 of the National Health Service Act 2006, for the integrated provision of adult mental health services is the product of ongoing service improvement work between Leeds Partnership foundation trust and Leeds Adult social care. This agreement provides a formal structure for further development of this work, outlining the governance of the agreement and establishing an partnership board.

This agreement specifically relates to the powers given enabling one organisation to lead and host the commissioning of another partner and to integrate provision.

3. Relevance to equality, diversity, cohesion and integration

All the council's strategies/policies, services/functions affect service users, employees or the wider community – city wide or more local. These will also have a greater/lesser relevance to equality, diversity, cohesion and integration.

The following questions will help you to identify how relevant your proposals are.

When considering these questions think about age, carers, disability, gender reassignment, race, religion or belief, sex, sexual orientation and any other relevant characteristics (for example socio-economic status, social class, income, unemployment, residential location or family background and education or skills levels).

Questions	**Yes**	**No**
Is there an existing or likely differential impact for the different equality characteristics?		x
Have there been or likely to be any public concerns about the policy or proposal?		x
Could the proposal affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	x	
Could the proposal affect our workforce or employment practices?	x	
Does the proposal involve or will it have an impact on • Eliminating unlawful discrimination, victimisation and harassment • Advancing equality of opportunity • Fostering good relations	x	

If you have answered **no** to the questions above please complete **sections 6 and 7**

If you have answered **yes** to any of the above and;

- Believe you have already considered the impact on equality, diversity, cohesion and integration within your proposal please go to **section 4.**
- Are not already considering the impact on equality, diversity, cohesion and integration within your proposal please go to **section 5.**

4. Considering the impact on equality, diversity, cohesion and integration

If you can demonstrate you have considered how your proposals impact on equality, diversity, cohesion and integration you have carried out an impact assessment.

Please provide specific details for all three areas below (use the prompts for guidance).

- **How have you considered equality, diversity, cohesion and integration?**

(**think about** the scope of the proposal, who is likely to be affected, equality related information, gaps in information and plans to address, consultation and engagement activities (taken place or planned) with those likely to be affected)

Leeds City council specialist adult mental health services have been co-located with Leeds partnership foundation trust[1] staff for some years under informal arrangements. In 2010 a project was initiated to develop this partnership. An equality impact assessment was undertaken lead by the Leeds Partnerships NHS Foundation Trust and Adult Social Care Mental Health Partnership Project at this time. This equality impact assessment supported the need to formalise these arrangements to ensure that work could progress.

The consultation and engagement work undertaken to develop that partnership was outlined in the actions of that EIA.

It also identified key areas of mental health need such as

- the under representation of males in access to Occupational therapists and consultant psychotherapists
- The peaks in care spells by age by gender. These show an initial peak at 31-40 years and a further peak at 71-80 years for males and 81-90 years for females.
- The ethnicity profile indicates that BME groups are over represented in inpatient care.
- Mapping of care spells per 1000 population by electoral wards indicated that care spells per population does not necessarily correlate with those expected by socioeconomic predictions.

These are all areas which require further exploration and where appropriate systematic change to address. One aim of the Transformation programme within LYPFT is to eliminate variation by developing ageless care pathways for both inpatients and community based care, another is to ensure that the correct skills mix to deliver equitable service is available in all teams. The implementation of the partnership agreement will give a formal basis on which to develop systems. The governance resulting from the partnership board to be established under this agreement requires formalisation of process and scrutiny around data. Better quality data will facilitate more rapid identification of areas where services are not being offered in an equitable manner.

The Section 75 agreement puts in place the framework for the establishment of a matrix management agreement for Adult social care staff. This will enable streamlining of task allocation whilst enhancing the clarity around professional accountability. A key driver in

[1] In March 2012 Leeds Partnership foundation trust merged with the York foundation trust becoming LYPFT

the development of a Matrix management structure has been consultation with staff and unions and has been identified as a more effective means of ensuring cohesion and integration that alternatives such as secondment.

- **Key findings**

(think about any potential positive and negative impact on different equality characteristics, potential to promote strong and positive relationships between groups, potential to bring groups/communities into increased contact with each other, perception that the proposal could benefit one group at the expense of another)

- A formal Section 75 agreement is required to underpin the existing levels of informal collocation and to provide the ability to further develop services jointly to ensure that both organisations can respond jointly to changing Health and Social Care policy .
- The Mental Health Services are currently collocated without any formal agreement which contributes to the risk of additional duplication of effort and with less opportunity to maximise efficiencies across both organisations.
- To minimise the risk to the council regarding future financial commitment appropriate clauses have been incorporated to allow for potential changes in future financial years. The Community Care budget will be a standing agenda item at the Partnership Board which will allow both organisations to take a view on the overall financial position and allow for any future efficiency savings.

This screen indicates that there are greater equality risks associated with continuing to deliver these services on an informal partnership arrangement at a time of significant operational change within the NHS and Adult Social Care.

- **Actions**

(think about how you will promote positive impact and remove/ reduce negative impact)

The governance of the agreement is critical to ensure that positive impacts are promoted and negative impacts are removed or reduced. A Partnership Board is being established on a jointly chaired basis by the Deputy Chief Executive of LYPFT and the Chief Officer responsible for Mental Health Services in ASC. This board will have the following responsibilities:

- To receive and request relevant information with regards to reports on the service and progress.
- To monitor and agree resource allocation taking into consideration cost pressures
- Approve changes to the provision of the services
- Consider the risks and benefits of a transition to a fully integrated model of service delivery. (Any further integration would align with complete financial years and would require the agreement of both LYPFT and the council. A variation notice would be agreed prior to implementation.)
- Oversee the performance and quality of service provision against standards
- The board will meet quarterly or by exception, decisions will be by consensus

The implementation of this board therefore enhances the formal scrutiny of all aspects of services delivery including equality characteristics, and is key to ensuring continued improvement in the

equity of provision.

Ensuring that consideration of eligibility for social care support is embedded throughout the pathway and minimising duplication of assessment whilst fulfilling both organisations statutory responsibilities is essential to the ongoing success of the partnership. Under the Transformation agenda, staff will be supported to work in a holistic way considering the individual's health and social care needs in terms of recovery, social inclusion and personalisation. This closer working will enable barriers to access to be minimised.

The service needs to consider that not all social care work presents through secondary mental health services and those presenting through area offices need an equally prompt and smooth service. Under the Transformation programme within LYPFT a single point of access to secondary mental health services has been developed. Adult social care and Leeds community health are currently exploring a Gateway service providing a single point of access to community health and social care services. The formalisation of agreement in place under this agreement enhances the relationship between all organisations, it is important to ensuring improved access to care that interfaces between these are not overlooked.

Consultation has identified that there is the potential for negative impact if a joint information and communication strategy across LPFT and ASC is not implemented. This strategy must ensure that all groups are kept informed of changes.

LPFT and ASC have two separate electronic patient data recording systems; it is proposed that an integrated information governance structure will be implemented to ensure information is cross referenced on both systems. The introduction for this will be within the parameters of the project as a whole.

5. If you are **not** already considering the impact on equality, diversity, cohesion and integration you **will need to carry out an impact assessment**.

Date to scope and plan your impact assessment:	
Date to complete your impact assessment	
Lead person for your impact assessment (Include name and job title)	

6. Governance, ownership and approval
Please state here who has approved the actions and outcomes of the screening

Name	Job title	Date

7. Publishing
This screening document will act as evidence that due regard to equality and diversity

has been given. If you are not carrying out an independent impact assessment the screening document will need to be published. Please send a copy to the Equality Team for publishing	
Date screening completed	
Date sent to Equality Team	
Date published (To be completed by the Equality Team)	

Equality Impact Assessment – Leeds Partnerships NHS Foundation Trust and Adult Social Care Mental Health Partnership Project

1. Introduction

This paper outlines the actions undertaken to identify and assess the potential impact of the proposed changes to partnership arrangements between Leeds Partnerships NHS Foundation Trust (LPFT) and the specialist mental health assessment and care management function in Leeds City Council Adult Social Care (ASC). The lead people for this equality impact assessment were John Lennon for Leeds City Council and Michele Moran for LPFT. Members of the assessment team were: Caroline Bamford, Richard Graham, James Hoult, Kim Adams, Iola Shaw and Julie Bootle.

The process included engagement with a range of stakeholders - service users, carers, health and social care staff, council members, voluntary sector organisations, health partners. This information has then informed the mitigating actions included in this assessment.

2. Overview

This is a joint Equality, Diversity, Cohesion and Integration Impact Assessment between Leeds City Council and Leeds Partnerships NHS Foundation Trust.

All local authorities and NHS Trusts need to ensure that all their strategies, policies, service and functions, both current and proposed have given proper consideration to equality, diversity, cohesion and integration. In all appropriate instances we will need to carry out an equality, diversity, cohesion and integration impact assessment.

The scope of this project is to develop joint adult mental health services for the population of the City of Leeds, through the provision of services which are service user focused and exemplary in their delivery.

In determining the future model of partnership working there are elements that must be included for the partnership to be a success:

- Clean and clear lines of responsibility for statutory functions including monitoring arrangements and accountability.
- A single management team hosted by one organisation to avoid duplication.
- Streamlined processes and clear pathways.

The project is being linked to wider work that LPFT is undertaking to redesign services around pathways that allow service users to access the support they need quickly without need for repeated assessments. Combining both pieces of work means that the new pathways can be developed holistically with consideration given to individuals' health and social care needs.

3. Scope

This assessment seeks to analyse the impact of the proposed changes on any specific group. The assessment utilises factual data collected by the Leeds City Council Adult Social Care, NHS Leeds, Leeds Partnerships NHS Foundation Trust (specialist mental health trust) and voluntary sector organisations.

The assessment also takes into account comments, opinions and views from a range of stakeholders including service users, staff and management. This information has been analysed by the assessment team to provide an evidence based assessment of potential impacts and identifies actions that may be taken to mitigate these impact should the decision be made to integrate provision.

4. Fact Finding – What do we already know?

4.1 Demographics

4.1.1 Leeds. Leeds is the second largest metropolitan district in England with an estimated population in excess of 750,000 people. Whilst the Leeds economy as a whole, has been a success story, Leeds has a significant amount of deprivation. Five wards in the city have more than half their super output areas (subdivisions of wards) in the 10 per cent most deprived in England. These five wards tend to have the highest levels of deprivation, proportion of people on unemployment benefits and proportion of households in receipt of council benefits.

Like many other cities in the UK, Leeds is now facing unprecedented change and uncertainty. The University of Leeds predicts that by 2026 the total number of people living in the Leeds local authority area will be 830,000. This will include larger numbers of people from ethnic minorities and higher numbers of younger people as well as an increase in people aged 75 and over. In general people are living longer and there are as many people over 60 as under 16. Although the rate of increase in the proportion of older citizens in Leeds is not likely to be as great as in some neighbouring authorities, it is predicted that the number of people in Leeds aged 65 and over will rise by almost 40 per cent to 153,600 in 2031, around 20 per cent of the population.

In particular:

- Leeds has a significantly higher proportion of 15 to 29 year olds (26 per cent compared to the national average approaching 20 per cent);

- there is a significant student population of over 60,000 studying in the two universities in the city;

- Stonewall estimates that a large city such as Leeds with an established gay scene may be made up of at least 10% lesbian, gay and bisexual people;

- Leeds population broken down by religion or belief is 69.9% Christians, 3% Muslims, 1.1% Sikh. 1.2% Jewish, 0.6% Hindu, 0.2% Buddhist and 24.9% no religion or not stated;

- Leeds is now home to over 130 different nationalities;

- in 2006 the Office for National Statistics (ONS) estimated that 15.1% of the total resident population comprised people from black and minority ethnic communities (including Irish and other white populations), a rise of 5 per cent from the 2001 census; and

- by 2030 the black and minority ethnic population in Leeds is estimated to increase by 55 per cent.

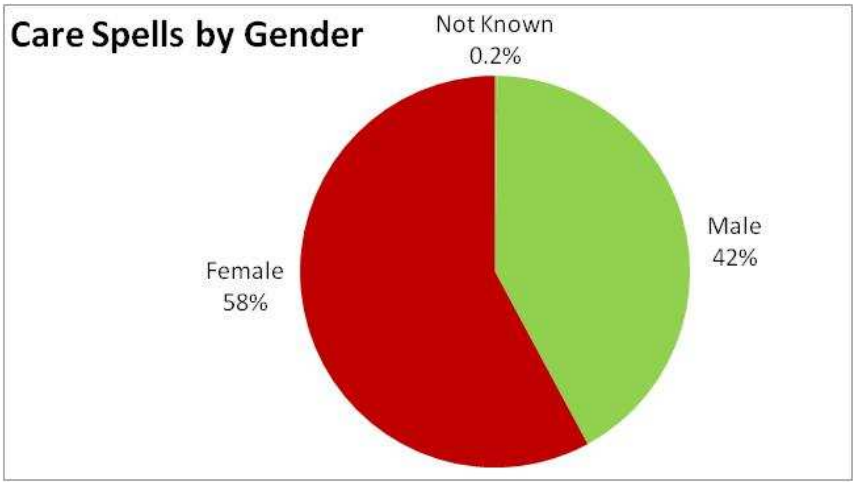
4.1.2. Mental Health Needs. Mental health problems are common. Around one in six adults suffer from a common mental health problem such as anxiety or depression. Nationally 29% of women and 17% of men will suffer some form of mental health problem during their lives; 1 in 4 women and 1 in 10 men will experience an episode of a depressive illness; self harm prevalence stands at 400 per 100,000 population. One in ten mothers suffer from post natal depression. Mental ill health occupies approximately one third of GP time. Ninety per cent of people with common mental health problems are managed entirely within primary care.

Incidence of mental health problems is more prevalent in the Lesbian, Gay and Bisexual communities. In 2006 research was undertaken with this community within Leeds (Noret, Rivers and Richards, 2006) and found that: over one third of LGB people encountered mental health challenges, with more than half reporting having had suicidal thoughts at some point in their lives. One third of participants also reported self-harming. Of those who reported self-harming, 24% had not accessed a mental health service. Similarly, 33% of those who reported having suicidal thoughts had not accessed a mental health service.

Data for Secondary Mental Health Services in Leeds
LPFT provide detailed information on patient demographics to the NHS Information Centre as part of the mental health minimum dataset (MHMD)[1]. Data from 2009/10 indicates that LPFT provided 19,576 spells of specialist mental health care to 18,331 service users[2]. This represents an access rate of approx 24 care spells per 1000 population.

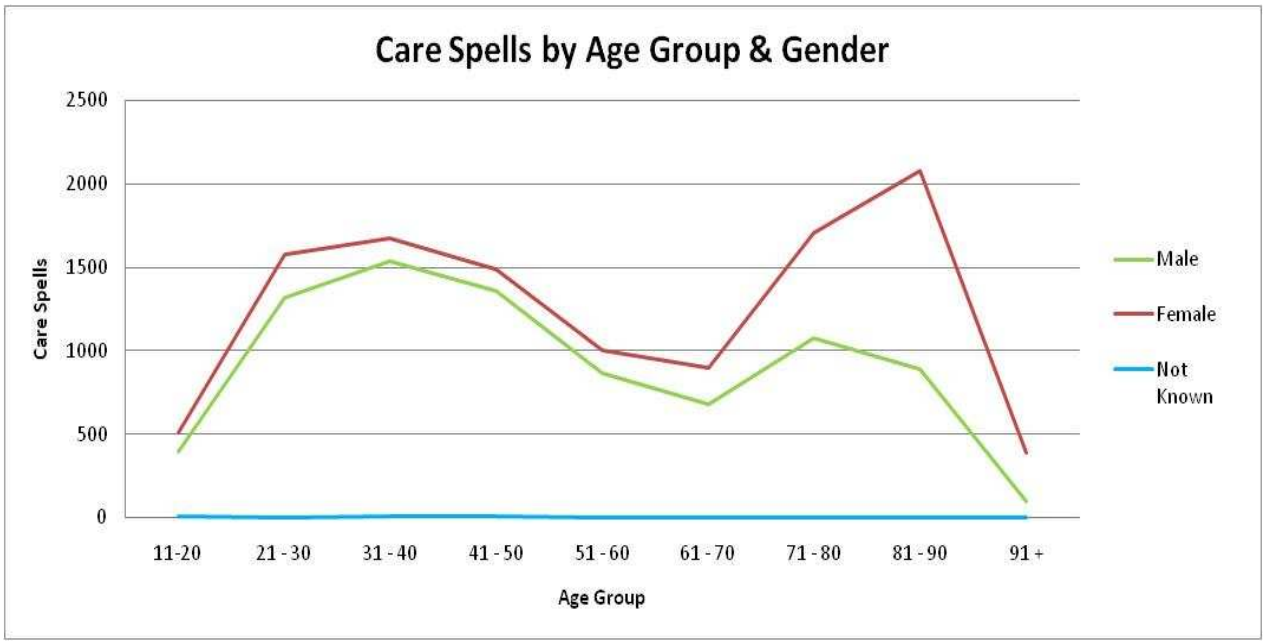
[1] The MHMDS is derived from all the activity data collected in the Trust on the Patient Record Administration System (PARIS), aggregated into care spells.
[2] A care spell in the MHMDS is taken as 'a period of specialist mental healthcare in the Trust during which the service user may receive different types of care, including inpatient, crisis resolution and from a community mental health team.' It commences with referral and terminates with discharge. The MHMDS is only as accurate and representative of the data as inputted into PARIS by Trust staff.

Gender. In the reporting period women comprised 58% of the total care spells, roughly the same proportion as the previous year.



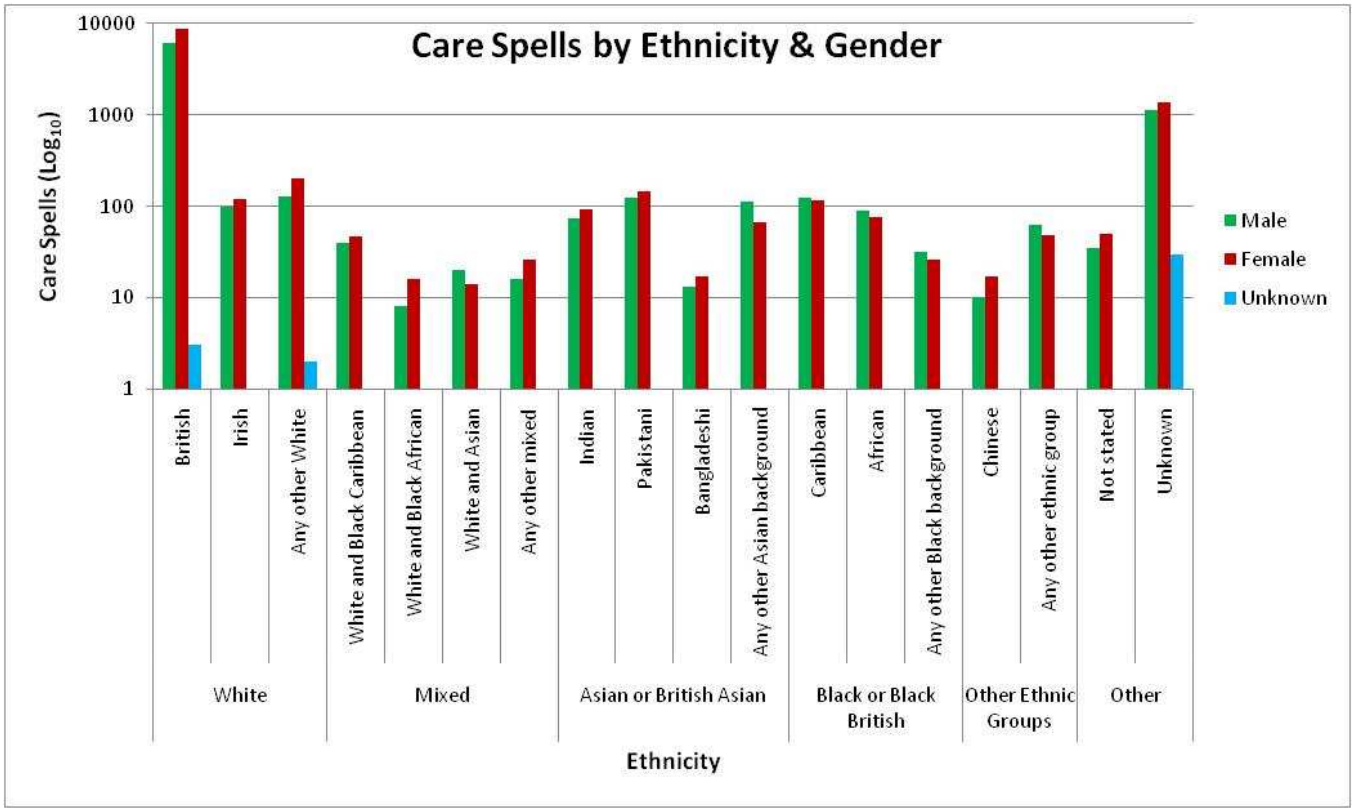
There was significant male under-representation in access to Occupational Therapists and Consultant Psychotherapists (almost 10% less than expected). It may be that male service users are unable to access these services or feel discouraged from doing so.

Age. There are more female than male care spells across all age groups. Both male and female care spells show an initial peak at 31-40 years. This may reflect the higher frequency onset of mental health problems in young adulthood. For males, a second peak occurs at 71-80 years, yet this is lower than the first peak and decreases rapidly towards later age groups, possibly reflecting lower male life expectancy. For females, the second peak at 81-90 years is the highest care spell level; care spells at age 65 and over account for 43% of total female care spells. This may reflect the increasing prevalence of age related dementia for older people as life expectancies increase.

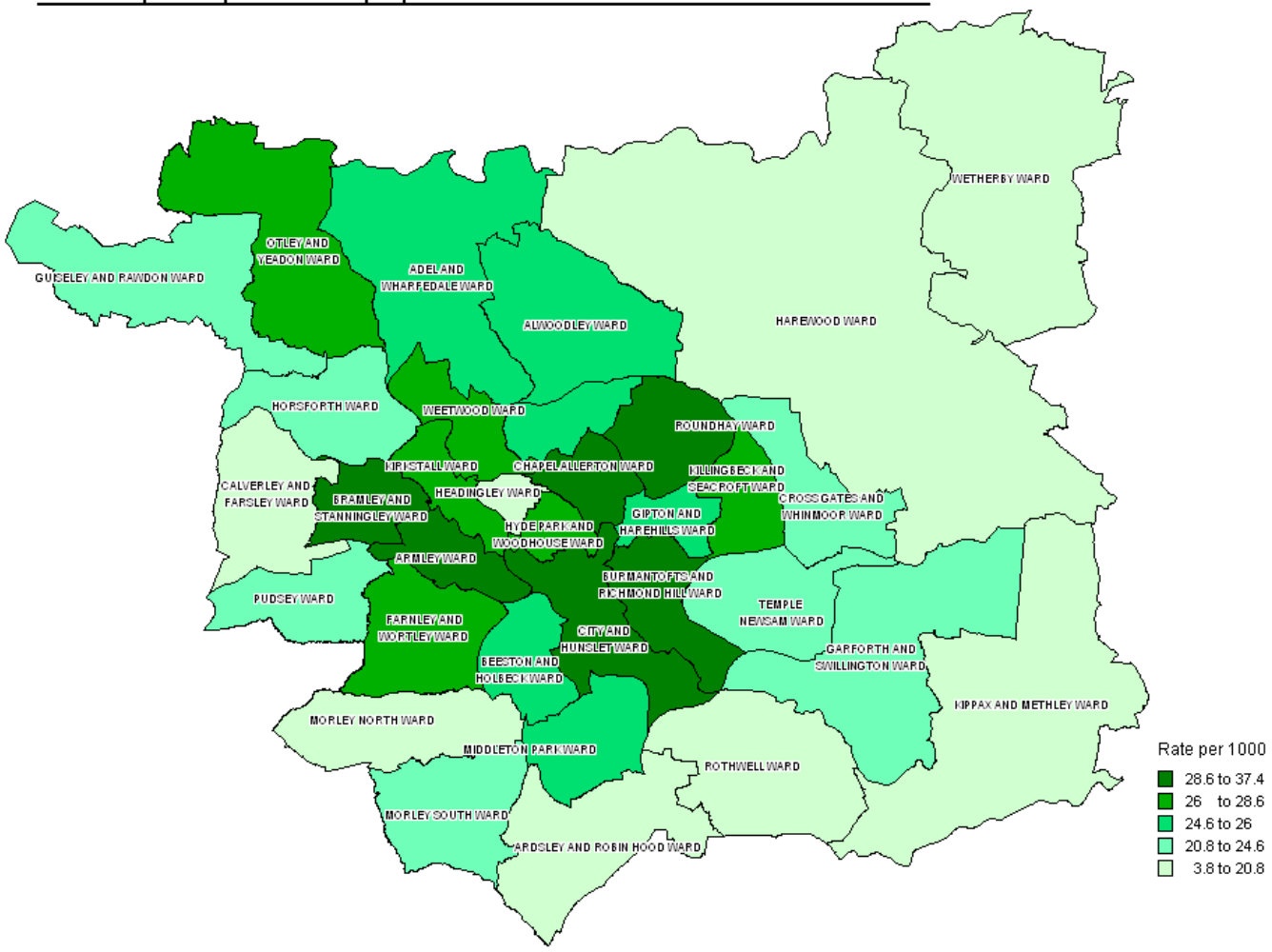


Ethnic Profile. BME groups accounted for 9.8% of Trust care spells. However, BME groups accounted for 17.2% of inpatient care spells, suggesting a BME over representation in inpatient Care.

There was variation in contact rate and the distribution of contacts among different ethnicities. For example, Mixed Ethnicity care spells averaged at 1 contact in 15 days, whereas Asian or Asian British averaged at 1 contact in 22 days. BME care spells are more likely to be on CPA.



Care Spells per 1000 population in the 2009 / 2010 MHMDS



This map of Leeds shows the care spells per 1,000 population across the electoral wards of Leeds.[3] (NB: Electoral ward population comes from ONS estimates of mid- 2007 population for 2009 wards.)

[3] Electoral Ward Population Source: Mid-2007 Quinary Estimates for 2009 wards (experimental) http:/www.statistics.gov.uk/statbase/Product.asp?vlnk=13893

The highest rate was Armley, with 44 spells per 1,000 people. The lowest rate was in Wetherby with 6 spells per 1,000 people. However, care spells per population does not necessarily correlate with socioeconomics, as shown by the high rate in the Roundhay ward (33 spells per 1,000 people) possibly due to its older population (mean service user age: 61.5 years).

Geographic proximity may be having an impact on service user numbers, for example with Wetherby GPs choosing to refer to North Yorkshire and York PCT mental health services in Harrogate.

4.2 Current Provision

4.2.1 Service Provision – Current Partnership Model

Leeds Partnerships NHS Foundation Trust (LPFT) provides specialist mental health services to adults within the Leeds metropolitan boundary.

For a number of years specialist mental health social workers have been co-located with LPFT teams. The majority of mental health service users referred for adult social care services come to the attention of Social Care staff via multi-disciplinary team meetings within LPFT. The service users are individuals from the age of 16 upwards who have complex mental health needs, requiring a multi-agency and multi-professional approach under the Care Programme Approach (CPA) framework.

Service users with complex needs who use a range of services have a Care Co-ordinator within CPA. It is the Care Coordinator's job to ensure that a service user's needs are met in a timely and appropriate way, and to maintain contact with service providers across sectors. Care Coordination is about making sure the right services are responding to the individual's needs in ways that have been agreed with the individual. For most people their Care Co-ordinator will be a member of the CMHT – a nurse, social worker or OT. In Leeds we also work in partnership with some voluntary sector organisations which provide specialist services and perform the Care Coordinator role for their clients.

4.2.2 Access to Social Care Services

There have been inconsistencies identified in the way in which people currently access social care services. Social workers are deployed differently in adult and older people's services. In adult services social workers are typically integrated within the multi-disciplinary teams and share a caseload with health staff. This means that some of the people that social workers are supporting would not have FACS eligible social care needs and some of the people nurses and OTs work with will have eligible needs but will not necessarily see a social worker. In Older People's services social workers operate as a distinct team within the team and only work with people with an identified social care need.

4.2.3 Self Directed Support.

One of the advantages of social workers operating as part of the multi disciplinary team is that service users can access a range of health and social care services without needing to undergo additional assessment. Health professionals have been able to access social care services on behalf of individuals without the need for additional processes and involvement of additional professionals. However, in the last 18 months self directed support (SDS) has been rolled out in social care across Leeds. This gives FACS eligible service users the option of opting for a personal budget in preference to pre commissioned services to shape and personalise the support they feel will best meet their needs.

In older people's services all eligible service users have an assessment for SDS and can make this choice. In adult services only the social workers are trained in SDS and different professionals have differing knowledge base of the opportunities from SDS. This has led to marked differences between over 65s and working age adults

with working age adults access to a personal budget being dependant on their Care Co-ordinator recognising that the individual may benefit from SDS.

The figures for self directed support are detailed in appendix one and indicate that the numbers for mental health are low (these figures refer to under 65s as the over 65s are included in older people's services). The target for mental health service users based on total number of people with mental health support needs accessing social care services is 300.

4.2.4 Partnership Models in Other Areas.

A Benchmarking exercise has been undertaken to look at models of joint working in comparative services (Sheffield, Barnsley, East Riding, Bradford, Lincoln and Nottingham) to consider good practice and lessons learnt in other parts of the country within their health and social care partnerships.

4.2.5 LPFT Transformation Project.

LPFT are concurrently running a project known as the Transformation project. The aims of the Transformation Project is to ensure a sustainable, innovative and service user responsive Care Services Directorate it is essential to transform our clinical services into a new, accessible, care pathways orientated model of care delivery. In particular the proposed model will move the services from the current directorates into 3 integrated care pathways orientated directorates;

- Acute Care Pathways,
- Community Care Pathways
- Regional/In reach Care Pathways

The pathways will be supported by a Clinical Support Unit, aimed at reducing bureaucracy and improving interfaces with corporate services. Learning Disabilities will be reviewed at a later phase in the transition.

The transition will improve access for service users and referrers, improve the delivery of health and social care services, protect posts in the current difficult financial climate and achieve savings of £8.7m by March 2013.

The transformation programme of work will be complex and involve numerous stakeholders to achieve a successful outcome by March 2013. Staff and service users will be central to the redesign work.

4.3 What do people think - Consultation?

In considering making changes to the partnership arrangements between LPFT and LCC we have consulted with a wide range of stake holders.

The consultation activities undertaken include:

- A workshop for service users

- Building Your Trust Event
- A series of workshops for health and social care staff
- Meetings with commissioners
- Discussion at the Joint Strategic commissioning group for mental health
- A questionnaire emailed to all affected staff
- Monthly drop ins and a regular newsletter for staff to update on progress
- Project sponsors send a letter to all directly affected staff after each board meeting to update them on progress.
- Project staff have visited staff teams and used these opportunities and the workshops to build a picture of what a health and social care partnership might look like.
- There are a number of work streams in place to progress the project and all have health and social care membership.
- An external facilitator has been commissioned by the Project Sponsors to undertake work with staff in both health and social care to identify areas of cultural difference and concerns for future joint working.

In addition the Project team have attended further meetings to ensure wider coverage of the project scope and aims are achieved; these have included:

- LPFT Board of Governors.
- LPFT Staff side committee
- Disabled Peoples/Older Peoples Board
- Health Scrutiny
- Adult Social Care Mental Health Managers meeting

4.3.1 Service Users.

Service users were invited to participate in a workshop in July to capture their experiences of health and social care services and to share what is important to them when accessing services. Posters were used to advertise the workshop across LPFT, ASC and the voluntary sector and staff were asked to promote the workshop. A summary of the comments are included at appendix 2. There were about 12 service users who attended the day.

The feedback from the event has helped shape the discussions with the staff teams on how the model of service delivery should look. Whilst the number of service users attending this event was low the feedback they gave reinforced feedback from other stakeholder engagement that had been undertaken for different projects and proposals. Broadly service users have told us that receiving appropriate help when they need it is more important to them than who provides that support and that they are being assessed too many times.

A mix of service users and staff took part in a Building Your Trust event which was held in December.

4.3.2 Staff.

There have been a number of methods used to consult with staff over the course of the project. At the beginning of the project all staff directly affected by the proposals were emailed a questionnaire to give feedback on how effective they felt joint working was under the current partnership arrangements. A summary of this is available. Staff indicated that they thought things could be more joined up – particularly in terms of a shared vision and shared objectives and clear management lines.

Staff have been kept informed of progress and invited to give comment and feedback through update letters, drop in sessions and regular newsletters. They have had the opportunity to give their views on what works and doesn't work within the partnership and on what good joint working should look like through a series of workshops in September and October. Some management team members from both health and social care have been invited to be part of the workstreams progressing the project.

Early in the project the team were concerned that health staff were less involved and engaged than social care staff. The culture change work gathered opinions from both groups and one of the areas of feedback was that there was confusion around the fit of this work with wider transformation work that had just commenced within LPFT. The project team had already identified crossovers and the two projects have more recently been joined so that the development of care pathways can be developed holistically, involving health and social care pathways.

4.3.3 NHS and Adult Social Care Commissioners. In considering the options around partnership working the providers have sought to involve health and social care commissioners. Regular meetings have been established with senior health and social care commissioners and the Programme Manager reports updates to the Mental Health Joint Strategic group whose membership includes commissioners and providers from across health, social care and voluntary sector.

4.3.4 Referrers, Partner Organisations and Other Interested Parties. Many of these organisations are represented through the MH Joint Strategic Group. The Programme Manager also updates a citywide mental health provider partnership group which brings together the voluntary sector umbrella organisations for older people, learning disability and mental health providers with LPFT and Adult Social Care.

4.3.5 The proposal to explore a new model of partnership has been discussed at Policy Cabinet, as part of a scrutiny inquiry into support for working age adults with severe and enduring mental health problems and at Health Scrutiny.

4.4 Workforce Profile

To be supplied by HR departments

5 Overview of Fact Finding and Consultation

From the evidence considered

1) The evidence seen indicates that there is a difference in the way that older people and working age adults access social care services. This can result in fewer working age adults being offered self directed support.

2) Initially health staff were less involved in the project than social care staff and had a perception that the changes would only affect social care staff. There was additional confusion around the fit with Transformation work taking place within LPFT clinical services.

3) Within the lifetime of the project LPFT took a decision to review the delivery of clinical services and to redevelop these around pathways to streamline access to support services. As both projects were looking at care pathways a decision was taken to join the projects.

The potential impacts identified from redesigning the partnership are:

Potential Impacts identified.

There will be a positive impact for all stakeholder groups, both ASC and LPFT services provide equality of services and the integrated project will benefit all stakeholder groups.

The redesigned service will impact positively on service users as the pathway through services will be more streamlined with less duplication of assessment. Service users should have equal access to services they are entitled to and be clearly signposted through the pathway to appropriate support.

Staff will be supported to work in a holistic way considering the individual's health and social care needs in terms of recovery, social inclusion and personalisation. Clear recording systems will be in place.

In looking at single point of access the service needs to consider that not all social care work presents through secondary mental health services and those presenting through area offices need an equally prompt and smooth service.

Consultation has identified that there is the potential for negative impact if a joint information and communication strategy across LPFT and ASC is not implemented. If service users are to experience a holistic, streamlined service clear pathways need to be in place to ensure peoples health and social care needs can be met by the service.

Currently LPFT and ASC have two separate electronic patient data recording systems; it is proposed that an integrated information governance structure will be implemented; the introduction for this will be within the parameters of the project as a whole.

Action plan to ensure mitigation is in place

Engagement with stakeholders needs to continue as pathways are determined to ensure that no equality group is disadvantaged.

Appendix One

Self Directed Support

User Group	As as 30/11/10				As as 31/12/10				As as 31/01/11			
	DP	PB	SDS	SDAQ	DP	PB	SDS	SDAQ	DP	PB	SDS	SDAQ
Older People	729	43	1837	143	732	50	1859	172	737	67	1883	220
Learning Disability	114	28	117	9	113	31	123	8	113	32	125	9
Physical Disability	316	53	155	18	316	56	155	23	316	66	157	31
Sensory Impairment	27	3	7	0	27	3	7	0	27	3	7	0
Mental Health	51	7	27	3	51	10	27	3	51	12	27	5
Other	20	2	2	2	20	3	3	1	20	4	3	1
Equipment (Phys Dis)	4	0	0	0	5	0	0	0	5	0	0	0
Carers(inc Citywide)	404	0	0	0	404	0	0	0	404	0	0	0
Unknown	1	1	0	0	1	1	0	0	1	1	0	0

Leeds CITY COUNCIL

Report author: John Lennon
Tel: 2478665

Report of Director of Adult Social Services

Report to Health & Wellbeing & Adult Social Care Scrutiny Board

Date: 21 November 2012

Subject: Update on Development of Integrated Neighbourhood Health and Social Care Teams and the use of risk stratification

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for Call-In?	☒ Yes	☐ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

Summary of main issues

1. Integrated neighbourhood health and social care teams have been operating across three neighbourhoods in the City for six months.

2. Rollout to a further nine neighbourhoods is underway with Citywide coverage by the end of the year.

3. The ability to discuss cases with colleagues and access one another's expertise has been one of the early benefits of this work. Co-location has allowed health and social care colleagues to share knowledge and signpost individuals quickly to appropriate support.

4. Work is now underway to develop more integrated care management system and a neighbourhood model for integrated teams clustered around GP practices and their patients

Recommendations

Scrutiny Board are asked to note the progress in developing integrated health and social care services in Leeds ,endorse the direction of travel in developing and delivering improvements in how health and social care services are provided to Leeds residents and offer their support to these developments.

1 Purpose of this report

1.1 This report provides an update on the rollout of integrated neighbourhood health and social care teams. It describes progress to date and future plans for development.

2 Background information

2.1 Many people who receive both health and social care support have to cope with two sets of professionals coming to see them, asking similar questions and assessing them for many of the same conditions and problems. Most of these people are living with one or more long-term conditions – and many are elderly.

2.2 In some parts of the country, health and social care teams have begun to work closely together in a more integrated way. They have found that this more streamlined, joined-up approach often results in services which patients and carers say are better for them – and fewer people ending up in hospital or in long-term residential care. The White paper 'Caring for our Future: Reforming Care and Support' set out a vision for a reformed care and support system with integrated services. The Government has made available funds to support the transformation of services and plans to invest a further £100 million in 2013/14and £200 million in 2014/15 in joint funding between the NHS and social care to facilitate development of better integrated care and support.

2.3 In Leeds we are looking at how we can work together more effectively by developing integrated health and social care teams. The development of integrated teams is being progressed together with two other key aspects of work: risk stratification – understanding the needs of the population and identifying those most at risk of needing high levels of health and social care support; and co-production and supported self-care, empowering individuals to take control of their treatment, care and support.

2.4 GP practices, health workers, social care staff and patients are working more closely together to improve outcomes and quality of care for older people and those with long-term conditions.

2.5 This paper looks at progress to date since the first neighbourhood health and social care teams went live in April and describes some of the key plans for progressing this work further over the coming months.

3 Main issues

3.1 **Demonstrator sites.** In April 2012 health and social care staff were co-located in three areas of the City – Kippax/Garforth, Pudsey and Meanwood. These sites were established as demonstrators, working closely together to try out more integrated ways of working. Social workers have been working alongside district nurses, community matrons, interface geriatricians[1] , GPs and other practice staff to consider how we provide more joined up care and support.

3.2 One of the early success stories with this work has been the ability to discuss cases with colleagues and access one another's expertise. Co-location has allowed health and

[1] geriatricians who spend part of their time working in a hospital setting and part of their time working in the community

social care colleagues to share knowledge and signpost individuals quickly to appropriate support.

3.3 Health and social care staff have also been able to carry out joint assessment visits to individuals in their own home. This reduces the number of times that an individual has had to tell their story but it has also enabled health and social care staff to develop a much greater understanding of one another's roles.

3.4 Members of the integrated neighbourhood teams have also been forming links with local community groups and voluntary sector organisations, particularly neighbourhood networks.

3.5 Staff from three existing demonstrator sites (Kippax/Garforth, Pudsey and Meanwood) have been looking at what impact establishing the demonstrator sites has had on ways of working so far. The intention now is to build on this approach and begin to test out a model of new, more integrated ways of working, between now and March 2013. Staff will firstly need to get an understanding of what input patients and service users *currently have* from different members of the team. They will then look at ways of working which will reduce the number of visits and professionals needing to be involved in that person's support on a regular basis, with a view to moving to one individual staff member being able to carry out an assessment on behalf of more than one professional group. The team will also ensure there is a named link through to specialist services and a single link to each GP practice. As new referrals are received the team will identify those who have complex needs and require a joined-up response. Assessment and care planning processes will be considered to see how these can be more joined-up, and Staff will consistently consider support available through the voluntary sector.

3.6 **Rolling out the model to other areas**. The demonstrators were the first wave of a rollout of the neighbourhood team model across the City. In September an integrated neighbourhood team went live in Armley. Hunslet and Chapeltown will 'go live' in October with co-location in the remaining six areas planned through November and December to give Citywide coverage by the end of the year. A full rollout timetable is provided at the end of this report.-see appendix 1

3.7 **Risk Stratification and Multi Disciplinary Team meetings.** The development of integrated teams has been progressed with two other initiatives. The first is the introduction of a tool (risk stratification tool) into GP practices which allows GPs to see the pattern of health service use for all of the patients in their practice. To date this has focused on access to a particular group of health services which are weighted within the tool to help identify people who are high users of health services now or may be in the near future. From November this year we will be expanding the number of health services that are included and also be incorporating information on use of social care services to give a much fuller picture of the range of support an individual receives.-see appendix 2

3.8 The addition of these services will not affect the weighting of individuals but will help in our goal of delivering better co-ordinated care as we can see at a glance who is involved in supporting an individual. It will also give us a much fuller picture of those individuals that the tool has highlighted will be high users of health services in the future. Where an individual is accessing lots of different services we will be able to use multi disciplinary team meetings with members of the integrated neighbourhood teams and GPs to discuss

whether all of these interventions are effective. Where an individual is only accessing one or two services we will be able to consider whether this is appropriate to meet their needs or whether the addition of preventative support now may reduce the need for more intensive support later.

3.9 **Supported Self management**. The other work being progressed in parallel with the development of neighbourhood teams and the use of the predictive modelling tool described above is the development of a series of initiatives around supported self management. This work is being progressed in partnership with voluntary and community groups, including Neighbourhood Networks. Projects include social prescribing and *timebanking*.-see appendix 3

3.10 **Evaluation.** An External evaluation has been commissioned to consider the success of integration from different perspectives. University of Birmingham and the Social Care Institute for Excellence have carried out some work to look at initial views of staff and the people who use services to the integration of health and social care. A report is currently being produced but initial findings suggest that staff are generally optimistic about what can be achieved through integration. People who use services and their carers have more mixed views on the impact that integration will have for them. Some people see integration as a good thing but others wonder whether it will really make a difference to patient experience and outcomes. The University of Leeds is supporting the evaluation of the impact that integrated teams have on use of the health and social care system, notably how it impacts on hospital admissions and long term care placements.

3.11 **Customer feedback.** Through this work we want to ensure that - together with improvements to processes - changes in the way health and social care are delivered make a noticeable difference to the people that use our services. We are collating questions and have developed a Frequently Asked Questions sheet. We are also interviewing people who are happy to share their experiences.

3.12 **Communication.** With change on this scale communication is a challenge. Within Leeds we have a large health and social care system and some staff are much more directly engaged with change at the moment than others. A number of different medium are being used to keep staff groups updated and engaged including leaflets, reference groups, workshops and engagement events, newsletter, website and Youtube links.

3.13 **Next steps.** Some of the next steps have been described above. Whilst still in development the agreed neighbourhood team model will be rolled out across the City. The experience of staff in demonstrators will be used to test out and inform more integrated ways of working. In addition to this we will be matching caseloads. This will involve health and social care staff considering the individuals they both support and working together to:

- discuss the person's needs,
- think about whether that person would benefit from any additional support, and
- make sure that the support the person *already* receives is as coordinated and seamless as it could be.

3.14 This work will start in Meanwood before rolling out across all 12 neighbourhood teams. It will allow us to build on the joint working staff have already been doing, but with a wider caseload. It will help staff develop their skills in managing patients with complex needs, and is expected to make a lasting, positive difference for the patients themselves..

4 Corporate Considerations

4.1 Consultation and Engagement

4.1.1 Consultation and engagement is taking place across the programme of work. There is a Patient and Public Involvement Lead appointed to co-ordinate engagement activity across the projects and a Charter for Involvement has been co-produced. There is also a virtual reference group of people interested in the work.

4.1.2 Staff are involved in a number of reference groups and workshops that are running throughout the programme timescale to capture views and incorporate staff experience into the design of services. Key stakeholders are represented on the Integrated Health and Social Care Board. The external evaluation includes capturing staff and service user views and experiences.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 The model being developed will have a consistent Citywide approach with flexibility in the system to be responsive to local needs. For example work with Neighbourhood Networks is helping to build strong local relationships and understand the supports available within a local area.

4.2.2 An Equality Impact Assessment will be undertaken as part of this programme of work.

4.3 Council policies and City Priorities

4.3.1 This proposal is about working more effectively in partnership with other organisations to improve outcomes for the citizens of Leeds. and is line with the City Priority Plan 2011 – 2015.

4.4 Resources and value for money

4.4.1 The integrated care pathways model aims to develop efficient streamlined services. These new pathways will remove duplication in management and in service delivery. This will improve the experience for service users in accessing a single service that can meet a range of support needs whilst maximising use of resources.

4.5 Legal Implications, Access to Information and Call In

4.5.1 There are no specific legal implications that arise from this report.

4.5.2 This report is eligible for call in.

4.6 Risk Management

4.6.1 Formal project management methodologies are being applied to this work and project assurance is provided by the NHS Leeds Programme Management Office on behalf of the City Transformation Board. Governance arrangements are in place and all elements of project delivery report into the Integrated Health and Social Care Board which meets on a monthly basis and has representation from all stakeholder groups.

5 Conclusions

5.1 Development of integrated services in Leeds is moving quickly. We have had teams integrated in three neighbourhoods for six months and now rolling out across Leeds to establish Citywide coverage by the end of the year.

5.2 We have taken early learning and are building on this to further integrate the support that people with a mix of health and social care needs access.

5.3 This work is being progressed in collaboration with staff and service users

5.4 Early evidence from patients and Service users is that more integrated working brings benefits in the quality of those services and improvements in patient experience.

6 Recommendations

6.1 Scrutiny Board are asked to note the progress in developing integrated health and social care services in Leeds, endorse the direction of travel in developing and delivering improvements in how health and social care services are provided to Leeds residents and offer their support to these developments**.**

7 Background documents[2]

7.1 Caring for our future: reforming care and support' White Paper, DH 2012

[2] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Integrated Neighbourhood Team Rollout Plan

Appendix 1

West CCG

Team Name / Area	Pudsey	Armley	Middleton	Woodsley
Expected Go live	**(1) April 2012**	**(2) 10th September**	**(3) 7th November**	**(4) 10th December**
Wards Covered	Pudsey Calverley & Farsley Bramley & Stanningley	Armley Farnley & Wortley Bramley & Stanningley	Morley South Morley North Middleton Park Ardsley & Robin Hood	Weetwood Adel & Wharfedale Kirkstall Headingley Hyde Park & Woodhouse City & Hunslet

North CCG

Team Name / Area	Meanwood	Chapeltown	Wetherby	Yeadon
Expected go live	**(1) April 2012**	**(2) 22nd October**	**(3) 12th November**	**(4) 10th December**
Wards covered	Moortown Alwoodley Roundhay Chapel Allerton	Burmantofts & Richmond Hill Chapel Allerton Gipton & Harehills City & Hunslet	Wetherby Harewood	Otley & Yeadon Guiseley & Rawdon Horsforth Adel & Wharfedale

South & East CCG

Team Name / Area	Kippax	Hunslet	Seacroft	Beeston
Expected go live	**(1) April 2012**	**(2) 19th November**	**(3) 19th November**	**(4) 17th December**
Wards covered	Kippax & Methley Garforth & Swillington Harewood	City & Hunslet Rothwell Middelton Park Ardsley & Robin Hood Beeston & Holbeck	Temple Newsam Killingbeck & Seacroft Harewood Roundhay Cross Gates & Whinmoor	Beeston & Holbeck Morley North City & Hunslet

GREEN – completed
RED – completion due Nov & Dec 2012

Appendix 2

RISK STRATIFICATION PROJECT – UPDATE TO SCRUTINY BOARD

1. Introduction

1.1 The Risk Stratification project is a key component of the Leeds Health and Social Care Transformation Programme and provides essential data to help to identify patients who are most at risk of needing services in the future and would therefore benefit from a more proactive approach to diagnosis and management of disease.

1.2 This report details what risk stratification is and how it will benefit services within Leeds. It outlines progress to date, an overview of the planned action to implement phase 2 of the risk stratification tool, the work that has been completed to support use of risk stratification outputs by integrated health and social care teams, and proposals for further development of the approach to risk stratification in Leeds.

2. What is Risk Stratification?

2.1 Risk Stratification is based on an algorithm that brings together various elements of data about patients and uses it to calculate their risk of needing a greater level of support within the following 12-month period. Within Leeds the model used is the `Adjusted Clinical Group` model developed by John Hopkins University. It assigns people to unique categories based on patterns of disease and the expected resources that will be needed to treat and support that person.

2.2 Within Leeds, Phase 1 of the tool incorporated the age, sex, primary care data (diagnosis, pharmacy), hospital data (care episodes) and healthcare cost for each patient providing information to help identify those people with complex clinical needs, and recording their current and future clinical profile, cost and risk of hospitalisation.

2.3 The tool supports primary care teams to manage their patients, measuring the health needs of individuals to help us plan how best to support them, allocate resources where needed most, and address health inequalities across the city.

2.4 A further key aim of the tool is to give us a view across the wider health economy using diagnostic and pharmacy data to get a clear picture of the local population profile and disease burden, as identify how resources are used and can be managed effectively.

3. Benefits of the Risk Stratification model

3.1 Within Leeds risk stratification is being utilised to identify those patients most likely to be high future resource users, and those who could benefit from more intensive interventions. In effect, the risk stratification tool can assist the integrated health and social care teams to target intervention where it can have the greatest effect, enabling a proactive approach aimed at supporting people living independently at home for longer.

3.2 A further benefit is to realise the potential uses of risk stratification outputs to inform future commissioning. The tool can assess what resources are being used to support people and can aggregate resource consumption at any level in the health system, including GP practices and at CCG level. Resource allocation can be made on the basis of actual need, built up from patient level. This will enable the tool to forecast costs and financial risk within a given period.

4. Implementation of risk stratification in Leeds

4.1 Roll out commenced in the three demonstrator sites for integrated health and social care teams and now 111 out of the 112 GP practices across Leeds have got risk stratification in place. An intensive training programme for practices and members of integrated health and social care teams has been implemented to support the effective use of the risk stratification tool.

4.2 The three CCGs have supported the establishment of multidisciplinary (MDT) meetings in all practices, bringing together GPs, other practice staff and members of the integrated health and social care teams to use the outputs from the risk stratification process to identify and review people who would benefit from a more proactive joined-up approach to their care. For this year, all practices are holding a minimum of two MDT meetings, to try out this new approach, and share and spread good practice. It is expected that the frequency of these meetings will increase in the future as we begin to understand what works and how the greatest impact can be gained.

5. Implementation of Phase 2 of the Risk Stratification tool

5.1 Following the introduction of phase 1 of the tool, we collated and took into consideration all of the practice feedback provided. An example of this feedback was the amount of time required to search through a list of patients. As a result the second phase of the tool includes NHS numbers and a patient search function which will greatly reduce the time needed to carry out this work. The inclusion of patient identifiable data and especially NHS numbers is significant as it means there is no longer a requirement for staff to search across clinical databases, during, for example, MDTs.

5.2 Further enhancements include an improved patient summary, including BMI and smoking status. Alongside this is an enhanced timeline that enables the member of

staff to see in graphical representation the patient journey over the last 12 months, how many times the patient has been to their GP, number of out patient appointments, whether the patient has attended A&E and so on.

5.3 Finally, a Data Sharing Agreement has been signed off between Adult Social Care, Leeds Community Health Care and Leeds and York Partnership Foundation Trust to enable the uplift of data into the risk stratification tool. This will allow data from these agencies to be incorporated into the risks stratification tool, including the patient timeline, detailed above.

5.4 The expectation is that phase 2 will `go live` to practices by the end of October 2012.

6. Support and training to Integrated Health and Social Care staff

6.1 Between January 2012 and March 2012 473 health and social care staff were given comprehensive training and support to use the Risk stratification tool at various levels of specificity.

6.2 With the introduction of phase 2 of the risk stratification tool, some additional training has been offered to update staff on the additional features of the risk stratification tool. Additional 1:1 training and group staff target sessions will be provided upon request.

6.3 An e- learning package has been created and shared with practices throughout Leeds. This e- learning resource will aid staff whilst navigating the tool.

6.4 A risk stratification helpdesk has been established to provide practices with a specific resource to resolve any incidents that may arise. This will be complemented by an intranet site to be used as an easily accessible information resource to keep staff aware of any developments.

7. Developing a predictor for future social care usage

7.1 The risk stratification tool is specifically a healthcare system and does not currently provide predictive information about future social care usage. In Leeds we are keen to develop our approach so that we have predictive information about an individual's likely future of health or social care services. This has not been done anywhere in the country and so we are currently considering options to support work with an academic partner review and identify how the predictive model may be developed to benefit social care delivery.

James Hoult

Risk Stratification Project Manager

October 2012

Timebanks

A timebank is a system of exchange where people are able to trade skills, resources and expertise. For every hour participants 'deposit' in a timebank by giving practical help and support to others, they are able to 'withdraw' equivalent support in time when they need something doing themselves. A timebank is usually run by a 'broker' who facilitates and records exchanges between individuals and plays an important role in the safe and secure running of the timebank[i].

Timebanks are based on the key principles of co-production, which include:

- Asset model – Timebanks work on the principle that everyone has something to offer and all offers are valued.
- Reciprocity – Timebanks are based on a two-way transaction between people, which fosters a culture of mutual support.
- Social capital – A timebank creates a social network which requires on-going investment by its members.

As part of the health and social care integration pilot in Garforth, the local Neighbourhood Network, Neighbourhood Elders' Team, have developed a timebank 'Time to Share', which will be officially launched in early November. The timebank will be a way for people in the community to come together to share skills with the aim of improving people's self-value. The timebank will be linked with the local GP practice who will refer people to it as appropriate.

Also due to launch in November is the Ladybird Timebank which will operate in Headingley. The timebank received a small start-up grant through Adult Social Care's Ideas that Change Lives investment fund.

[i] Timebanking UK (2011), 'People Can'

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REPORT FOR SCRUTINY BOARD 21 NOVEMBER 2012

Integrated CIC Bed Programme South Unit (ex Harry Booth House)

In February 2012 Scrutiny Board (Health and Wellbeing and Adult Social Care) considered a report from the Director of Adult Social Care that provided an overview of the development of the City's first intermediate residential care facility in the south of Leeds.

The service will form an integrated part of a seamless continuum of services linking health promotion, preventative services, social care, and support for carers and acute hospital care. It supports the future commissioning priorities of Adult Social Care to work with health partners to reshape services at the intermediate tier and provide a service that is responsive and prevents older people needing access to more intensive health and social care support services.

More specifically this jointly commissioned community based service will provide short term assessment, rehabilitation, re-ablement and recovery care, delivered by an integrated health and social care team lead by Leeds Community Healthcare Trust in a residential community setting

Based at ex Harry Booth House in Beeston, the service aims to:

- Enable older people to return to and remain in their own home and to prevent avoidable admissions to hospital and into long-term care.

- Promote an ethos of re-ablement with the aim of maximising the independence of service users.

- Work in a co-ordinated and integrated way with complimentary community based health and social care services and share the responsibility for achieving improved customer outcomes

- Provide a high quality recovery and reablement service within in a safe environment

Since the submission of the last report to Scrutiny Board, much more detailed negotiations have taken place with NHS Leeds Community Healthcare Trust aimed at developing this new operating model integrating clinical, therapeutic and social care staff within a single intermediate care unit. In terms of works required to ex Harry Booth House, the primary focus has been on the extensive changes to the building required to reach the very high levels of infection control required to promote faster recovery from illness thereby preventing unnecessary acute hospital re- admission and premature admission to long-term residential care. Complex discussions on the physical changes required extended the design process and delayed the operational date beyond that originally reported to Scrutiny Board.

Following the consideration of a design and cost report to Executive Board in June 2012, the refurbishment of ex Harry Booth House to provide the first integrated intermediate care unit was approved and included within the Council's Capital Programme. Following a tender process, work to adapt ex Harry Booth House commenced in October 2012 and is progressing to programme. The new unit will be handed back by the contractor in early February giving time for furniture and specialist equipment to be installed and IT and nurse call/telecare systems to be commissioned.

The planned operational date for the south unit is the 1 April 2013. Recruitment of the clinical team by Leeds Community Healthcare Trust is now well underway in preparation for the opening of the unit. Care and support staff from ex Harry Booth House will be offered the opportunity to return to work in the new unit should they wish. The Council will retain ownership of the building and provide all hotel services under the new integrated arrangements.

Key performance indicators have been drafted by commissioners to monitor improvements on baseline data supplied from the existing dispersed CIC beds and Seacroft V Ward. These include:

- reductions in length of stay
- increased numbers of referrals from the community
- reductions in the levels of health associated infections
- reductions in dependency at discharge
- reduction in transfers to hospital and long term care
- service user satisfaction

A new name for ex Harry Booth House will be unveiled in the near future following consultation with the Executive Member for Adult Social Care, local members, local community groups and ex residents of Harry Booth House.

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of the Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Well-Being and Adult Social Care)

Date: 21 November 2012

Subject: Review of Children's Congenital Heart Services in England: Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) – referral to the Secretary of State for Health (draft report)

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Not applicable Appendix number: Not applicable	☐ Yes	☒ No

Summary of main issues

1. The purpose of this report is to present the draft report of the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) to support its referral of the Joint Committee of Primary Care Trusts' (JCPCT) decision around the reconfiguration of Children's Congenital Cardiac Surgical Centres across England.

2. The Joint HOSC is scheduled to meet on 16 November 2012 to consider its draft report, which is attached for consideration by the Scrutiny Board (Health and Wellbeing and Adult Social Care).

Background

3. Proposals around the future of Children's Congenital Heart Services in England were launched for public consultation on 1 March 2011, running until 1 July 2011.

4. In October 2011, the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) (Joint HOSC) agreed its consultation response and a detailed report. The Joint HOSC subsequently referred its formal report to the Secretary of State for Health on the basis of inadequate consutation.

5. At its meeting on 4 July 2012, the JCPCT agreed consultation Option B for implementation and the designation of congenital heart networks led by the following surgical centres:

    - Newcastle upon Tyne Hospitals NHS Foundation Trust
    - Alder Hey Children's Hospital NHS Foundation Trust
    - Birmingham Children's Hospital NHS Foundation Trust
    - University Hospitals of Bristol NHS Foundation Trust

- Southampton University Hospitals NHS Foundation Trust
- Great Ormond Street Hospital for Children NHS Foundation Trust
- Guy's and St. Thomas' NHS Foundation Trust

6. At its meeting on 24 July 2012, the Joint HOSC considered the JCPCT's decision and the associated Decision-Making Business Case made the following resolutions:

   (a) That the 4 July 2012 decision of the Joint Committee of Primary Care Trusts, regarding the future reconfiguration of Children's Congenital Cardiac Surgical Centres, and associated network configuration, be referred to the Secretary of State for Health for consideration, on the basis of the decision not being in the interest of the local NHS.

   (b) That, reflecting the evidence considered and the issues raised by members of the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber), a draft report be prepared to support the referral to the Secretary of State for Health

7. At its meeting on 25 July 2012, the Scrutiny Board (Health and Wellbeing and Adult Social Care) considered an update on the work of the Joint HOSC and received an update from the Chair in this regard. Members of the Scrutiny Board discussed the details presented at the meeting.

8. Such were the implications of the JCPCT's decision on the LGI and patient care in Leeds, that the Scrutiny Board concluded that it was appropriate to refer the decision to the Secretary of State.

9. .

Recommendations

10. To consider the attached information and determine the content of the Scrutiny Board's referral report to the Secretary of State for Health, in this regard.

7.0 Background documents[1]

None used

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of the Head of Scrutiny and Member Development

Report to the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber)

Date: 16 November 2012

Subject: Review of Children's Congenital Heart Services in England: Referral to the Secretary of State for Health – draft report

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Not applicable Appendix number: Not applicable	☐ Yes	☒ No

Summary of main issues

1. Proposals around the future of Children's Congenital Heart Services in England were launched for public consultation on 1 March 2011, running until 1 July 2011.

2. At its meeting on 4 October 2011, the Joint HOSC agreed its consultation response and outline report. The Joint HOSC submitted its formal response to the consultation on 5 October 2011 and subsequently issued a formal report to the Joint Committee of Primary Care Trusts (JCPCT) – as the appropriate decision-making body – on 10 October 2011.

3. At its meeting on 4 July 2012, the JCPCT agreed consultation Option B for implementation and the designation of congenital heart networks led by the following surgical centres:

    - Newcastle upon Tyne Hospitals NHS Foundation Trust
    - Alder Hey Children's Hospital NHS Foundation Trust
    - Birmingham Children's Hospital NHS Foundation Trust
    - University Hospitals of Bristol NHS Foundation Trust
    - Southampton University Hospitals NHS Foundation Trust
    - Great Ormond Street Hospital for Children NHS Foundation Trust
    - Guy's and St. Thomas' NHS Foundation Trust

4. A formal response to the Joint HOSC's report was received on 18 July 2012 and considered at the Joint HOSC's previous meeting on 24 July 2012.

5. At the same meeting (24 July 2012) the Joint HOSC considered the JCPCT's decision and the associated Decision-Making Business Case. The Joint HOSC also heard from a range of interested parties / stakeholders, including:

    - The JCPCT and supporting secretariat;
    - Parent representatives;
    - The Children's Heart Surgery Fund;
    - Leeds Teaching Hospitals NHS Trust
    - Executive Member for Health and Wellbeing (Leeds City Council)
    - Stuart Andrew (MP)

6. At that meeting, the Joint HOSC made the following resolutions:

    (a) That the 4 July 2012 decision of the Joint Committee of Primary Care Trusts, regarding the future reconfiguration of Children's Congenital Cardiac Surgical Centres, and associated network configuration, be referred to the Secretary of State for Health for consideration, on the basis of the decision not being in the interest of the local NHS.

    (b) That, reflecting the evidence considered and the issues raised by members of the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber), a draft report be prepared to support the referral to the Secretary of State for Health

7. The purpose of this report is to present the draft report to support the referral to the Secretary of State for Health detailed above.

Recommendations

8. That the Joint HOSC:
    a. Considers the details presented in draft report and identifies any necessary amendments; and,
    b. Subject to any amendments, agree the report for submission to the Secretary of State for Health.

1.0 Purpose of this report

1.1 The purpose of this report is to present the draft report to support the referral to the Secretary of State for Health of the decision of the Joint Committee of Primary Care Trusts (JCPCT) decision in relation to the review of Children's Congenital Heart Services in England and the reconfiguration of designated surgical centres.

2.0 Background information

2.1 Proposals around the future of Children's Congenital Heart Services in England were launched for public consultation on 1 March 2011, running until 1 July 2011

2.2 At its meeting on 4 October 2011, the Joint HOSC agreed its consultation response and outline report. The Joint HOSC submitted its formal response to the consultation on 5 October 2011 and subsequently issued a formal report to the Joint Committee of Primary Care Trusts (JCPCT) – as the appropriate decision-making body – on 10 October 2011.

2.3 A formal response to the Joint HOSC's report was received on 18 July 2012 and considered at the Joint HOSC's previous meeting on 24 July 2012.

2.4 The Joint HOSCs report highlighted a number of areas that it believed required further and more detailed consideration, while the overall view of the Joint HOSC was that any future service model that did not include a designated children's cardiac surgical centre at Leeds would have a disproportionately negative impact on the children and families across Yorkshire and the Humber. This view, as detailed in the full report, was specifically based on the evidence considered in relation to:

- Co-location of services;
- Caseloads;
- Population density;
- Vulnerable groups;
- Travel and access to services;
- Costs to the NHS
- The impact on children, families and friends;
- Established congenital cardiac networks;
- Adults with congenital cardiac disease;
- Views of the people across Yorkshire and the Humber

2.5 In October 2011, the Joint HOSC referred this matter to the Secretary of State for Health on the basis of inadequate consultation. The outcome of this referral was that, while the consultation arrangements overall were deemed satisfactory, there was agreement that some of the information requested by the Joint HOSC (namely the PwC report that tested the assumed patient travel flows and clinical networks under each of the four options presented for public consultation) should have been made available ahead of the consultation deadline.

2.6 Additional comments on the findings of the PwC report that tested the assumed patient travel flows and clinical networks under each of the four options presented for public consultation were issued to the JCPCT at the end of April 2012.

2.7 At its meeting on 4 July 2012, the JCPCT agreed consultation Option B for implementation and the designation of congenital heart networks led by the following surgical centres:

- Newcastle upon Tyne Hospitals NHS Foundation Trust
- Alder Hey Children's Hospital NHS Foundation Trust
- Birmingham Children's Hospital NHS Foundation Trust
- University Hospitals of Bristol NHS Foundation Trust
- Southampton University Hospitals NHS Foundation Trust
- Great Ormond Street Hospital for Children NHS Foundation Trust
- Guy's and St. Thomas' NHS Foundation Trust

3.0 Main issues

3.1 At its meeting on 24 July 2012, the Joint HOSC considered the JCPCT's decision and the associated Decision-Making Business Case. The Joint HOSC also heard from a range of interested parties / stakeholders, including:

- The JCPCT and supporting secretariat;
- Parent representatives;
- The Children's Heart Surgery Fund;
- Leeds Teaching Hospitals NHS Trust
- Executive Member for Health and Wellbeing (Leeds City Council)
- Stuart Andrew (MP)

3.2 At that meeting, the Joint HOSC made the following resolutions:

(a) That the 4 July 2012 decision of the Joint Committee of Primary Care Trusts, regarding the future reconfiguration of Children's Congenital Cardiac Surgical Centres, and associated network configuration, be referred to the Secretary of State for Health for consideration, on the basis of the decision not being in the interest of the local NHS.

(b) That, reflecting the evidence considered and the issues raised by members of the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber), a draft report be prepared to support the referral to the Secretary of State for Health

3.3 The purpose of this report is to present the draft report to support the referral to the Secretary of State for Health detailed above.

4.0 Corporate Considerations

4.1 Consultation and Engagement

4.1.1 There are no specific considerations relevant to this report.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 When initially considering the potential impact of the proposed changes during the consultation period, the Joint HOSC considered a regional Health Impact Assessment (HIA) produced by the Yorkshire and Humber Specialised Commissioning Group (SCG) and a nationally commissioned Interim HIA report, produced by Mott McDonald.

4.2.2 Both reports identified potential negative impacts associated with three of the proposed options put forward for consultation. In particular, the HIA interim report produced by Mott McDonald identified the following as vulnerable groups:

- Children (under 16s)* who are the primary recipient of the services under review and, therefore, most sensitive to service changes;
- People who experience socio-economic deprivation;
- People from Asian ethnic groups, particularly those with an Indian, Pakistani, Bangladeshi and other Indian subcontinent heritage;
- Mothers who smoke during pregnancy; and
- Mothers who are obese during pregnancy;

These are defined as vulnerable groups because they are more likely to need the services under review and, are most likely to experience disproportionate impacts.

4.2.3 A finalised Health Impact Assessment report has been completed (dated June 2012) and was referenced as an appendix to the Decision-Making Business Case. A summary analysis of the impacts of the different configurations of surgical centres considered by the JCPCT was included within the Decision-Making Business Case document itself This provided high level analysis (i.e. on a national level) of the total number of patients, including those living within vulnerable postcode districts, who would experience significant travel impacts under the various configuration models considered. A regional breakdown of the overall numbers was not provided in the Decision-Making Business Case, however maps of the country identifying the vulnerable postcode districts experiencing significant travel time impacts are included in the final HIA report (June 2012) produced by Mott MacDonald.

4.2.4 Prior to finalising its initial report in October 2011, the Joint HOSC requested a detailed breakdown of information on the likely impacts on identified vulnerable groups across Yorkshire and the Humber (as referred to in the Health Impact Assessment (interim report)). This information has not been provided.

4.3 Council Policies and City Priorities

4.3.1 There are no specific considerations relevant to this report.

4.4 Resources and Value for Money

4.4.1 Prior to completing its report in October 2011, the Joint HOSC was advised that the proposed model of care for the delivery of children's congenital cardiac services was likely to result in an increased level of expenditure. The Joint HOSC was also specifically advised of a likely significant increase in costs associated with the transport and retrieval service in Yorkshire and the Humber.

4.4.2 Financial analysis details considered by the JCPCT were presented in Chapter 14 of the Decision-Making Business Case.

4.5 Legal Implications, Access to Information and Call In

4.5.1 This report does not contain any exempt or confidential information.

4.6 Risk Management

4.6.1 There are no specific considerations relevant to this report.

5.0 Conclusions

5.1 At its meeting on 4 July 2012 , the JCPCT agreed consultation Option B for implementation and the designation of congenital heart networks led by the following surgical centres:

- Newcastle upon Tyne Hospitals NHS Foundation Trust
- Alder Hey Children's Hospital NHS Foundation Trust
- Birmingham Children's Hospital NHS Foundation Trust
- University Hospitals of Bristol NHS Foundation Trust
- Southampton University Hospitals NHS Foundation Trust
- Great Ormond Street Hospital for Children NHS Foundation Trust
- Guy's and St. Thomas' NHS Foundation Trust

5.2 At its meeting on 24 July 2012, the Joint HOSC considered the JCPCT's decision and the associated Decision-Making Business Case. The Joint HOSC also heard from a range of interested parties / stakeholders, including:

- The JCPCT and supporting secretariat;
- Parent representatives;
- The Children's Heart Surgery Fund;
- Leeds Teaching Hospitals NHS Trust
- Executive Member for Health and Wellbeing (Leeds City Council)
- Stuart Andrew (MP)

5.3 At that meeting, the Joint HOSC made the following resolutions:

(c) That the 4 July 2012 decision of the Joint Committee of Primary Care Trusts, regarding the future reconfiguration of Children's Congenital Cardiac Surgical Centres, and associated network configuration, be referred to the Secretary of State for Health for consideration, on the basis of the decision not being in the interest of the local NHS.

(d) That, reflecting the evidence considered and the issues raised by members of the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber), a draft report be prepared to support the referral to the Secretary of State for Health

5.4 The purpose of this report is to present the draft report to support the referral to the Secretary of State for Health detailed above

6.0 Recommendations

6.1 That the Joint HOSC:

(a) Considers the details presented in draft report and identifies any necessary amendments; and,
(b) Subject to any amendments, agree the report for submission to the Secretary of State for Health

7.0 Background documents[1]

None used

[1] The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

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Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 247 4707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Wellbeing and Adult Social Care)

Date: 21 November 2012

Subject: Work Schedule – November 2012

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	☐ Yes	☒ No
Are there implications for equality and diversity and cohesion and integration?	☐ Yes	☒ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	☒ No

1 Purpose of this report

1.1 The purpose of this report is to consider the Scrutiny Board's work schedule for the forthcoming municipal year.

2 Main issues

2.1 The work schedule, as agreed at the previous meeting (24 October 2012) is attached at Appendix 1. This incorporates the areas previously discussed and identified for inclusion in the work schedule, including the following matters raised at the October meeting:

- Public Health transition update. This will include details of any Public Health funding allocations that may have been announced (scheduled for January 2013);
- Progress update against the Local Account (scheduled for March 2013)

2.2 Attached at Appendix 2 are the minutes from the Executive Board meeting held on 17 October 2012.

2.3 It should be noted, that the Chair of the Board has received a formal request from a member of the Board (Cllr Robinson) for the Board to examine 'the matter of the 'care ring' service in Leeds, the recent consultation and Adult Social Care's plan for this service'. Councillor Robinson stated, 'The consultation on an introduction of charges for this service could risk people opting out as they cannot afford it or refuse to pay, and may put elderly and vulnerable people at risk.'

2.4 Within the context of its overall work schedule, Members of the Scrutiny Board are asked to consider this request in more detail.

2.5 Following the Board's consideration of the Core Strategy at its previous meeting, a copy of the Board's statement agreed with the Chair is attached at Appendix 2 for information. Members should note that the statement was presented to Scrutiny Board (Sustainable Economy and Culture) at its meeting on 1 November 2012 and appended to the formal Scrutiny submission presented to Executive Board on 7 November 2012.

2.6 It should be noted that the work schedule is likely to be subject to change throughout the municipal year, to reflect any emerging issues and/or any changes in the Scrutiny Board's priorities.

3 Recommendations

3.1 Members are asked to:

a) Note the information presented; and,
b) Consider the current outline work schedule and agree any amendments if/ where appropriate.

4. Background papers[1]

None used

[1]The background documents listed in this section are available to download from the Council's website, unless they contain confidential or exempt information. The list of background documents does not include published works.

Scrutiny Board (Health and Wellbeing and Adult Social Care) 2012/13 Municipal Year **Appendix 1**

	Schedule of meetings/visits during 201213		
Area of review	**June**	**July**	**August**
Dementia in Leeds		Draft Strategy SB 25 July 2012 @ 10 am	
Mental Health Services in Leeds			
Loneliness and Social Isolation		Initial briefing around issues SB 25 July 2012 @ 10 am	
Balancing planning authority duties with future public health responsibilities			
Review of Partnership effectiveness and associated arrangements			
Other (details defined)		• Review of Children's Congenital Cardiac Services • Review of Services for Adults with Congenital Heart Disease SB 25 July 2012 @ 10 am	Call-in – Decision around the replacement Adult Social Care Records System. SB 9 August 2012 @ 2:30 pm
Briefings	• Potential work areas/ topics • Equality Improvement Priorities SB 27 June 2012 @ 10 am		
Budget & Policy Framework Plans			
Recommendation Tracking			
Performance Monitoring	2011/12 Quarter 4 performance report SB 27 June 2012 @ 10 am		

Key: SB – Scrutiny Board (Health and Wellbeing and Adult Social Care) Meeting WG – Working Group Meeting

Updated: November 2012

	Schedule of meetings/visits during 201213		
Area of review	**September**	**October**	**November**
Dementia in Leeds			
Mental Health Services in Leeds	• Mental Health Needs Assessment • Current Provision • Leeds Suicide Audit SB 26 September 2012 @ 10 am		
Loneliness and Social Isolation			
Balancing planning authority duties with future public health responsibilities		Report to SB SB 24 October 2012 @ 10 am	
Review of Partnership effectiveness and associated arrangements			

Key: SB – Scrutiny Board (Health and Wellbeing and Adult Social Care) Meeting WG – Working Group Meeting

Updated: November 2012

Scrutiny Board (Health and Wellbeing and Adult Social Care) 2012/13 Municipal Year **Appendix 1**

	Schedule of meetings/visits during 201213		
Area of review	**September**	**October**	**November**
Transformation of Health and Social Care			Update reports from previous Scrutiny Inquiry, relating to: (a) Recommendation 7 – risk stratification (b) Recommendation 8 – integrated health and social care teams (including lessons from demonstrator sites) (c) Recommendation 9 – partnership arrangements ASC / LYPFT (d) Recommendation 10 – update on general governance arrangements associated with service integration (e) Recommendation 11 – Harry Booth House progress SB 21 November 2012 @ 10 am
Other (details defined)	Update on Services for the Blind and Visually Impaired SB 26 September 2012 @ 10 am	Consideration of the draft Adult Social Care Local Account SB 24 October 2012 @ 10 am	Health Service Developments Working Group – update on the work of Clinical Commissioning Groups WG date to be determined
Briefings			Transformation of Health and Social Care – overview of the work of the Transformation Board WG 7 November 2012
Budget & Policy Framework Plans			

Key: SB – Scrutiny Board (Health and Wellbeing and Adult Social Care) Meeting WG – Working Group Meeting

Updated: November 2012

Scrutiny Board (Health and Wellbeing and Adult Social Care) 2012/13 Municipal Year **Appendix 1**

	Schedule of meetings/visits during 201213		
Area of review	**September**	**October**	**November**
Recommendation Tracking			
Performance Monitoring	• 2012/13 Quarter 1 performance report • NHS Airedale Bradford and Leeds Cluster – performance report SB 26 September 2012 @ 10 am	• 2012/13 Quarter 1 performance report (Pubic Health) SB 24 October 2012 @ 10 am	

Key: SB – Scrutiny Board (Health and Wellbeing and Adult Social Care) Meeting WG – Working Group Meeting

Updated: November 2012

Scrutiny Board (Health and Wellbeing and Adult Social Care) 2012/13 Municipal Year **Appendix 1**

	Schedule of meetings/visits during 201213		
Area of review	**December**	**January**	**February**
Dementia in Leeds		Update on Strategy and Action Plan SB 23 January 2013 @ 10 am	
Mental Health Services in Leeds	WG – date to be determined		WG – date to be determined
Loneliness and Social Isolation	WG – date to be determined		WG – date to be determined
Balancing planning authority duties with future public health responsibilities			
Review of Partnership effectiveness and associated arrangements			
Other (details defined)	Care Quality Commission – local activity report SB 19 December 2012 @ 10 am Quality Accounts: Updates on progress/ priorities identified in 2012 from: • LTHT • LYPFT • LCH • YAS (particularly focus on Patient Transport Service performance/ progress) To include commissioner assurance – NHS ABL/ CCGs. SB 19 December 2012 @ 10 am	Update on progress against the Leeds Tobacco Action Plan and previous Scrutiny Board recommendations. Public Health transition update – to include details of any Public Health funding allocations that may have been announced. SB 23 January 2013 @ 10 am Health Service Developments Working Group WG date to be determined	Update on Services for the Blind and Visually Impaired SB 20 February 2013 @ 10 am Draft Quality Accounts for 2012/13 from: • LTHT • LYPFT • LCH • YAS To include commissioner assurance – NHS ABL/ CCGs. SB 20 February 2013 @ 10 am

Key: SB – Scrutiny Board (Health and Wellbeing and Adult Social Care) Meeting WG – Working Group Meeting

Updated: November 2012

Scrutiny Board (Health and Wellbeing and Adult Social Care) 2012/13 Municipal Year **Appendix 1**

	Schedule of meetings/visits during 201213		
Area of review	**December**	**January**	**February**
Briefings			
Budget & Policy Framework Plans			
Recommendation Tracking			
Performance Monitoring	• 2012/13 Quarter 2 performance report • NHS Airedale Bradford and Leeds Cluster – performance report SB 19 December 2012 @ 10 am		

Key: SB – Scrutiny Board (Health and Wellbeing and Adult Social Care) Meeting WG – Working Group Meeting

Updated: November 2012

Scrutiny Board (Health and Wellbeing and Adult Social Care) 2012/13 Municipal Year **Appendix 1**

	Schedule of meetings/visits during 201213		
Area of review	**March**	**April**	**May**
Dementia in Leeds			
Mental Health Services in Leeds			
Loneliness and Social Isolation			
Balancing planning authority duties with future public health responsibilities			
Review of Partnership effectiveness and associated arrangements	Annual Assessment by the SB SB 27 March 2013 @ 10 am		
Other (details defined)	Progress update against the Local Account SB 27 March 2013 @ 10 am Health Service Developments Working Group WG date to be determined	Health Service Developments Working Group WG date to be determined	
Briefings			
Budget & Policy Framework Plans			
Recommendation Tracking			
Performance Monitoring	• 2012/13 Quarter 3 performance report • NHS Airedale Bradford and Leeds Cluster – performance report SB 27 March 2013 @ 10 am		

Key: SB – Scrutiny Board (Health and Wellbeing and Adult Social Care) Meeting WG – Working Group Meeting

Updated: November 2012

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EXECUTIVE BOARD

WEDNESDAY, 17TH OCTOBER, 2012

PRESENT: Councillor K Wakefield in the Chair

Councillors J Blake, M Dobson, P Gruen, R Lewis, L Mulherin and A Ogilvie

Councillor R Downes – Substitute Member
Councillor C MacNiven – Substitute Member
Councillor J Procter – Substitute Member

79 Substitute Members

Under the terms of Executive and Decision Making Procedure Rule 2.3, Councillors J Procter, R Downes and C MacNiven were invited to attend the meeting on behalf of Councillors A Carter, S Golton and L Yeadon respectively, who had all submitted their apologies for absence from the meeting.

80 Exempt Information - Possible Exclusion of the Press and Public

RESOLVED – That the public be excluded from the meeting during the consideration of the following parts of the agenda designated as exempt 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 public were present there would be disclosure to them of exempt information so designated as follows:-

(a) Appendix 1 to the report referred to in Minute No. 84 under the terms of Access to Information Procedure Rule 10.4(3) and Appendix 2 to the same report under the terms of Access to Information Procedure Rule 10.4(5) on the grounds that the information contained within the Appendices relates to the financial or business affairs of any particular person (including the authority holding that information). Specifically, Appendix 1 relates to costs which are confidential due to the competition to attract the Tour, whilst Appendix 2 includes details of the Heads of Terms of any contract between Welcome to Yorkshire and Leeds City Council. It is therefore considered that the public interest in maintaining the content of Appendix 1 and 2 as exempt outweighs the public interest in disclosing the information.

(b) Appendix B to the report referred to in Minute No. 92 under the terms of Access to Information Procedure Rule 10.4(3) and on the grounds that it contains information relating to the financial and business affairs of GMV –Twelve and the Council. The public interest in maintaining the exemption in relation to Appendix B outweighs the public interest in disclosing the information by reason of the fact that it contains information and financial details which, if disclosed, would adversely affect the business of the Council and GMV – Twelve.

81 Declaration of Disclosable Pecuniary and Other Interests

Councillor Gruen declared an 'Other Significant Interest' in respect of the matters contained within agenda item 21, 'Basic Need Programme – Outcome of Competitions to Create Two New Primary Schools', as a member of LEAF Academy Trust (Minute No. 98 refers).

Councillors J Procter and Downes both declared 'Other Significant Interests' in respect of the matters contained within agenda items 13 'Review of Governance Arrangements in West Yorkshire', 14 'West Yorkshire Plus Transport Fund', 15 'Support to the Leeds Rail Growth Package' and 16 'New Generation Transport (NGT) Scheme', due to their respective positions on the West Yorkshire Integrated Transport Authority (Minute Nos. 90, 91, 92 and 93 refer respectively).

A further declaration was made at a later point in the meeting (Minute No. 92 refers).

82 Minutes

RESOLVED – That the minutes of the meeting held on 5th September 2012, be approved as a correct record.

LEISURE AND SKILLS

83 Garforth Leisure Centre

Further to Minute No. 205, 30th March 2011, the Director of City Development submitted a report regarding the current position in respect of the Executive Board resolution to explore the possible Community Asset Transfer (CAT) of Garforth Leisure Centre to the Schools Partnership Trust. In addition, the report also outlined new proposals relating to the status of the CAT process and details regarding the operational performance of Garforth Leisure Centre.

Prior to the meeting, Board Members had received correspondence clarifying the content of the Equality, Diversity, Cohesion and Integration Screening Document, which was appended to the report, in order to ensure that Members had all relevant information before them when considering the matter.

The Board paid tribute to the work which had been undertaken to successfully improve the operating performance of the centre, and it was suggested that a similar approach could be taken when looking to improve the performance of other centres, where appropriate.

Members highlighted the need to ensure that a collaborative and robust approach was taken when considering potential Community Asset Transfers in the future.

RESOLVED –

(a) That the proposal to explore the potential of a community asset transfer of Garforth Leisure Centre to the School Partnership Trust be discontinued.

(b) That Garforth Leisure Centre be retained under Council management on 58.5 hours per week.

(c) That the Council seeks to enter into partnership with the School Partnership Trust (and other interested parties) with the aim of seeking to extend the opening hours beyond 58.5 hours per week.

84 Tour de France: The Grand Depart in Yorkshire

The Director of City Development submitted a report outlining a proposal to host the "The Grand Départ" of The Tour de France in Yorkshire. The report detailed the associated opportunities and implications and sought approval to enter into agreement with 'Welcome to Yorkshire' in order to bring the Tour to Leeds and to contribute towards the associated costs.

The Board highlighted the significant opportunities that the hosting of "The Grand Départ" would present for the both the city and the region. Members then discussed the potential financial implications associated with holding the event and it was agreed that Board Members and Group Leaders would receive regular updates in respect of such matters. In addition, when details of any potential routes were known, it was requested that relevant Ward Members were kept informed, as appropriate.

Following consideration of Appendices 1 and 2 to the submitted report, designated as exempt under Access to Information Procedure Rules 10.4(3) and 10.4(5) respectively, which were considered in private at the conclusion of the meeting, it was

RESOLVED – That with the concurrence of the Leader of the Council, delegated authority be provided to the Chief Executive, to enter into an agreement with 'Welcome to Yorkshire' in order to enable Leeds City Council to confirm its commitment to staging the Grand Départ within the parameters, as outlined within the exempt appendices to the submitted report.

ADULT SOCIAL CARE

85 Strategy for Governance in Integrated Working with Health

The Director of Adult Services submitted a report regarding the means by which more integrated commissioning and service provision between NHS commissioners and service providers and their Local Authority counterparts could be encouraged and supported in the future. In addition, the report set out the intention to use the powers contained within the 2006 Health Act, in order to utilise legal flexibilities to ensure good governance and accountability for the use of public funds in the pursuit of joint improvement. Also, the report detailed the intention to have one overall Section 75 Agreement to cover all joint commissioning arrangements between Leeds City Council Adult Social

Care and NHS Leeds or its successors and outlined how other dedicated Section 75 agreements would be used to ensure good governance and accountability between providers of NHS care for specific services and their Local Authority counterparts.

RESOLVED –

(a) That the approach to Section 75, Section 76 and Section 256 agreements for the governance and pooling of Health and Social Care resources be endorsed.

(b) That the process for the Director of Adult Social Services to approve future agreements under the delegations afforded to her within the Council's Constitution, Officer Delegation Scheme (Executive Functions), be noted.

(c) That it be noted that the agreements will be subject to formal review every 3 years, but monitored annually during this time in order to assure their continuing relevance and effectiveness.

RESOURCES AND CORPORATE FUNCTIONS

86 Financial Health Monitoring 2012/13 - Month 5 Report

The Director of Resources submitted a report setting out the Council's projected financial health position for 2012/2013 after five months of the financial year.

RESOLVED – That the projected financial position of the authority after five months of the financial year be noted.

87 Financial Strategy 2013 to 2017

The Director of Resources submitted a report regarding the development of a medium to long term financial strategy for the Council, providing information on the Government's technical consultation exercise upon Business Rates Retention and highlighting the potential implications for the Council's financial strategy.

Concerns were raised in respect of the funding of the Government's New Homes Bonus initiative, and the significant implications it potentially had for Local Authorities such as Leeds. Members also highlighted the important role to be played by brownfield development in respect of housing provision in Leeds. In response, it was agreed that cross-party representations were made to Government in relation to the issues which had been raised.

Responding to an enquiry, the Board was provided with assurances regarding departmental spending levels, and it was highlighted that such spending levels had not increased in real terms.

RESOLVED –

(a) That the contents of the submitted report, together with the response to the Technical Consultation, as detailed within Appendix 2, be noted.

(b) That it be noted that a further report on the development of the Council's financial strategy will be submitted to the December 2012 meeting of the Board as part of the Council's Initial Budget proposals for 2013/2014.

(c) That an all-party letter be submitted to Government regarding the issues which had been raised during the meeting in relation to the New Homes Bonus initiative.

88 Leeds City Region Business Rates Pool

The Director of Resources submitted a report regarding the development of the proposed Leeds City Region (LCR) business rates pool, outlining the benefits of pooling and seeking approval for Leeds to act as the "lead authority" for the LCR pool.

Prior to the meeting, Board Members had received correspondence clarifying the content of the Equality, Diversity, Cohesion and Integration Screening Document, which was appended to the report, in order to ensure that Members had all relevant information before them when considering the matter.

RESOLVED –

(a) That the inclusion of Leeds within the final pooling proposal, to be submitted on behalf of the Leeds City Region, be approved.

(b) That the governance arrangements, as appended to the submitted report be approved in principle, and that the responsibility for finalising detailed matters be delegated to the Director of Resources.

(c) That it be agreed that Leeds should act as the "lead authority" for the proposed pool.

(d) That a further report be presented to the December 2012 Board meeting, once the 2013/2014 funding details are known, so that a final decision on whether to go ahead can be taken.

89 Community Right to Challenge

Further to Minute No. 221(C), 7th March 2012, the Director of Resources submitted a report providing an update on the Community Right to Challenge initiative, whilst also facilitating an opportunity for the Board to consider how the Council would implement the legislation within the Localism Act 2011.

Members highlighted the need to ensure that community organisations were fully engaged in the proposed process, and that, in progressing this matter, it was requested that a further report be submitted to the Board on how the Council was engaging more proactively with community organisations in respect of service provision.

RESOLVED –

(a) That the publication of the Localism Act 2011 regulations, be noted.

(b) That the following proposed approach to decisions upon Community Right to Challenge expressions of interest be endorsed:-

(i) PPPU/PU and directorates jointly consider any expression;
(ii) Relevant Members are consulted and the Executive Board Member who is responsible for the service area that is being considered in the expression of interest may refer the expression to Executive Board for a decision;
(iii) Liaison is undertaken with Area Leadership;
(iv) A report is provided jointly by the PPPU/PU lead and the directorate, taking account of feedback;
(v) The Chief Officer PPPU and Procurement approves the report
(vi) The relevant Director makes a decision on an expression, except where referred to Executive Board.

(c) That it be noted that the relevant schemes of delegation will need to be amended to reflect the proposals detailed within resolution (b) above.

(d) That the proposed approach towards engagement, as referred to within paragraph 3.3 of the submitted report, be supported.

(e) That a further report be submitted to the Board on how the Council was engaging more proactively with community organisations in respect of service provision.

90 Review of Governance Arrangements in West Yorkshire

The Assistant Chief Executive (Customer Access and Performance) and the Director of City Development submitted a joint report seeking authority for a statutory review of specified functions to be undertaken with the intention of a further report being prepared in due course to include a draft Scheme of Governance for a Combined Authority, should the Review conclude that this was the most beneficial option for the area, and that it satisfied the statutory tests.

By way of an introduction to the report, the Chief Executive advised that although the primary focus of the proposals was upon transport provision, potentially it could also relate to wider arrangements aimed at the promotion of economic development and regeneration in West Yorkshire. The Board was also informed that York City Council had expressed an interest in being more formally involved in the potential establishment of a Combined Authority for the area.

The suggestion was welcomed that a cross-party approach would be taken in respect of the further work to be carried out on the potential establishment of a Combined Authority.

RESOLVED –

(a) That it be agreed that the Council should be party, together with other West Yorkshire Authorities (including the ITA), to a Review of governance arrangements relating to transport, economic development and regeneration in West Yorkshire, pursuant to Section 108 of the Local Democracy, Economic Development and Construction Act 2009 and Section 82 of the Local Transport Act 2008.

(b) That the Chief Executive in consultation with the Leader be authorised to commission the preparation of the Review, in consultation with the other West Yorkshire Authorities.

(c) That the Chief Executive in consultation with the Leader be authorised to commission the preparation (in consultation with the other West Yorkshire Authorities) of a draft Scheme for a Combined Authority for consideration by Executive Board and Council, if the Review recommends that a Combined Authority would be the most beneficial option for West Yorkshire.

(d) That the provisional timetable and next steps on the governance review process be noted, including, if appropriate, the submission of a draft Scheme to Executive Board and Council by January 2013 and a final scheme which takes account of consultation and submitted to the Secretary of State by July 2013, in order to be in a position by April 2014 to receive significant devolved powers and funding via the City Deal.

DEVELOPMENT AND THE ECONOMY

91 West Yorkshire Plus Transport Fund

The Director of City Development submitted a report providing an update upon the progress made to date in developing a West Yorkshire Transport Fund and which sought approval to continue the development work, which would enable authorities to confirm the setting up of the Fund and the associated 10 year programme later this year.

Responding to an enquiry, assurances were provided regarding the timescales in place for the fund to reach £1billion and the primary funding sources involved.

RESOLVED –

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

(b) That the further development and progression of the work on the West Yorkshire Plus Transport Fund be agreed.

92 Support to the Leeds Rail Growth Package

The Director of Resources and the Director of City Development submitted a joint report seeking in principle agreement to the Council providing financial assistance to support the delivery of the Leeds Rail Growth Package.

The Board was informed by the City Solicitor that the relevant legal powers detailed within the report under which the financial assistance was being proposed was Section 3 of the Local Authorities (Land) Act 1963. However, Members noted that those powers only covered loans where the person to whom the money was advanced undertook the work. In this instance it would be Metro who built the rail infrastructure, rather than the owner/developer involved. Therefore, the powers in Section 3 would only be appropriate where the recipient of the loan undertook the works, and insofar as this was not the case, then the appropriate power was the new general power of competence within the Localism Act 2011.

Following consideration of Appendix B to the submitted report, designated as exempt under Access to Information Procedure Rules 10.4(3), which was considered in private at the conclusion of the meeting, it was

RESOLVED – That in principle agreement be given to the Council providing financial assistance to support the delivery of the Leeds Rail Growth Package, but that this be subject to the finalisation of the agreement of terms and conditions which ensure that the Council's position is as secure as possible, and that final agreement be sought from Executive Board.

(Prior to the consideration of the exempt appendix to this item and the subsequent resolutions made by the Board, Councillor Wakefield vacated his position of Chair and left the meeting room for the remainder of the discussion. This was due to Councillor Wakefield's potential decision making role with respect to the Growing Places Fund, and wanted to avoid any perception of bias or predetermination on this matter. Councillor Blake assumed the position of Chair for the duration of the discussion upon the exempt appendix and the subsequent making of the resolutions).

93 New Generation Transport (NGT) Scheme

Further to Minute No. 220, 18th May 2011, the Director of City Development submitted a report providing an update on the New Generation Transport (NGT) scheme following the Department for Transport's confirmation of Programme Entry Approval. In addition, the report sought approval to a capital programme injection and spend which would enable a Transport and Works Order to be submitted to the Secretary of State for Transport for powers to construct and operate the scheme.

It was requested that when appropriate, political groups received briefings in respect of the proposals regarding route alignments.

RESOLVED –

(a) That the contents of the submitted report be noted.

(b) That authority be given to spend £1,200,000 from within the existing Capital Programme in order to progress the scheme which would enable a Transport and Works Order to be submitted to the Secretary of State for Transport for powers to construct and operate the scheme.

94 Planning Applications Highways issues (White Paper 16)

Further to Minute No. 235, 11th April 2012, the Director of City Development submitted a report providing an update on the further four month trial period undertaken in relation to Ward Member notification of planning applications on which Highways had been consulted. The report included Member feedback received on the success and value of the process and sought agreement to the continuation of the current notification process without further modification.

RESOLVED –

(a) That the issues raised during the further four month Member consultation trial period and the views raised from the Member feedback exercise, be noted.

(b) That it be agreed that the current process be adopted in its current format.

(c) That it be noted that amended processes to improve public engagement at the pre-application stage have been proposed by the Chief Planning Officer with support from the Executive Member for Neighbourhoods, Planning and Support Services and that such proposals were noted at Full Council on 12 September 2012.

ENVIRONMENT

95 Green Deal Go Early

The Director of Environment and Neighbourhoods submitted a report providing an update on a recently announced grant opportunity for energy efficiency improvements, linked to the City Deal. In addition, the report sought authority to spend a capital grant of £1,280,000 on energy efficiency grants and loans in 2012-2013 and to make a contingency budget of £10,000 available in 2013-14. The report also sought approval for the proposed approach towards the targeting and marketing of the grants and loans.

RESOLVED –

(a) That the proposed delivery approach, as described within section 3 of the submitted report, be approved.

(b) That approval be given to use the outcome of the current Leeds City Region Domestic Energy Efficiency Programme (LCR DEEP) tender process to award contract(s) to the highest scoring bidder(s) to manage and deliver each of the lots that make up the different elements of this project.

(c) That approval be given to the injection of, and the authority to spend the Department of Energy, Climate and Change grant of £1,278,400 on a mixture of grants and loans for energy efficiency measures, together with associated administration costs.

(d) That approval be given to move £10,000 of the existing 'Wrap Up Leeds' budget from 2012-2013 to 2013-2014, as contingency for up to 20 small grants.

(e) That the necessary authority be delegated to the Director of Environment and Neighbourhoods to take operational decisions in order to ensure that the grant is fully disbursed.

(f) That approval be given to ring-fence the loan repayments in an account to be spent on future domestic energy efficiency projects, particularly preparing for the Green Deal and tackling fuel poverty.

NEIGHBOURHOODS, PLANNING AND SUPPORT SERVICES

96 Gambling Act 2005 Statement of Licensing Policy

The Head of Licensing and Registration submitted a report advising of the progress made in respect of the triennial review of the Gambling Act 2005 Statement of Licensing Policy and which sought approval for the matter to be referred to full Council for approval in accordance with the Budget and Policy Framework.

RESOLVED – That the contents of the submitted report be noted and that the matter be referred to the 14th November 2012 full Council meeting for approval, in line with the Budget and Policy Framework.

(The resolutions referred to within this minute were not eligible for Call In, as the ultimate determination of such matters are reserved to Council, in line with the Council's Budget and Policy Framework)

97 Review of ALMO Arrangements

Further to Minute No. 111, 3rd November 2010, the Assistant Chief Executive (Customer Access and Performance) submitted a report setting out the background to the review of housing management services in Leeds and the proposal to extend the Management Agreements with the ALMOs for up to an additional year.

Responding to an enquiry, the Board was provided with assurances regarding the inclusive approach towards communication and consultation which would be undertaken with tenants and Elected Members in respect of any proposals regarding future ALMO arrangements.

RESOLVED –

(a) That a report be submitted to the December 2012 Executive Board meeting, in order to consider the option(s) for the future governance and delivery arrangements for the management of council housing in Leeds, prior to wider consultation on the future direction.

(b) That an extension in the term of contract for the ALMOs for a period of up to one year be agreed, in order to allow time for the review to be concluded and any current arrangements implemented.

CHILDREN'S SERVICES

98 Basic Need Programme - Outcome of competitions to Create two new Primary Schools

Further to Minute No. 181, 4th January 2012, the Director of Children's Services and the Director of Environment and Neighbourhoods submitted a joint report on the outcome of two competitions held to establish new primary schools in Harehills and South Leeds. The report outlined a recommendation relating to the preferred bidders to run the new schools, a final decision for which was required to be made by no later than 20th October 2012.

The Board noted that representations had been received from one organisation who had submitted a bid, but who had not been identified as one of the organisations recommended to run one of the schools. The representations were in relation to some perceived inaccuracies within the submitted Executive Board report. Prior to discussing the matter, the Board was provided with details of the perceived inaccuracies and also provided with the accompanying responses from Children's Services.

Members raised concerns regarding the increasing number of children starting school across the city and the pressures which as a result were being placed upon school places and education provision. In response it was suggested that Ward Members were invited to become further involved in the work which was ongoing to address this issue.

Responding to an enquiry, the Board was provided with assurances regarding the proposal to close of the Stanley Road Household Waste Sorting Site, specifically in respect of the alternative provision which would be available to service users in the area.

RESOLVED –

(a) That approval be given for the Co-Operative to be the party to open the new 420 place primary school with 26 place FTE nursery at Florence Street, Harehills, to open in September 2013 and to serve families in that area.

(b) That approval be given for the The Learning Trust South Leeds to be the party to open the new 420 place school with a 26 place nursery on land at the former South Leeds Sports Centre, and to open in September 2014 and serve families in that area.

(c) That the closure of the Stanley Road Household Waste Sorting Site be approved, and that agreement be given to the site's incorporation into the Harehills school design (in accordance with section 3.10 of the submitted report).

(The matters referred to within this minute were not subject to Call In, as a decision was required within two months of the end of the 'summary of bids'

notice period, which was no later than 20th October 2012. Therefore, due to the timescales involved, this matter was not subject to Call In)

DATE OF PUBLICATION: 19TH OCTOBER 2012

LAST DATE FOR CALL IN OF ELIGIBLE DECISIONS: 26TH OCTOBER 2012 (5.00 P.M.)

(Scrutiny Support will notify Directors of any items called in by 12.00 p.m. on 29th October 2012)

APPENDIX 3

Scrutiny Board (Health and Wellbeing and Adult Social Care)

Comments on Leeds' draft Local Development Framework Core Strategy

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Balancing the Council's duties as a planning authority with its future public health responsibilities

Introduction and background

1. In November 2008, Professor Sir Michael Marmot was asked by the then Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England. In February 2010, the final report 'Fair Society: Healthy Lives' was published and concluded that reducing health inequalities would require action on the following six policy objectives:

    - Give every child the best start in life;
    - Enable all children, young people and adults to maximise their capabilities and have control over their lives;
    - Create fair employment and good work for all;
    - Ensure healthy standard of living for all;
    - Create and develop healthy and sustainable places and communities;
    - Strengthen the role and impact of ill-health prevention.

2. As part of the NHS reforms arising from the Health and Social Care Act 2012, from April 2013 Public Health responsibilities will transfer from local Primary Care Trusts (which will be abolished and replaced by Clinical Commissioning Groups) to local authorities. This shift in responsibility will mean that local authorities will become directly accountable for public health services and outcomes from April 2013.

3. The Council is preparing the Local Development Framework (LDF) for Leeds, which consists of a number of Development Plan Documents and Supplementary Planning Documents that, together, make up the overall development plan.

4. The Core Strategy is the main document that details the key strategic policies and vision of the Local Development Framework (LDF) – setting out the broad framework that will guide the delivery of development and investment for Leeds over the coming years. All other LDF documents are directly guided by the Core Strategy. The policies set out in the Core Strategy must be supported by and referenced to appropriate evidence.

5. In June 2012, the Scrutiny Board (Health and Wellbeing and Adult Social Care) identified balancing the duties of a planning authority with public health responsibilities (through the Local Development Framework (LDF)) as a potential area for consideration during 2012/13. Recognising the on-going work of the Development Plan Panel in finalising the LDF Core Strategy, reference to this was again made at the September 2012 meeting of the Scrutiny Board (Health and Wellbeing and Adult Social Care).

Scrutiny process

6. In order to help formulate comments on the draft Core Strategy for Leeds, we considered general issues associated with balancing the Council's duties as a planning authority with its future public health responsibilities, at our meeting on 24 October 2012. We heard from the following representatives, and would like to express our thanks for their input and contribution to our discussions:

    - Councillor L Mulherin (Executive Board Member for Health and Wellbeing), Leeds City Council
    - Dr. Ian Cameron (Joint Director of Public Health) – NHS Airedale Bradford & Leeds/Leeds City Council
    - David Feeney (Head of Forward Planning and Implementation) –City Development, Leeds City Council

7. We were presented with and considered the following source documents/ information:

    - Proposed changes to text within the Core Strategy, to better reflect the health issues and priorities for Leeds and strengthen the relationship between planning and improving public health outcomes.
    - Core Strategy – Leeds Local Development Framework – Health Background Topic Paper (Publication Draft – February 2012)
    - Fair Society, Healthy Lives – The Marmot Review –Strategic Review of Health Inequalities in England post 2010 (Executive Summary)
    - Public Health in Leeds City Council – New Responsibilities – Report of Director of Public Health to the Executive Board (20 June 2012).

8. The Joint Director of Public Health made reference to an additional document produced by Marmot (The Marmot Review: Implications for Spatial Planning), which provided evidence on the relationship between aspects of spatial planning, the built environment, health and health inequalities.

9. The Joint Director of Public Health advised us that representatives from Public Health had contributed to the development of the draft documents presented – in particular the proposed changes to text within the Core Strategy – and had considered the following three broad questions, namely:

    - Whether the Core Strategy reflected planning's contribution to health;
    - Whether the Core Strategy covered the breadth of planning's contribution to health; and,
    - In terms of implementation, whether there was sufficient assurance that the health and wellbeing aspect of planning would become incorporated into development proposals as they occur over future years.

10. While earlier drafts of the Core Strategy had underplayed some of the health challenges facing the City and the potential contribution of planning in helping address such challenges, the Joint Director of Public Health provided assurance that the proposed changes to the Core Strategy text were much more reflective of:

    - The health issues facing the City,
    - The contributions that planning can make towards addressing the health issues facing the City; and
    - The Council's emerging Public Health duties/ responsibilities.

11. We welcome the general assurances provided by the Joint Director of Public Health and recognise that the proposed changes to the text of the Core Strategy significantly strengthen the published consultation draft.

Comments on the draft Core Strategy and other information presented

General matters

12. We discussed general complexities associated with health and well-being and the relationship with inter-dependencies such as employment, income, housing, education and the built environment. As such, we believe it is important that the Core Strategy provides a sufficient framework for areas of the City that have historically had higher levels of deprivation, to benefit from improved greater consideration of the impact of planning and development proposals on the health of the City and local communities.

Greenspace availability

13. We were advised that the general availability and/or provision of green space would form part of the 'site allocation' process. We were advised that this process would consider where different aspects of provision (including green space, housing etc.) should be allocated across the City.

14. We recognise the difficulties associated with creating additional open/ green spaces in existing highly populated urban areas. We welcome the Core Strategy's overall policy aim to improve opportunities for walking and cycling, and access to green infrastructure across the City. However, we believe the protection of existing playing pitches forms an essential part of the general policy objectives and is fundamental to the Council's future public health responsibilities.

15. Furthermore, where issues associated with the re-provision of playing pitches elsewhere in the City are considered, the 'elsewhere' needs to be considered within the context and demographics of those communities where the original provision may be lost.

Health Background Topic paper (February 2012)

16. We were concerned about the rapid Health Impact Assessment process adopted to consider the health implications / considerations of planning (outlined in the Health Background Topic paper). We believe this reinforces and reflects the position that, historically, health implications have not been considered early enough within the planning/ development processes.

17. Nonetheless, we acknowledge the assurances provided by the Joint Director of Public Health, and details of a much closer working relationship between City Development and Public Health that has developed over recent months. We are hopeful that such closer working will continue into the future. We welcome the proposal to establish a health and planning reference group, and believe this has the potential to ensure the policy objectives outlined in the draft Core Strategy are considered and implemented in practice.

18. We queried the accuracy of the population growth projections (approx. 200,000 by 2033 (20 years)) detailed in the Health Background Topic paper (February 2012)), as the projections represented more than double the current health

dynamic in the City (i.e. the difference between current rates of births and deaths in the City). Such population growth projections will have significant potential implications across the City – for example in terms of infrastructure and the availability of affordable housing across the City.

19. We were advised that changes to the affordable housing policy were proposed, which would make the policy applicable to all residential developments (from 1 property upwards). Given the relationship between housing and health, we welcome this proposal.

20. However, we believe population projections and the associated potential implications for the City's infrastructure need to be material considerations for the health and planning reference group.

21. As part of our consideration of the Health Background Topic paper, we discussed some of the changes made to the Core Strategy policies as a result of the Health Impact Assessment work undertaken. We made specific reference to 'Improving opportunities for local people to get jobs through S106 employment opportunities' and concerns among members around the strength of language used. Despite the suggestion that with a policy in place, the issues raised were associated the application and implementation of the policy, we believe that wording of relevant policies should be strengthened to read 'Local people to get jobs through S106 employment opportunities'.

22. Given the date of the Health Background Topic paper (i.e. February 2012), it is disappointing that there is no reference to the additional document (highlighted by the Joint Director of Public Health) produced by Marmot (The Marmot Review: Implications for Spatial Planning), which provided evidence on the relationship between aspects of spatial planning, the built environment, health and health inequalities. We understand that this report was published in 2011.

Future advice and guidance on public health

23. We discussed the range of existing and anticipated public health guidance from the National Institute for Health and Clinical Excellence (NICE) to local authorities. We recognised the need to take into account the best available evidence and guidance when considering the contribution of planning in improving public health. However we also recognised the organic nature of evidence and guidance, which would therefore be difficult to reflect in a long-term strategy document.

24. We acknowledge the advice regarding the importance of the ongoing involvement of Public Health professionals within the planning process, and the key role of the Joint Director of Public Health in ensuring that the most up-to-date guidance / evidence is made available and considered by the health and planning reference group.

25. However, within the Core Strategy, we believe it would be useful to specifically reflect on the important role of NICE (or any successor body) and other recognised health organisations in developing and/or updating public health guidance for local authorities. We believe this is particularly important where such guidance may relate to the contribution of planning in addressing public health matters, and therefore may be a material consideration of the health and planning reference group.

Conclusion

26. We hope that our comments and observations inform the ongoing discussions and consideration of the draft Core Strategy, including those held at the Scrutiny Board (Sustainable Economy and Culture) and the Executive Board, ahead of the final draft being presented for agreement at Full Council in November 2012.

Councillor John Illingworth
Chair, Scrutiny Board (Health and Wellbeing and Adult Social Care)

October 2012

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