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

Meeting to be held in Civic Hall, Leeds, LS1 1UR on Tuesday, 15th July, 2014 at 10.00 am

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

MEMBERSHIP

Councillors

J Akhtar	Hyde Park and Woodhouse;
D Coupar (Chair)	Cross Gates and Whinmoor;
B Flynn	Adel and Wharfedale;
G Hussain	Roundhay;
S Lay	Otley and Yeadon;
P Latty	Guiseley and Rawdon;
J Lewis	Kippax and Methley;
K Maqsood	Gipton and Harehills;
E Taylor	Chapel Allerton;
S Varley	Morley South;
J Walker	Headingley;

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

Agenda compiled by:
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Civic Hall
LEEDS LS1 1UR
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Principal Scrutiny Adviser:
Steven Courtney
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A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded). (* In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the 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 have been identified.**	

Item No	Ward/Equal Opportunities	Item Not Open		Page No
3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATION OF DISCLOSABLE PECUNIARY INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-16 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 - 30 APRIL 2014** To confirm as a correct record, the minutes of the meeting held on 30 April 2014.	1 - 8
7			**SCRUTINY BOARD TERMS OF REFERENCE** To receive a report from the Head of Scrutiny and Member Development presenting the Board's terms of reference.	9 - 14
8			**LOCAL AUTHORITY HEALTH SCRUTINY** To receive a report from the Head of Scrutiny and Member Development presenting the Department of Health guidance specifically in relation to its Health Scrutiny Board function.	15 - 48
9			**CO-OPTED MEMBERS** To receive a report from the Head of Scrutiny and Member Development on the appointment of co-opted members to Scrutiny Boards.	49 - 54

Item No	Ward/Equal Opportunities	Item Not Open		Page No
10			**JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE NOMINATION** To consider a report from the Head of Scrutiny and Member Development seeking nomination of a member from within its membership (subject to Full Council agreement) to sit on the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) in relation to the new review of Congenital Heart Disease services.	55 - 58
11			**CARE QUALITY COMMISSION - LEEDS TEACHING HOSPITALS NHS TRUST: HOSPITAL INSPECTION REPORT** To receive a report from the Head of Scrutiny and Member Development presenting the findings and areas of improvement, following the recent inspection of Leeds Teaching Hospitals NHS Trust.	59 - 84
12			**THE REPORT OF THE INVESTIGATION INTO MATTERS RELATING TO JIMMY SAVILE AT LEEDS TEACHING HOSPITALS NHS TRUST** To receive a report from the Head of Scrutiny and Member Development presenting a summary report, including findings and recommendations, following the investigation commissioned by Leeds Teaching Hospitals NHS Trust in December 2012.	85 - 104
13			**SOURCES OF WORK FOR THE SCRUTINY BOARD** To receive a report from the Head of Scrutiny and Member Development on potential sources of work for the Scrutiny Board.	105 - 140
14			**WORK SCHEDULE** To consider the Board's work schedule for the forthcoming municipal year.	141 - 154

Item No	Ward/Equal Opportunities	Item Not Open		Page No
15			**DATE AND TIME OF THE NEXT MEETING** Tuesday, 30 September at 10.00am in the Civic Hall, Leeds (Pre-meeting for all Board Members at 9.30am) **THIRD PARTY RECORDING** Recording of this meeting is allowed to enable those not present to see or hear the proceedings either as they take place (or later) and to enable the reporting of those proceedings. A copy of the recording protocol is available from the contacts named on the front of this agenda. Use of Recordings by Third Parties– code of practice a) Any published recording should be accompanied by a statement of when and where the recording was made, the context of the discussion that took place, and a clear identification of the main speakers and their role or title. b) Those making recordings must not edit the recording in a way that could lead to misinterpretation or misrepresentation of the proceedings or comments made by attendees. In particular there should be no internal editing of published extracts; recordings may start at any point and end at any point but the material between those points must be complete.	

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

WEDNESDAY, 30TH APRIL, 2014

PRESENT: Councillor J Illingworth in the Chair

Councillors G Hussain, J Walker, K Bruce, J Lewis, C Towler, S Lay and N Buckley

121 Chair's Opening Remarks

The Chair opened the meeting and welcomed everyone in attendance.

The Chair reported the sudden and untimely passing of Councillor Clive Fox, who had been a member of the Scrutiny Board for a number of years, and a key contributor during this time. Members offered their condolences for Councillor Fox's family during this difficult time.

The Scrutiny Board stood and observed a minute of silent reflection in memory of Councillor Fox.

122 Late Items

In accordance with his powers under Section 100B(4)(b) of the Local Government Act 1972, the Chair agreed to accept the following late and supplementary information for consideration at the meeting:

- NHS Specialised Services: Impact assessment of proposed changes to specific service specifications
  - Submission by Embrace
    (Minute 126 refers)

- Urgent and Emergency Care
  - Submission by Leeds North Clinical Commissioning Group
    (Minute 128 refers)

The above documents were not available at the time of the agenda despatch, but had been made available to the public at the meeting. Copies of the papers had also been made available on the Council's website.

123 Declaration of Disclosable Pecuniary Interests

There were no disclosable pecuniary interests declared to the meeting.

124 Apologies for Absence and Notification of Substitutes

The following apologies for absence had been received and were reported to the Scrutiny Board.

- Councillor S Varley
- Councillor E Taylor

No substitute members were in attendance.

125 Minutes - 21 March 2014 and 28 March 2014

RESOLVED – That the minutes of the previous meetings held on 21 March 2014 and 28 March 2014 be approved as a correct record.

126 NHS Specialised Services: Impact assessment of proposed changes to specific service specifications

The Head of Scrutiny and Member Development submitted a report which introduced the following:

- Proposed changes to 14 specialised service areas
- Written submission/ briefing by Leeds Teaching Hospitals NHS Trust

The following additional information was provided for the Scrutiny Board to consider (Minute 122 refers):

- Written submission by Embrace – the specialist transport service for critically ill infants and children in Yorkshire and the Humber

The following representatives were in attendance to help the Scrutiny Board consider the information presented:

- Laura Sherburn (Interim Head of Specialised Commissioning) – NHS England (South Yorkshire & Bassetlaw Area Team)
- Dr Mark Smith (Chief Operating Officer – Leeds Teaching Hospitals NHS Trust)
- David Berridge (Medical Director (Operations) – Leeds Teaching Hospitals NHS Trust)

In addressing the Scrutiny Board, the Interim Head of Specialised Commissioning (NHS England (South Yorkshire & Bassetlaw Area Team)) provide a brief reminder of the Board's previous consideration on proposed changes to specific service specifications.

As outlined in the paper presented to the Scrutiny Board, it was confirmed that of the proposed changes to 15 specialised service areas, it was considered appropriate that the specific impact assessments in the following areas warranted specific consideration by the Scrutiny Board:

- Adult Cardiac Surgery Service Specification (A10/S/a);
- Complex Disability Equipment Prosthetics Service Specification (D01/S/d); and,
- Paediatric Critical Care – Level 2 (E07/S/b)

Members were assured there were no 'patient safety' issues to consider and the overall purpose of the proposed changes was to improve the quality of services; to standardise and raise the level of consistency in the provision of specialised services across the country.

Members were also assured that the proposed changes to the Adult Cardiac Surgery and Complex Disability Equipment Prosthetics Service Specifications sought to clarify and strengthen the previous specifications. There was no indication that the proposed changes would necessitate any changes to the existing provider landscape across Yorkshire and the Humber.

Representatives from Leeds Teaching Hospitals NHS Trust were supportive of the comments made at the meeting and confirmed that the proposed changes would not present any significant challenges to the Trust.

It was highlighted that the Paediatric Critical Care – Level 2 represented a new specification for 2014/15 and the key impacts were highlighted as follows:

- Potentially more patients treated in tertiary centres or Level 2 Units – although any increase in activity was unquantified.
- Potential increase in paediatric transport activity across the region.
- The need for more work to assess the volume of activity, in order to understand the impact of the proposed change on both the receiving and referring organisations in terms of capacity and sustainability.
- The need for more work around the potential impact of rapid repatriation, steps on the care pathway and patient and carer choice.
- It was not known how readily new standards relating to staffing numbers and training packages could be met.

The issues around the potential increase in paediatric transport activity across the region and the potential impact of rapid repatriation were further emphasised by the written submission from Embrace. However, it was reported that Embrace was well placed to absorb a moderate increase in paediatric activity, with paediatric transfers making up around one third of the total workload for the service.

The Principal Scrutiny Adviser advised the Scrutiny Board that the Yorkshire Ambulance Service (YAS) had been invited to comment on the proposed changes to the specialised service changes and, for the majority of the proposed changes, no significant implications were anticipated. However, in

relation to Paediatric Critical Care, any increase in demand and/or journey length would need to be reflected in changes to relevant contracts.

The Scrutiny Board discussed the report and the details highlighted at the meeting. A number of matters were raised and discussed – particularly relating to the proposals around Paediatric Critical Care, including:

- The balance between specialisation / the development of centres of excellence and care closer to home.
- The potential shift from clinically led services to a time led specification.
- Assuming the revised specifications are approved, queries around the communication with parents and families in terms of what level of service should be expected.
- The potential need for a two-stage engagement process that allows some form of 'sense checking' followed by more formal consultation once local impacts have been considered and assessed.
- Any impact on the parallel process for developing the 5-year strategy for specialised services.

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) That, based on the information presented and discussed, the Principal Scrutiny Adviser draft a formal response to the current consultation around NHS Specialised Service specification, and consult members of the Scrutiny Board on its content ahead of the 21 May 2014 deadline.
(c) That the Scrutiny Board maintain an overview of progress and, subject to the revised specification for Paediatric Critical Care (Level 2) being adopted, that a further report detailing the precise implications be presented to the Scrutiny Board at a future date.

At the conclusion of the discussion, the Chair thanked those in attendance for their contributions to the meeting.

127 Children's Epilepsy Surgery

The Head of Scrutiny and Member Development submitted a report that introduced further information relating to the provision of Children's Epilepsy Surgery. The Scrutiny Board considered an initial letter to and subsequent response from NHS England in this regard, appended to the report.

The Principal Scrutiny Adviser reminded members that in July 2013 the Scrutiny Board had previously considered a request for scrutiny and agreed to consider issues related to the provision of Children's Epilepsy Surgery in Leeds and the associated procurement process.

The following representatives were in attendance to help the Scrutiny Board consider the information presented:

- Laura Sherburn (Interim Head of Specialised Commissioning) – NHS England (South Yorkshire & Bassetlaw Area Team)
- Dr Mark Smith (Chief Operating Officer – Leeds Teaching Hospitals NHS Trust)
- David Berridge (Medical Director (Operations) – Leeds Teaching Hospitals NHS Trust)

In addressing the Scrutiny Board, the Interim Head of Specialised Commissioning (NHS England (South Yorkshire & Bassetlaw Area Team)) briefly outlined the NHS England's response, which covered the following areas:

- Background and context to identifying four providers to deliver a Children's Epilepsy Surgery Service – acknowledging there was no specialised surgical service centre (for children under 5) located in Yorkshire and the Humber or the North East of England;
- Response to the issues raised by the Scrutiny Board, following the initial request for scrutiny.
- The development of the North East Paediatric Neurosciences Network

The Chair expressed concern that, despite the relatively small number of children/ families likely to be affected, the existing provision did not sufficiently reflect the population profile or geography of Yorkshire and the Humber. There was also concern that the lack of provision might be seen as an erosion of services and have a negative impact on other service areas, including other neuroscience services, at Leeds Teaching Hospitals NHS Trust.

Addressing the Scrutiny Board, representatives from Leeds Teaching Hospitals NHS Trust (LTHT), made a number of points and outlined a range of matters, including:

- Leeds Teaching Hospitals NHS trust was fully supportive of its clinicians in maintaining and further developing paediatric neurosurgical service;
- There was a larger population of children (aged 6 and over) that require epilepsy surgery and there was a desire to maintain and develop such a service in Leeds.
- It was recognised that the establishment and development of an effective Neurosciences Network (covering Sheffield, Newcastle and Leeds) would be beneficial to each centre and the populations they serve.
- More recently there had been a much greater degree of cohesive and a collaborative approach in relation to the establishment and development of a North East Paediatric Neurosciences Network;
- Through the North East Paediatric Neurosciences Network, the Trust planned to contact NHS England in order to seek a review of provision within Yorkshire and Humber / the North of England.

The Scrutiny Board discussed the report and the details highlighted at the meeting and welcomed the more collaborative approach in relation to the establishment and development of a North East Paediatric Neurosciences Network reported.

The Scrutiny Board also welcomed the proposal to seek a review of provision within Yorkshire and Humber / the North of England, as outlined at the meeting

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) To request a copy of the letter from the North East Paediatric Neurosciences Network to NHS England seeking a review of service provision within Yorkshire and Humber / the North of England.
(c) To maintain an overview of the existing provision of Children's Epilepsy Surgery services, as necessary.

At the conclusion of the discussion, the Chair thanked those in attendance for their contributions to the meeting.

128 Urgent and Emergency Care

The Head of Scrutiny and Member Development submitted a report that provided a summary of the Board's previous consideration of urgent and emergency care during the municipal year 2013/14.

The following additional information was provided for the Scrutiny Board to consider (Minute 122 refers):

- Written submission by Leeds North Clinical Commissioning Group

The following representatives were in attendance to help the Scrutiny Board consider the information presented:

- Nigel Grey (Chief Officer – Leeds North Clinical Commissioning Group)
- Debra Taylor-Tate (Strategic Commissioning Lead (Urgent Care) – Leeds North Clinical Commissioning Group)
- Steven Courtney (Leeds City Council, Principal Scrutiny Adviser)

The Principal Scrutiny Adviser summarised the Scrutiny Board's consideration of urgent and emergency care during the current municipal year, 2013/14.

In addressing the Scrutiny Board, representatives from Leeds North Clinical Commissioning Group (CCG) reminded the Scrutiny Board that Leeds North CCG held a co-ordinating role for work around urgent and emergency care across the City. In outlining the written submission provided, a number of specific areas were highlighted, including:

- Operational urgent care and the 4 hour emergency care standard.

- Work of the Strategic Urgent Care Board and the development of the vision for urgent and emergency care across the City.
- Development of the following workstreams to deliver the vision:
  - Frail and Elderly;
  - Mental Health;
  - Children and Young People;
  - Alcohol.
  - Preparation for the forthcoming Tour de France.

The Scrutiny Board discussed the report and the details highlighted at the meeting. A number of matters were raised and discussed, including:

- Public and Patient involvement, including that of HealthWatch Leeds, in the ongoing review of urgent and emergency care across the City.
- Reporting and governance arrangements associated with the Strategic Urgent Care Board.
- The similarity of current urgent and emergency care issues with those facing the national and local system for the past 10 years.
- The current economic imperative in relation to the review of urgent and emergency care across the City.
- How improvements would be judged and the associated 'measures of improvement'.

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) To maintain an overview of the ongoing review of urgent and emergency care across the City and to receive further update reports in the new municipal year (i.e. 2014/15).

The Chair thanked those in attendance for their contributions to the meeting and concluded by thanking all members of the Scrutiny Board for their attendance and contributions throughout the municipal year.

(The meeting concluded at 11:40am)

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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: 15 July 2014

Subject: Scrutiny Board Terms of Reference

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 presents the terms of reference for the Scrutiny Board (Health and Wellbeing and Adult Social Care) for Members' information.

Recommendation

2. Members are requested to note the Scrutiny Board's terms of reference.

1.0 Purpose of this report

1.1 This report presents the terms of reference for the Scrutiny Board (Health and Wellbeing and Adult Social Care).

2.0 Background information

Scrutiny Board's terms of reference

2.1 The Annual Review of the Constitution more often than not identifies areas for amendment in relation to the Scrutiny Boards' terms of reference to ensure consistency in wording and provide procedural clarity.

2.2 On this occasion there have been no changes to the remit of this Scrutiny Board. The terms of reference are attached for Members' information (Appendix 1).

2.3 The Board's terms of reference relate to the functions delegated to the Director of Adult Social Services. In general terms, these cover the following areas:

- Social Services so far as those functions relate to adults;
- Functions exercisable on behalf of an NHS body, so far as those functions relate to adults; and,
- Arrangements to protect and promote the welfare of vulnerable adults, including vulnerable young people moving into adulthood.

2.4 The following function delegated to the Director of Public Health also falls within the remit of this Scrutiny Board:

- Taking appropriate steps to improve the health of the people in the authority's area;
- Dental public health;
- Joint working with the prison service;
- The medical inspection of pupils and weighing and measuring children;
- Research, obtaining and analysing data or other information and obtaining advice from persons with appropriate professional expertise;
- Planning for, or responding to, emergencies involving a risk to public health;
- Co-operating with arrangements for assessing risks posed by violent or sexual offenders;
- Any public heath function of the Secretary of State (or functions exercisable in connection with those functions):
    - which the authority is required by regulation to exercise, or;
    - in respect of which arrangements have been made.
- Any other function prescribed by the Secretary of State as the responsibility of the Director of Public Health; and,
- The oversight of clinical governance arrangements

2.5 In terms of Executive Members, the Scrutiny Board's role encompasses the areas of responsibility assigned to the Executive Members for:

- Adult Social Care; and
- Health and Wellbeing.

2.6 In addition, as outlined in the attached terms of reference, the Scrutiny Board also has a specific remit / responsibility in relation to reviewing and scrutinising any matter relating to the planning, provision and operation of the local health service and to comment on specific NHS service changes or developments, as referred to the authority by a relevant NHS body or health service provider. This specific aspect of the Scrutiny Board's remit is considered in more detail elsewhere on the agenda.

3.0 Corporate Considerations

Consultation and Engagement

3.1 The Council's Constitution was formally considered and approved by Council on 9 June 2014.

Equality and Diversity / Cohesion and Integration.

3.2 In line with the Scrutiny Board Procedure Rules, the Scrutiny Boards will continue to ensure through service review that equality and diversity/cohesion and integration issues are considered in decision making and policy formulation.

Council Policies and City Priorities

3.3 The terms of reference of the Scrutiny Boards continue to promote a strategic and outward looking Scrutiny function that focuses on the City Priorities. Scrutiny Boards will continue to review outcomes, targets and priorities within the Business Plan and specific "Best City for…. " priorities set out within the City Priority Plan.

Resources and Value for Money

3.4 This report has no specific resource and value for money implications.

Legal Implications, Access to Information and Call In

3.5 This report has no specific legal implications.

Risk Management

3.6 This report has no risk management implications.

4.0 Recommendation

4.1 Members are requested to note the Scrutiny Board's terms of reference.

5.0 Background documents[1]

5.1 None

[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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Scrutiny Board (Health and Well-being and Adult Social Care)

The Scrutiny Board (Health and Well-being and Adult Social Care) is authorised to discharge

1. the following overview and scrutiny functions:[1]

   a) to review or scrutinise decisions made or other action taken in connection with any council or executive function or any matter which affects the authority's area or the inhabitants of that area;[2]

   b) to review or scrutinise the performance of the Health and Wellbeing Board;[3]

   c) to carry out such other reviews or policy development tasks as it may be requested to do by the Executive Board, the Council or the Health and Wellbeing Board;

   d) to act as the appropriate Scrutiny Board in relation to the Executive's initial proposals for a relevant plan or strategy[4] within the Budget and Policy Framework;[5]

   e) to review or scrutinise executive decisions made that have been Called In;

   f) to review outcomes, targets and priorities within the Council Business Plan and the Best city for…health and wellbeing priorities in the City Priority Plan;

   g) to receive requests for scrutiny and councillor calls for action and undertake any subsequent work; and

   h) to make such reports and recommendations as it considers appropriate and to receive and monitor formal responses to any reports or recommendations made by the Board.

2. the following functions of the authority:[6]

   a) to review and scrutinise any matter relating to the planning, provision and operation of the health service in its area and to make reports and recommendations on any such matter it has reviewed or scrutinised;

   b) to comment on, make recommendations about, or report to the Secretary of State in writing about such proposals as are referred to the authority by a relevant NHS body or a relevant health service provider; and

   c) to nominate Members to any joint overview and scrutiny committee appointed by the authority.[7]

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[1] In relation to functions delegated to the Director of Adult Social Services and the Director of Public Health under the Officer Delegation Scheme whether or not those functions are concurrently delegated to any other committee or officer, and functions exercised by the Health and Wellbeing Board.

[2] Including matters pertaining to outside bodies or partnerships to which the authority has made appointments.

[3] The Scrutiny Board has a duty to do this each municipal year – Scrutiny Board Procedure Rule 10.3

[4] Namely the Health and Wellbeing City Priority Plan.

[5] In accordance with Budget and Policy Framework Procedure Rules.

[6] In accordance with regulations issued under Section 244 National Health Service Act 2006 (the regulations).

[7] such nominations to reflect the political balance of the Board.

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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: 15 July 2014

Subject: Local Authority Health Scrutiny

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

1.0 Introduction

1.1 As detailed elsewhere on the agenda, the Scrutiny Board has a specific remit / responsibility in relation to reviewing and scrutinising any matter relating to the planning, provision and operation of the local health service. There is also a responsibility to consider and comment on specific NHS service changes or developments, as referred to the authority by a relevant NHS body or health service provider. These functions of Council are delegated to the Scrutiny Board (Health and Wellbeing and Adult Social Care) and detailed in the terms of reference (presented elsewhere on the agenda).

1.2 On 27 June 2014, the Department of Health published its 'Local Authority Health Scrutiny' guidance to support local authorities and partners deliver effective health scrutiny. The guidance is attached at Appendix 1.

2.0 Local Authority Health Scrutiny

2.1 Some of the key messages from the guidance are reported below for ease of reference.

- The primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the commissioning and delivery of health services. The new legislation extends the scope of health scrutiny and increases the flexibility of local authorities in deciding how to exercise their scrutiny function.

- Health scrutiny also has a strategic role in taking an overview of how well integration of health, public health and social care is working and in making recommendations about how it could be improved.

- At the same time, health scrutiny has a legitimate role in proactively seeking information about the performance of local health services and bodies; in challenging the information provided to it and in testing this information by drawing on different sources of intelligence.

- Health scrutiny is part of the accountability of the whole system and needs the involvement of all parts of the system. Engagement of relevant NHS bodies and relevant health service providers with health scrutiny is a continuous process. It should start early with a common understanding of local health needs and the shape of services across the whole health and care system.

- Effective health scrutiny requires clarity at a local level about respective roles between the health scrutiny function, the NHS, the local authority, health and wellbeing boards and local Healthwatch.

- In the light of the Francis Report, local authorities will need to satisfy themselves that they keep open effective channels by which the public can communicate concerns about the quality of NHS and public health services to health scrutiny bodies. Although health scrutiny functions are not there to deal with individual complaints, they can use information to get an impression of services overall and to question commissioners and providers about patterns and trends.

- In addition, health scrutiny needs to consider ways of independently verifying information provided by relevant NHS bodies and relevant health service providers – for example, by seeking the views of local Healthwatch.

- Health scrutiny should be outcome focused, looking at cross-cutting issues, including general health improvement, wellbeing and how well health inequalities are being addressed, as well as specific treatment services.

- Where there are concerns about proposals for substantial developments or variation in health services (or reconfiguration as it is also known) local authorities and the local NHS should work together to attempt to resolve these locally if at all possible, taking advice from the Independent Reconfiguration Panel (IRP) and/or the Centre for Public Scrutiny (CfPS) if appropriate and necessary.

- If the decision is ultimately taken to formally refer the local NHS's reconfiguration proposals to the Secretary of State for Health, then this referral must be accompanied by an explanation of all steps taken locally to try to reach agreement in relation to those proposals.

- In considering substantial reconfiguration proposals health scrutiny needs to recognise the resource envelope within which the NHS operates and should therefore take into account the effect of the proposals on sustainability of services, as well as on their quality and safety.

- Local authorities should ensure that regardless of any arrangements adopted for carrying out health scrutiny functions, the functions are discharged in a transparent manner that will boost the confidence of local people in health scrutiny.

- Health scrutiny should be held in an open forum and local people should be allowed to attend and use any communication methods such as filming and tweeting to report the proceedings. This will be in line with the new transparency measure in the Local Audit and Accountability Act 2014 and will allow local people, particularly those who are not present at scrutiny hearing-meetings, to have the opportunity to see or hear the proceedings.

3.0 Recommendations

3.1 Members of the Scrutiny Board (Health and Wellbeing and Adult Social Care) are asked to note the guidance provided and consider how this is reflected in its operation throughout the current municipal year, and beyond..

4.0 Background documents[1]

4.1 None.

[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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Department of Health

Local Authority Health Scrutiny

Guidance to support Local Authorities and their partners to deliver effective health scrutiny.

June 2014

Title: **Local Authority Health Scrutiny:** Guidance to support Local Authorities and their partners to deliver effective health scrutiny
Author: SCLGCP/PCLG/18280
Document Purpose: Guidance
Publication date: June 2014 To be reviewed in June 2015
Target audience: • Local Authorities • Local Government Association • Health and Wellbeing Boards • Clinical Commissioning Groups • NHS trusts (acute, community, mental health) • NHS England • Healthwatch
Contact details: Local Government Team Department of Health Room 330, Richmond House 79 Whitehall London SW1A 2NS

Published to gov.uk, in PDF format only.

www.gov.uk/dh

Local Authority Health Scrutiny

Guidance to support Local Authorities and their partners to deliver effective health scrutiny.

Prepared by the People, Communities and Local Government Division of the Department of Health.

Contents

Key messages

- The primary aim of health scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the commissioning and delivery of health services and that those services are effective and safe. The new legislation extends the scope of health scrutiny and increases the flexibility of local authorities in deciding how to exercise their scrutiny function.

- Health scrutiny also has a strategic role in taking an overview of how well integration of health, public health and social care is working – relevant to this might be how well health and wellbeing boards are carrying out their duty to promote integration - and in making recommendations about how it could be improved.

- At the same time, health scrutiny has a legitimate role in proactively seeking information about the performance of local health services and institutions; in challenging the information provided to it by commissioners and providers of services for the health service ("relevant NHS bodies and relevant health service providers"[1]) and in testing this information by drawing on different sources of intelligence.

- Health scrutiny is part of the accountability of the whole system and needs the involvement of all parts of the system. Engagement of relevant NHS bodies and relevant health service providers with health scrutiny is a continuous process. It should start early with a common understanding of local health needs and the shape of services across the whole health and care system.

- Effective health scrutiny requires clarity at a local level about respective roles between the health scrutiny function, the NHS, the local authority, health and wellbeing boards and local Healthwatch.

- In the light of the Francis Report, local authorities will need to satisfy themselves that they keep open effective channels by which the public can communicate concerns about the quality of NHS and public health services to health scrutiny bodies. Although health scrutiny functions are not there to deal with individual complaints, they can use information to get an impression of services overall and to question commissioners and providers about patterns and trends.

- Furthermore in the light of the Francis Report, health scrutiny will need to consider ways of independently verifying information provided by relevant NHS bodies and relevant health service providers – for example, by seeking the views of local Healthwatch.

[1] In this guidance, "health service commissioners and providers" is a reference to:
a) certain NHS bodies, (i.e. NHS England, clinical commissioning groups, NHS trusts and NHS foundation trusts) and
b) providers of NHS and public health services commissioned by NHS England, clinical commissioning groups and local authorities.
Each of these is "a responsible person", as defined in the Regulations, on whom the Regulations impose certain duties for the purposes of supporting local authorities to discharge their health scrutiny functions.

- Health scrutiny should be outcome focused, looking at cross-cutting issues, including general health improvement, wellbeing and how well health inequalities are being addressed, as well as specific treatment services.

- Where there are concerns about proposals for substantial developments or variation in health services (or reconfiguration as it is also known) local authorities and the local NHS should work together to attempt to resolve these locally if at all possible. If external support is needed, informal help is freely available from the Independent Reconfiguration Panel (IRP)[2] and/or the Centre for Public Scrutiny[3]. If the decision is ultimately taken to formally refer the local NHS's reconfiguration proposals to the Secretary of State for Health, then this referral must be accompanied by an explanation of all steps taken locally to try to reach agreement in relation to those proposals.

- In considering substantial reconfiguration proposals health scrutiny needs to recognise the resource envelope within which the NHS operates and should therefore take into account the effect of the proposals on sustainability of services, as well as on their quality and safety.

- Local authorities should ensure that regardless of any arrangements adopted for carrying out health scrutiny functions, the functions are discharged in a transparent manner that will boost the confidence of local people in health scrutiny. Health scrutiny should be held in an open forum and local people should be allowed to attend and use any communication methods such as filming and tweeting to report the proceedings. This will be in line with the new transparency measure in the Local Audit and Accountability Act 2014 and will allow local people, particularly those who are not present at scrutiny hearing-meetings, to have the opportunity to see or hear the proceedings.

[2] Independent Reconfiguration Panel website: www.irpanel.org.uk/view.asp?id=0
[3] Centre for Public Scrutiny website: www.cfps.og.uk

1. Introduction

This guidance is intended to support local authorities, relevant NHS bodies and relevant health service providers in discharging their responsibilities under the relevant regulations; and thereby supporting effective scrutiny. The guidance needs to be conscientiously taken into account. However, the guidance is not intended to be a substitute for the legislation or to provide a definitive interpretation of the legislation. Only the courts can provide a definitive interpretation of legislation. Anyone in doubt should seek legal advice.

1.1 Background

1.1.1 The primary aim of health scrutiny is to act as a lever to improve the health of local people, ensuring their needs are considered as an integral part of the commissioning, delivery and development of health services. For some time, local authority overview and scrutiny[4] of health has been an important part of the Government's commitment to place patients at the centre of health services. It is even more important in the new system.

1.1.2 Health scrutiny is a fundamental way by which democratically elected local councillors are able to voice the views of their constituents, and hold relevant NHS bodies and relevant health service providers to account. To this end, it is essential that health scrutiny functions are also carried out in a transparent manner, so that local people have the opportunity to see and hear proceedings, in line with the new transparency measure in the Local Audit and Accountability Act 2014. Local government itself is making an even greater contribution to health since taking on public health functions in April 2013 (and will itself be within the scope of health scrutiny). Social care and health services are becoming ever more closely integrated and impact on each other, with the result that scrutiny of one may entail, to a certain extent, scrutiny of the other. In many cases, health scrutiny reviews will be of services which are jointly commissioned by the NHS and local government.

1.1.3 Within the NHS, there has been increasing emphasis on the need to understand and respond to the views of patients and the public about health and health services: the NHS Constitution, the Government's Mandate to NHS England and the NHS Operating Framework together provide a strong set of principles underpinning the NHS's accountability to the people it serves. Responding positively to health scrutiny is one way for the NHS to be accountable to local communities.

1.1.4 This is an important and challenging time for local authority scrutiny of the health service in England. The wider context includes huge financial pressures on the public services and the challenges of an ageing society in which more people are living for longer with illness and long-term medical conditions and disability. The NHS and local government are operating in a completely new health landscape underpinned by new legislation; with care commissioned and, in many cases, potentially delivered, by more and varied organisations. New health scrutiny legislation permits greater flexibility in the way that local authorities discharge their health scrutiny functions. Local government is working ever more closely with the NHS through health and wellbeing boards, taking a holistic view of the health, public health and social care system.

[4] Referred to as 'review and scrutiny' in the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

1.1.5 At the same time, the whole health and care system and the public accountability mechanisms that surround it are grappling with the implications of the Francis inquiry into the shocking failure of care at Mid-Staffordshire NHS Trust. Among many other recommendations, the Francis report says that:

- The Care Quality Commission should expand its work with overview and scrutiny committees.
- Overview and scrutiny committees and local Healthwatch should have access to complaints information.
- The "quality accounts" submitted by providers of NHS services should contain observations of commissioners, overview and scrutiny committees and local Healthwatch.

1.1.6 Following the Francis report and recommendations, the role and importance of effective health scrutiny will become more prominent. The Francis inquiry increased expectations for local accountability of health services. It is expected that health scrutiny will develop working relationships and good communication with Care Quality Commission local representatives, NHS England's local and regional Quality Surveillance Groups as well as with local Healthwatch. While there is no legislative stipulation as to the extent of support that should be made available for the health scrutiny function, the health and social care system as a whole will need to think about how the function is supported nationally, regionally and locally to enable the powers and duties associated with the function to be exercised appropriately.

1.2 Purpose of guidance

1.2.1 It is against this background that this guidance has been prepared. It is intended to provide an up-to-date explanation and guide to implementation of the regulations under the National Health Service Act 2006 governing the local authority health scrutiny function. The relevant regulations are the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 ("the Regulations"), which came into force on 1st April 2013[5]. They supersede the 2002 Regulations under the Health and Social care Act 2001[6]. The Regulations have implications for relevant NHS bodies and relevant health service providers, including local authorities carrying out the local authority health scrutiny function[7], health and wellbeing boards and those involved in patient and public engagement activities. The duties in the Regulations are aimed at supporting local authorities to discharge their scrutiny functions effectively. Failure to comply with those duties would place the relevant NHS body or relevant health service provider in breach of its statutory duty and render it at risk of a legal challenge.

1.2.2 This guidance is, therefore, of relevance to:

- Local authorities (both those which have the health scrutiny functions and district councils).
- Clinical commissioning groups (CCGs).
- NHS England.

[5] References to numbered Regulations throughout this guide are to the Local Authority (Public Health, Health and wellbeing boards and Health Scrutiny) Regulations 2013.
[6] These had effect as if made under the National Health Service Act 2006.
[7] The health scrutiny function is conferred on the152 councils with social services responsibilities.

- Providers of health services including those from the public, private and voluntary sectors.
- Those involved in delivering the work of local Healthwatch.

The guidance should be read alongside other guidance issued by the Department of Health and NHS England, such as the guidance on the NHS duty to involve[8], and guidance for NHS commissioners on the good practice principles and process for planning of major service change.

1.3 Scope of the Regulations

1.3.1 The Regulations explained in this guidance relate to matters relating to the health service, i.e. including services commissioned and/or provided by the NHS as well as public health services commissioned by local authorities. This includes services provided to the NHS by external non-NHS providers, including local authorities (this is discussed in more detail in section 3).

1.3.2 The NHS Constitution, the Mandate to NHS England, and the NHS Outcomes Framework provide a set of guiding principles and values for the NHS which indicate that the NHS is not just a sickness service, but is there to improve health, wellbeing and to address health inequalities: "to pay particular attention to groups or sections of society where improvement in health and life expectancy are not keeping pace with the rest of the population[9]". The Mandate makes clear that one of NHS England's priorities should be a focus on "preventing illness, with staff using every contact they have with people as an opportunity to help people stay in good health[10]". Since the creation of the health scrutiny functions under the Health and Social Care Act 2001, local authority scrutiny committees have prioritised issues of health improvement, prevention and tackling health inequalities as areas where they can add value through their work. In their reviews, local authorities have looked at the wider social determinants of health and health inequalities, not least because of local government's own contribution through the whole range of its services.

1.3.3 NHS services can themselves impact on health inequalities and general wellbeing of communities, for example, by improving access to services for the most deprived and least healthy communities. Moreover the Department of Health has always advised and local authorities have recognised that the best use of their health scrutiny powers will depend on scrutiny extending to health issues, the health system and health economy rather than being limited to services commissioned or managed by the NHS or local authorities.

1.3.4 The duties of health service commissioners and providers under the Regulations apply to NHS commissioners and to providers of health services as part of the health service, including NHS bodies and local authorities, as discussed below. However, local authority health scrutiny committees have often drawn on their wider powers to promote

[8] http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf
[9] NHS Constitution, *The NHS belongs to us all*, March 2013: http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf
[10] The Mandate: A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015, p8: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213131/mandate.pdf

community wellbeing to carry out overview and scrutiny of a range of health issues which go beyond NHS services. In the new health landscape, public health is a responsibility of local government and health and wellbeing boards provide strategic leadership of the health system through partnership, with a specific duty to encourage integrated working across health and social care. We can expect an increasing number of services to be jointly commissioned between local authorities and the NHS. Any health scrutiny exercise may therefore include reviewing the local authority's own contribution to the health of local people and the provision of health services, as well as the role of the health and wellbeing board, and of other agencies involved in the health care of local people.

1.3.5 Responses to matters that are scrutinised may therefore be the responsibility of a number of stakeholders. In this light, the power to scrutinise the health service should be seen and used in the wider context of the local authority role of community leadership and of other initiatives to promote and facilitate improvement and reduce inequalities. In the context of the NHS reforms, this includes:

- A greater emphasis on involving patients and the public from an early stage in proposals to improve services.
- The work of health and wellbeing boards as strategic bodies bringing together representatives of the whole local health and care system.
- The work of other relevant local partnerships, such as community safety partnerships and partnerships with the community and voluntary sectors.

1.3.6 The new legislation in the 2012 Act lays increased emphasis on the role of patients and the public in shaping services. This is recognised in the introduction of local Healthwatch organisations and their membership of health and wellbeing boards. The Regulations make provision about the referral of matters by local Healthwatch to local authority health scrutiny. This is discussed in section 3 below.

1.3.7 Section 2 below outlines those aspects of the health scrutiny system that remain the same for each of the key players: local authorities, the NHS and the patient and public involvement system. Section 3 discusses in detail what has changed following the new legislation for each of these key players and how the changes should be implemented. Section 4 discusses the important issue of consultation on substantial reconfiguration proposals (i.e. proposals for a substantial development of the health service or for a substantial variation in the provision of such service). Section 5 provides references and links to relevant additional documents.

2. What remains the same following the new legislation?

2.1 For local authorities

2.1.1 Under the Regulations, local authorities in England (i.e. "upper tier" and unitary authorities[11], the Common Council of the City of London and the Council of the Isles of Scilly) have the power to:

- Review and scrutinise matters relating to the planning, provision and operation of the health service in the area. This may well include scrutinising the finances of local health services.
- Require information to be provided by certain NHS bodies about the planning, provision and operation of health services that is reasonably needed to carry out health scrutiny.
- Require employees including non-executive directors of certain NHS bodies to attend before them to answer questions.
- Make reports and recommendations to certain NHS bodies and expect a response within 28 days.
- Set up joint health scrutiny committees with other local authorities and delegate health scrutiny functions to an overview and scrutiny committee of another local authority.
- Refer NHS substantial reconfiguration proposals to the Secretary of State if a local authority considers:

    - The consultation has been inadequate in relation to the content or the amount of time allowed.
    - The NHS body has given inadequate reasons where it has not consulted for reasons of urgency relating to the safety or welfare of patients or staff.
    - A proposal would not be in the interests of the health service in its area.

(In the case of referral, the Regulations lay down additional conditions and requirements as to the information that must be provided to the Secretary of State – these are listed in section 4.7 below.)

2.1.2 As previously, executive members may not be members of local authority overview and scrutiny committees, their sub-committees, joint health overview and scrutiny committees and sub-committees. Overview and scrutiny committees may include co-opted members i.e. those who are not members of the relevant local authority (for example, co-opted members of overview and scrutiny committees of district councils or representatives of voluntary sector organisations). Co-opted members may not be given voting rights except where permitted by the relevant local authority in accordance with a scheme made by the local authority[12].

[11] i.e. county councils, district councils other than lower-tier district councils and London Borough councils. However, in general, health scrutiny functions may be delegated to lower-tier district councils (except for referrals – see regulations 28 and 29) or their overview and scrutiny committees, or carried out by a joint committee of those councils and another local authority.

[12] Section 9FA of and Schedule A1 to the Local Government Act 2000, Regulations 5 and 11 of the Local Authorities (committee system) (England) Regulations 2012 and Regulation 30 of the Local Authority (Public Health, Health and wellbeing boards and Health Scrutiny) Regulations 2013.

2.1.3 The position of councils which have returned to a committee system of governance is discussed in section 3 below.

2.1.4 The position in relation to these matters remains following the new legislation, but the legislation is extended to cover additional and new organisations and diverse local authority arrangements, as described in section 3 below.

2.2 For the NHS

2.2.1 Regulations under the Health and Social Care Act 2001 created duties on the NHS which mirror the powers conferred on local authorities. These duties are carried forward into the new legislation, and require the NHS to:

- Provide information about the planning, provision and operation of health services as reasonably required by local authorities to enable them to carry out health scrutiny (section 3 lists all those now covered by this requirement).
- Attend before local authorities to answer questions necessary for local authorities to carry out health scrutiny.
- Consult on any proposed substantial developments or variations in the provision of the health service[13].
- Respond to health scrutiny reports and recommendations: NHS service commissioners and providers have a duty to respond in writing to a report or recommendation where health scrutiny requests this, within 28 days of the request. This applies to requests from individual health scrutiny committees or sub-committees, from local authorities and from joint health scrutiny committees or sub-committees.

2.2.2 These duties remain in place, and (following the abolition of PCTs and Strategic Health Authorities) now apply to CCGs; NHS England; local authorities as providers of NHS or public health services; and providers of NHS and public health services commissioned by CCGs, NHS England and local authorities. Additional responsibilities are described in section 3 below.

2.3 For patient and public involvement

2.3.1 Legislation has created a number of far-reaching requirements on the NHS to consult service users and prospective users in planning services, in the development and consideration of proposals for changes in the way services are provided and in decisions affecting the operation of those services.

2.3.2 For NHS trusts, the duty as to involvement and consultation is set out in section 242 of the 2006 Act (as amended by the Health and Social Care Act 2012). The public involvement duties of NHS England and of CCGs are set out in sections 13Q and 14Z2 respectively of the 2006 Act. These are separate duties from those set out in the Regulations discussed here. Together they add up to a web of local accountability for health services.

2.1.1 The Health and Social Care Act 2012 introduced local Healthwatch to represent the voice of patients, service users and the public; and health and wellbeing boards to promote partnerships across the health and social care sector. The Regulations set up formal relationships between local Healthwatch and local authority health scrutiny, to ensure

[13] Subject to exceptions as set out in the 2013 Regulations.

that the new system reflects the outcomes of involvement and engagement with patients and the public, as described in section 3 below.

3. Changes arising from the new legislation

3.1 Powers and duties – changes for local authorities

Councils as commissioners and providers of health services

3.1.1 As commissioners or providers of public health services and as providers of health services to the NHS, services commissioned or provided by local authorities are themselves within the scope of the health scrutiny legislation.

3.1.2 To that end local authorities may be bodies which are scrutinised, as well as bodies which carry out health scrutiny.

3.1.3 The duties which apply to scrutinised bodies such as the duty to provide information, to attend before health scrutiny and to consult on substantial reconfiguration proposals will apply to local authorities insofar as they may be "relevant health service providers"[14].

3.1.4 Being both scrutineer and scrutinee is not a new situation for councils. It will still be important, particularly in making arrangements for scrutiny of the council's own health role, to bear in mind possible conflicts of interest and to take steps to deal with them.

Councils as scrutineers of health services

3.1.5 The Local Government Act 2000 (as amended by the Localism Act 2011) makes provision for authorities:

- To retain executive governance arrangements (i.e. comprising a Leader and cabinet or a Mayor and cabinet).
- To adopt a committee system of governance.
- To adopt any other form of governance prescribed by the Secretary of State.

3.1.6 Health scrutiny arrangements will differ in some respects depending on the system that the council chooses to operate. Most importantly:

- Councils operating executive governance arrangements are required to have at least one overview and scrutiny committee. In this case, the scrutiny is independent of the executive.
- If a council adopts a committee system, they can operate overview and scrutiny committees if they choose, but are not required to do so.

3.1.7 At present, most local authorities are retaining executive governance arrangements. For those councils moving to a committee system, a further discussion of the differences and implications for health scrutiny is included on page 16 below.

3.1.8 Generally health scrutiny functions are in the form of powers. However, there are certain requirements under the Regulations as follows. Local authorities on whom health scrutiny functions have been conferred should:

- Have a mechanism in place to deal with referrals made by Local Healthwatch organisations or contractors[15].

[14] See section 244 of the NHS Act and Regulation 20 of the 2013 Regulations for the meaning of "relevant health service provider".
[15] See Regulation 21 of the 2013 Regulations.

- Have a mechanism in place to respond to consultations by relevant NHS bodies and relevant health service providers on substantial reconfiguration proposals. Such responses could be made through the full council, an overview and scrutiny committee with delegated powers from the full council, a joint overview and scrutiny committee or a committee appointed under s101 of the Local Government Act.
- Councils also need to consider in advance how the members of a joint health scrutiny committee would be appointed from their council where the council was required to participate in a joint health scrutiny committee with other councils to respond to substantial reconfiguration proposals covering more than one council area.

Conferral of health scrutiny function on full council

3.1.9 The National Health Service Act 2006, as amended by the Health and Social Care Act 2012, confers health scrutiny functions on the local authority, as distinct from any overview and scrutiny committee or panel within the local authority section 244 (2ZD). This new provision is designed to give local authorities greater flexibility and freedom over the way they discharge health scrutiny functions. The full council of each local authority will determine which arrangement is adopted. For example:

- It may choose to continue to operate its existing health overview and scrutiny committee, delegating its health scrutiny functions to the committee.
- It may choose other arrangements such as appointing a committee involving members of the public and delegating its health scrutiny functions (except the function of making referrals) to that committee.
- It may operate its health scrutiny functions through a joint scrutiny committee with one or more other councils.

3.1.10 As indicated above local authorities may delegate their health scrutiny functions under section 101 of the Local Government Act 1972 but are not permitted to delegate the functions to an officer (Regulation 29).

3.1.11 Executive members of councils operating executive governance arrangements (that is a Leader and cabinet or a Mayor and cabinet) may not be members of local authority overview and scrutiny committees or of their sub-committees or of joint health overview and scrutiny committees and sub-committees.

3.1.12 Overview and scrutiny committees are a proven model offering a number of benefits that other structures may not, including having a clear identity within the local authority, political balance and, in many cases, an established reputation within the local community for independence and accessibility.

Delegation of health scrutiny function by full council

3.1.13 The legislation enables health scrutiny functions to be delegated to:

- An overview and scrutiny committee of a local authority or of another local authority (Regulation 28).
- A sub-committee of an overview or scrutiny committee (Local Government Act 2000).
- A joint overview and scrutiny committee (JOSC) appointed by two or more local authorities or a sub-committee of such a joint committee.
- A committee or sub-committee of the authority appointed under section 102 of the Local Government Act 1972 (section 101 of the Local Government Act 1972) (except for referrals).
- Another local authority (section 101 of Local Government Act 1972) (except for referrals).

3.1.14 Local authorities may not delegate the health scrutiny functions to an officer – this option under the Local Government Act 1972 is disapplied (disallowed) by Regulation 29.

3.1.15 If a council decides to delegate to a health scrutiny committee, it need not delegate *all* of its health scrutiny functions to that committee (i.e. it could retain some functions itself). For example, it might choose to retain the power to refer issues to the Secretary of State for Health as discussed below. Equally, it might choose to delegate that power to the scrutiny committee.

Joint health scrutiny arrangements

3.1.16 As before, local authorities may appoint a discretionary joint health scrutiny committee (Regulation 30) to carry out all or specified health scrutiny functions, for example health scrutiny in relation to health issues that cross local authority boundaries. Establishing a joint committee of this kind does not prevent the appointing local authorities from separately scrutinising health issues. However, there are likely to be occasions on which a discretionary joint committee is the best way of considering how the needs of a local population, which happens to cross council boundaries, are being met.

3.1.17 Regulation 30 also requires local authorities to appoint joint committees where a relevant NHS body or health service provider consults more than one local authority's health scrutiny function about substantial reconfiguration proposals (referred to below as a mandatory joint health scrutiny committee). In such circumstances, Regulation 30 sets out the following requirements (see section 4 on consultation below for more detail).

- Only the joint committee may respond to the consultation (i.e. rather than each individual local authority responding separately).
- Only the joint committee may exercise the power to require the provision of information by the relevant NHS body or health service provider about the proposal.
- Only the joint committee may exercise the power to require members or employees of the relevant NHS body or health service provider to attend before it to answer questions in connection with the consultation.

3.1.18 These restrictions do not apply to referrals to the Secretary of State. Local authorities may choose to delegate their power of referral to the mandatory joint committee but they need not do so. If a local authority had already appointed a discretionary committee, they could even delegate the power to that committee if they choose to.

3.1.19 If the local authority has delegated this power, then they may not subsequently exercise the power of referral. If they do not delegate the power, they may make such referrals.

3.1.20 A situation might arise where one of the participating local authorities had delegated their power of referral to the joint committee but not the other(s). In such a case a referral could be made by: the JOSC or any of the authorities which had not delegated their power of referral to the JOSC, but not the authorities which had delegated their power of referral to the JOSC.

Reporting and making recommendations

3.1.21 Regulation 22 enables local authorities and committees (including joint committees, sub-committees and other local authorities to which health scrutiny functions have been delegated) to make reports and recommendations to relevant NHS bodies and health

service providers. The following information must be included in a report or recommendation:

- An explanation of the matter reviewed or scrutinised.
- A summary of the evidence considered.
- A list of the participants involved in the review or scrutiny.
- An explanation of any recommendations on the matter reviewed or scrutinised.

3.1.22 A council can choose to delegate to an overview and scrutiny committee (including joint committee, sub-committee or another local authority) the function of making scrutiny reports and recommendations to relevant NHS bodies and health service commissioners. Alternatively, a council can choose to delegate only the function of *preparing* such reports and recommendations, and retain for itself the function of actually *making* that report or recommendation. The latter approach would give the full council the opportunity to endorse the report or recommendation before it was sent to the NHS.

3.1.23 Where a local authority requests a response from the relevant NHS body or health service provider to which it has made a report or recommendation, there is a statutory requirement (Regulation 22) for the body or provider to provide a response in writing within 28 days of the request.

Conflicts of interest

3.1.24 Councils should take steps to avoid any conflict of interest arising from councillors' involvement in the bodies or decisions that they are scrutinising. A conflict might arise where, for example, a councillor who was a full voting member of a health and wellbeing board was also a member of the same council's health scrutiny committee or of a joint health scrutiny committee that might be scrutinising matters pertaining to the work of the health and wellbeing board.

3.1.25 Conflicts of interest may also arise if councillors carrying out health scrutiny are, for example:

- An employee of an NHS body.
- A member or non-executive director of an NHS body.
- An executive member of another local authority.
- An employee or board member of an organisation commissioned by an NHS body or local authority to provide services.

3.1.26 These councillors are not excluded from membership of overview and scrutiny committees, and, clearly, where the full council has retained the health scrutiny function, they will be involved in health scrutiny. However they will need to follow the rules and requirements governing the existence of interests in matters considered at meetings. Where such a risk is identified, they should consult their monitoring officer for advice on their involvement.

Councils operating a committee system

3.1.27 Councils which have returned to a committee system under the Local Government Act 2000 may or may not have retained a council-wide overview and scrutiny function. If they have retained such function, they will be able to delegate their health scrutiny functions to overview and scrutiny committees in the same way as those councils operating executive arrangements that have executive and scrutiny functions.

3.1.28 Councils with a committee system that have not retained a council-wide scrutiny function will need to decide what to do about their health scrutiny functions. The health scrutiny function is conferred on the full council but delegation to a committee, joint committee, sub-committee or another local authority is permitted (except in the case of referrals in relation to which delegation under section 101 of the Local Government Act 1972 is not permitted). Therefore such a council might retain health scrutiny functions or delegate these to a committee, joint committee or sub-committee (or indeed to another council or its overview and scrutiny committee).

3.1.29 In deciding how to operate a health scrutiny function, councils operating a committee system will need to consider issues of potential conflicts of interest. Like upper tier and unitary councils, they will need to have a health and wellbeing board whose work will be within the scope of health scrutiny insofar as it relates to the planning, provision and operation of the health service. They may also have a health and social care committee or a stand-alone health committee which makes decisions about the commissioning of public health services. A conflict might arise where, for example, under a committee system, the members of any committee of the council which is taking commissioning decisions on public health services, are also members of its health scrutiny committee or where a health and social care committee of a council operating a committee system is also acting as a health overview and scrutiny committee. The solution might be to have a separate health overview and scrutiny committee, with different members.

3.1.30 Regardless of the governance arrangements being operated by a council, the health scrutiny function may not be delegated to an officer (Regulation 29).

The role of district councils

3.1.31 As previously, under the new Regulations (Regulation 31), district councillors in two tier areas, who are members of district overview and scrutiny committees, may be co-opted by the upper tier county council onto health overview and scrutiny committees of those councils or other local authorities. Such co-option may be on a long term (i.e. for the life of the overview and scrutiny committee or until the county council decides) or ad hoc basis (i.e. for review and scrutiny of a particular matter) (Regulation 31).

3.1.32 District councillors in two tier areas may also (Regulation 30 read with the Local Government Act 2000) be co-opted onto joint health scrutiny committees between the upper tier county councils and other local authorities.

3.1.33 District councillors in two tier areas may also be on joint health scrutiny committees of the relevant district council and the upper tier county council (Regulation 30).

3.1.34 Many county councils have taken the opportunity to co-opt district councillors onto their scrutiny committees, as district councillors bring very local knowledge of their communities' needs and may also provide a useful link to enhance the health impact of district council services. Health and wellbeing strategies in two-tier areas are likely to include reference to the role of district councils in improving health and reducing inequalities, for example through their housing and leisure functions. As health and wellbeing boards' functions including their strategies (insofar as related to the planning, provision and operation of the health service) will be within the scope of health scrutiny, this provides an additional reason for considering the co-option of district councillors.

3.2 Powers and duties – changes for the NHS

Extension of scope of health scrutiny

3.2.1 A significant change for the NHS in the new health landscape is the extension of certain duties in the Regulations to cover providers of health services (commissioned by NHS England, CCGs or local authorities) who are not themselves NHS bodies. Together with relevant NHS bodies these are known as 'responsible persons' in the legislation and these include:

- CCGs
- NHS England
- Local authorities (insofar as they may be providing health services to CCGs, NHS England or other local authorities).
- NHS trusts and NHS foundation trusts.
- GP practices and other providers of primary care services (previously not subject to specific duties under health scrutiny regulations as independent contractors, they are now subject to duties under the new Regulations as they are providers of NHS services).
- Other providers of primary care services to the NHS, such as pharmacists, opticians and dentists.
- Private and voluntary sector bodies commissioned to provide NHS or public health services by NHS England, CCGs or local authorities.

3.2.2 Under the Regulations, 'responsible persons' are required to comply with a number of duties to assist the health scrutiny function. These duties are underpinned by the duty of co-operation which applies between the NHS and local authorities under section 82 of the NHS Act 2006 which requires them, in exercising their respective functions, to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

Required provision of information to health scrutiny

3.2.3 Regulation 26 imposes duties on 'responsible persons' to provide a local authority with such information about the planning, provision and operation of health services in the area of the authority as it may reasonably require to discharge its health scrutiny functions. All relevant NHS bodies and health service providers (including GP practices and other primary care providers and any private, independent or third sector providers delivering services under arrangements made by clinical commissioning groups, NHS England or the local authority) have a duty to provide such information.

3.2.4 In addition, the duty of candour under the NHS Standard Contract is also relevant in relation to the provision of information to patients generally.

3.2.5 The type of information requested and provided will depend on the subject under scrutiny. It may include:

- Financial information about the operation of a trust or CCG, for example budget allocations for the care of certain groups of patients or certain conditions, or capital allocations for infrastructure projects, such as community facilities.
- Management information such as commissioning plans for a particular type of service.
- Operational information such as information about performance against targets or quality standards, waiting times.

- Patient information such as patient flows, patient satisfaction surveys, numbers and types of complaints and action taken to address them.
- Any other information relating to the topic of a health scrutiny review which can reasonably be requested.

3.2.6 Confidential information that relates to or identifies a particular living individual or individuals cannot be provided unless the individual or individuals concerned agree to its disclosure. However, the information can be disclosed in a form from which identification is not possible. In such a situation, health scrutiny bodies (i.e. councils or council health overview and scrutiny committees or sub-committees carrying out delegated health scrutiny functions) can require that the information be put in a form from which the individual cannot be identified in order that it may be disclosed.

3.2.7 In some cases, information, such as financial information, may be commercially sensitive. In such cases, it may be possible for health scrutiny to receive this information in confidence to inform, but not be directly referred to in, its reports and recommendations.

Required attendance before health scrutiny

3.2.8 Members and employees of a relevant NHS body or relevant health service provider have a duty to attend before a local authority when required by it (provided reasonable notice has been given) to answer questions the local authority believes are necessary to carry out its health scrutiny functions. This duty now applies to all those listed at the beginning of this section. So, for example, if a local authority were to require the attendance of a member of a CCG, or of a private company commissioned to provide particular NHS services, it could do so under the Regulations. Bodies, the employees or members of which are required to attend by local authority health scrutiny, are expected to take the appropriate steps to ensure the relevant member or employee complies with this requirement[16].

3.2.9 As regards the attendance of particular individuals, identification of the appropriate member or employee to attend will depend on the type of scrutiny review being undertaken and its aims. By way of example, where the local authority has required attendance of a particular individual, say the accountable officer of a clinical commissioning group, and it is not practicable for that individual to attend or if that individual is not the most suitable person to attend, the CCG would be expected to suggest another, relevant individual. Thus, in such situations, both the local authority and the commissioner or provider (as the case may be) would be expected to co-operate with each other to agree on a suitable person for attendance and, in doing so, to act reasonably at all times.

Responding to scrutiny reports and recommendations

3.2.10 Depending on the topic being reviewed, reports and recommendations by local authority health scrutiny bodies may be made to any of the relevant NHS bodies or health service providers covered by the legislation (and, in the case of health scrutiny by a body to which the function has been delegated, to the delegating authority e.g. the relevant local authority or in the case of a sub-committee appointed by a committee, that committee or its local authority).

[16] The meaning of 'member' is given in section 244 of the NHS Act 2006 and includes people who are members of committees or sub-committees of CCGs who are not members of the CCG, directors of NHS trusts and directors and governors of NHS foundation trusts. They also include directors of bodies which provide health services commissioned by NHS England, CCGs and local authorities.

3.2.11 Relevant NHS bodies and health service providers to which a health scrutiny report or and recommendation has been made must by law, if a response is requested, respond within 28 days of the request. Reports and recommendations are expected to be based on evidence. Respondents should take the evidence presented seriously, giving a considered and meaningful response about how they intend to take forward reports or recommendations. Meaningful engagement is likely to lead to improvements in quality and access to services.

3.2.12 Many local authorities, as part of their work plan, return to completed scrutiny reviews after a certain period – usually 6 months or a year – to find out whether and how their recommendations have been implemented and how they have influenced improvements. Relevant NHS bodies and health service providers to whom scrutiny reports have been presented should be prepared for this kind of follow-up and be able to report on progress and improvements resulting from scrutiny reviews.

3.3 Powers and duties – referral by local Healthwatch

3.3.1 Local Healthwatch organisations and contractors have specific roles which complement those of health scrutiny bodies. For example, they can “enter and view” certain premises at which health and social care services are provided. This can enable local Healthwatch to act as the “eyes and ears” of patients and the public; to be a means for health scrutiny to supplement and triangulate information provided by service providers; and to gain an additional impression of quality of services, safety and issues of concern around specific services and provider institutions. Health scrutiny bodies and local Healthwatch are likely each to benefit from regular contact and exchange of information about their work programmes. It may also be helpful in planning work programmes, to try to ensure that certain aspects are aligned. For example, if a health scrutiny body is planning a review of a certain service, it might be useful if local Healthwatch plans to visit the service in a timely way to inform the review.

3.3.2 Local Healthwatch organisations and their contractors carry out certain statutory activities including that of making reports and recommendations concerning service improvements to scrutiny bodies. This would cover the provision of information and the referral of matters relating to the planning, provision and operation of health services in their area (which could potentially include concerns about local health services or commissioners and providers) to local authority health scrutiny bodies.

3.3.3 Regulation 21 sets out duties that apply where a matter is referred to a local authority by a local Healthwatch organisations or contractors. The local authority must:

- Acknowledge receipt of referrals within 20 working days.
- Keep local Healthwatch organisations (or contractors as the case may be) informed of any action it takes in relation to the matter referred.

4.Consultation

4.1 The context of consultation

4.1.1 The duty on relevant NHS bodies and health service providers to consult health scrutiny bodies on substantial reconfiguration proposals should be seen in the context of NHS duties to involve and consult the public. Focusing solely on consultation with health scrutiny bodies will not be sufficient to meet the NHS's public involvement and consultation duties as these are separate. The NHS should therefore ensure that there is meaningful and on-going engagement with service users in developing the case for change and in planning and developing proposals. There should be engagement with the local community from an early stage on the options that are developed.

4.1.2 The backdrop to consultation on substantial reconfiguration proposals is itself changing. The ideal situation is that proposals for change emerge from involving service users and the wider public in dialogue about needs and priorities and how services can be improved. Much of this dialogue may take place through representation of service users and the public on health and wellbeing boards and through the boards' own public engagement strategies. With increasing integration of health and care services, many proposals for change may be joint NHS-local authority proposals which may have been discussed at an early stage through the health and wellbeing board. Health scrutiny bodies should be party to such discussions – local circumstances will determine the best way for this to happen. If informally involved and consulted at an early enough stage, health scrutiny bodies in collaboration with local Healthwatch, may be able to advise on how patients and the public can be effectively engaged and listened to. If this has happened, health scrutiny bodies are less likely to raise objections when consulted.

4.1.3 NHS England has published good practice guidance for NHS commissioners on the planning and development of proposals for major service changes and reconfigurations. The guidance is designed to support commissioners, working with local authorities and providers, to carry out effective service reconfiguration in a way that puts quality of care first, is clinically evidence-based and which involves patients and the public throughout. It is intended to be used as a reference guide to help develop and implement plans in a clear and consistent way. The guidance is available at:

http://www.england.nhs.uk/wp-content/uploads/2013/12/plan-del-serv-chge1.pdf

4.2 When to consult

4.2.1 Regulation 23 requires relevant NHS bodies and health service providers to consult a local authority about any proposal which they have "under consideration" for a substantial development of or variation in the provision of health services in the local authority's area. The term "under consideration" is not defined and will depend on the facts, but a development or variation is unlikely to be held to be "under consideration" until a proposal has been developed. The consultation duty applies to any "responsible person" under the legislation, i.e. relevant NHS bodies and health service commissioners which now come under the scope of health scrutiny as described above.

4.2.2 As previously, "substantial development" and "substantial variation" are not defined in the legislation. Many local authority scrutiny bodies and their NHS counterparts have developed joint protocols or memoranda of understanding about how the parties will

reach a view as to whether or not a proposal constitutes a “substantial development” or “substantial variation”. Although there is no requirement to develop such protocols it may be helpful for both parties to do so. The local authority may find a systematic checklist, of the kind often contained in such protocols, useful in reaching a view about whether a proposed development or variation is substantial and, for example, NHS commissioners may find it helpful in explaining to providers what is likely to be regarded as substantial.

4.3 Who consults

4.3.1 In the case of substantial developments or variation to services which are the commissioning responsibility of CCGs or NHS England, consultation is to be done by NHS commissioners rather than providers i.e. by the relevant CCG(s) or NHS England. When these providers have a development or variation “under consideration” they will need to inform commissioners at a very early stage so that commissioners can comply with the requirement to consult as soon as proposals are under consideration.

4.4 Timescales for consultation

4.4.1 The Regulations now require timescales to be provided to health scrutiny bodies and to be published by the proposer of substantial developments or variations, (Regulation 23). When consulting health scrutiny bodies on substantial developments or variations, a relevant NHS body or health service provider is required by the Regulations to notify the health scrutiny body of the date by which it requires the health scrutiny body to provide comments in response to the consultation and the date by which it intends to make a decision as to whether to proceed with the proposal[17]. These dates must also be published. This is so that local patients and communities are aware of the timescales that are being followed. Any changes to these dates must be notified to the relevant health scrutiny body and published. Constructive dialogue between relevant NHS bodies and health service providers on the one hand, and health scrutiny bodies on the other, when communicating on timescales for comments or decisions in relation to substantial developments or variations should help ensure that timescales are realistic and achievable.

4.4.2 It is sensible for health scrutiny to be able to receive details about the outcome of public consultation before it makes its response so that the response can be informed by patient and public opinion.

4.5 When consultation is not required

4.5.1 The Regulations set out certain proposals on which consultation with health scrutiny is *not* required. These are:

- Where the relevant NHS body or health service commissioner believes that a decision has to be taken without allowing time for consultation because of a risk to safety or welfare of patients or staff (this might for example cover the situation where a ward needs to close immediately because of a viral outbreak) – in such cases the NHS body or health service provider must notify the local authority that consultation will not take place and the reason for this.

[17] Government guidance on consultation principles was published in July 2012 (see references).

- Where there is a proposal to establish or dissolve or vary the constitution of a CCG or establish or dissolve an NHS trust, unless the proposal involves a substantial development or variation.
- Where proposals are part of a trusts special administrator's report or draft report (i.e. when a trust has financial difficulties and is being run by an administration put in place by the Secretary of State) – these are required to be the subject of a separate 30-day community-wide consultation.

4.6 Responses to consultation

4.6.1 Where a health scrutiny body has been consulted by a relevant NHS body or health service provider on substantial developments or variations, the health scrutiny body has the power to make comments on the proposals by the date (or changed date) notified by the body or provider undertaking the consultation. Having considered the proposals and local evidence, health scrutiny bodies should normally respond in writing to the body undertaking the consultation and when commenting would need to keep within the timescale specified by them.

4.6.2 Where a health scrutiny's body's comments include a recommendation and the consulting organisation disagrees with that recommendation, that organisation must notify the health scrutiny body of the disagreement. Both the consulting organisation and the health scrutiny body must take such steps as are reasonably practicable to try to reach agreement. Where NHS England or a clinical commissioning group is acting on behalf of a provider, in accordance with the Regulations, as mentioned above, the health scrutiny body and NHS England or the CCG (as the case may be) must involve the provider in the steps they are taking to try to reach agreement.

4.6.3 Where a health scrutiny body has not commented on the proposal or has commented but without making a recommendation, it must notify the consulting organisation as to its decision as to whether to refer the matter to the Secretary of State and if so, the date by which it proposes to make the referral or the date by which it will make a decision on whether to refer the matter to the Secretary of State.

4.7 Referrals to the Secretary of State

4.7.1 Local authorities may refer proposals for substantial developments or variations to the Secretary of State in certain circumstances outlined below. The circumstances remain largely the same as in previous legislation.

4.7.2 The new Regulations set out certain information and evidence that are to be provided to the Secretary of State and the steps that must be taken before a referral can be made. On receiving a referral from a local authority, overview and scrutiny committee, joint committee or sub-committee, the Secretary of State may ask for advice from the Independent Reconfiguration Panel (IRP), an advisory non-departmental public body. The new Regulations do not affect the position of the IRP. The IRP will undertake an initial assessment of any referral to the Secretary of State for Health where its advice is requested**.** It may then be asked to carry out a full review. Not all referrals to the Secretary of State for Health will automatically be reviewed in full by the IRP – this is at the Secretary of State's discretion. The IRP has published a summary of its views on what can be learned from the referrals it has received and the reviews it has undertaken from the perspective both of the NHS and of health scrutiny. The IRP also offers pre-

consultation advice and support to NHS and other interested bodies on the development of local proposals for reconfiguration or significant service change - including advice and support on methods for public engagement and formal public consultation.

Relevant NHS bodies, health service providers and local authority scrutiny may also find it helpful to read its report on the *Safe and Sustainable* review of children's heart surgery, the first national reconfiguration proposal referred to the IRP, whose recommendations were accepted by the Secretary of State (see references).

4.7.3 The powers under the previous Regulations to refer matters relating to NHS foundation trusts to Monitor have been removed, as this was not considered appropriate to the role of Monitor and the new licensing regime.

Circumstances for referral

4.7.4 The circumstances for referral of a proposed substantial development or variation remain the same as in previous legislation. That is, where a health scrutiny body has been consulted by a relevant NHS body or health service provider on a proposed substantial development or variation, it may report to the Secretary of State in writing if:

- It is not satisfied with the adequacy of content of the consultation.
- It is not satisfied that sufficient time has been allowed for consultation.[18]
- It considers that the proposal would not be in the interests of the health service in its area.
- It has *not* been consulted, and it is not satisfied that the reasons given for not carrying out consultation are adequate.

4.7.5 However, there are certain limits on the circumstances in which a health scrutiny bodies may refer a proposal to the Secretary of State.

In particular, where a health scrutiny body has made a recommendation and the relevant NHS body or health service provider has disagreed with the recommendation, the health scrutiny body may not refer a proposal unless:

- it is satisfied that reasonably practicable steps have been taken to try to reach agreement (with steps taken to involve the provider where NHS England or a CCG is acting on the provider's behalf) but agreement has not been reached within a reasonable time; or
- it is satisfied that the relevant NHS body or health service provider has failed to take reasonably practicable steps to try to reach agreement within a reasonable period.

In a case where a health scrutiny body has not commented on the proposal or has commented without making a recommendation, the health scrutiny body may not refer a proposal unless:

- It has informed the relevant NHS body or health service provider of-
  - its decision as to whether to exercise its power of referral and, if applicable, the date by which it proposed to exercise that power, or
  - the date by which it proposes to make a decision as to whether to exercise its power of referral.

- In a situation where it informed the relevant NHS body or health service provider of the date by which it proposed to decide whether to exercise the power of referral, it has made that decision by that date and informed the body or provider of the decision.

[18] The referral power in the context of inadequate consultation only relates to the consultation with the local authority, and not consultation with other stakeholders.

Who makes the referral?

4.7.6 Where a local authority has a health overview and scrutiny committee (e.g. under section 9F of the Local Government Act 2000, as amended by the Localism Act 2011) as the means of discharging its health scrutiny functions, the health overview and scrutiny committee may exercise the power of referral on behalf of the local authority where this has been delegated to it. The power of referral may also be delegated to an overview and scrutiny committee of another local authority in certain circumstances (Regulation 28). Where a local authority has retained the health scrutiny function for the full council to exercise, or where it has delegated some health scrutiny functions, but not the power of referral to a committee, the full council would make the referral.

4.7.7 Where a local authority has established an alternative mechanism to discharge its health scrutiny functions, such as delegation to a committee, sub-committee or another local authority under section 101 of the Local Government Act 1972, the referral power cannot be delegated to that committee, sub-committee or other local authority but must instead be exercised by the local authority as a function of the full council (or delegated to an overview and scrutiny as above, although local authorities would need to consider the appropriateness of separate delegation to an overview and scrutiny committee in such circumstances)[19].

4.7.8 Where a local authority is participating in a joint overview and scrutiny committee (JOSC) (see pages 14-15), who makes the referral will depend on whether the power to refer has been delegated to the joint committee or retained by the local authority.

4.7.9 The following applies to both discretionary joint committees (i.e. where councils have chosen to appoint the joint committee to carry out specified functions) and mandatory joint committees (i.e. where councils have been required under Regulation 30 to appoint a joint committee because a local NHS body or health service provider is consulting more than one local authority's health scrutiny function about substantial reconfiguration proposals):

- Where the power to refer has been delegated to the joint committee, only the joint committee may make a referral.
- Where the power to refer has not been delegated to the joint committee, the individual authorities that have appointed the joint committee (or health overview and scrutiny committees or sub-committees to whom the power has been delegated) may make a referral.

4.7.10 In the case of either mandatory or discretionary JOSCs, where individual authorities have retained the power to refer, they should ensure that they are in a position to satisfy the relevant requirements under Regulation 23 to include certain explanations and evidence with the referral. They should also ensure that they can demonstrate compliance with the conditions set out in Regulation 23(10), bearing in mind that in the case of a mandatory JOSC, only that JOSC may make comments to the consulting body and that, where the JOSC makes a recommendation which is disagreed with by the consulting body, certain requirements have to be satisfied before a referral can be made.

Information and evidence to be sent to Secretary of State

[19] See Regulation 29.

4.7.11 When making a referral to the Secretary of State, certain information and evidence must be included. Health scrutiny will be expected to provide very clear evidence-based reasons for any referral to the Secretary of State. These requirements are new since the previous Regulations, so they are given here in full. Referrals must now include:

- An explanation of the proposal to which the report relates.
- An explanation of the reasons for making the referral.
- Evidence in support of these reasons.
- Where the proposal is referred because of inadequate consultation, the reasons why the health scrutiny body is not satisfied of its adequacy.
- Where the proposal is referred because there was no consultation for reasons relating to safety or welfare of patients or staff, reasons why the health scrutiny body is not satisfied that the reasons given for lack of consultation are adequate.
- Where the health scrutiny body believes that proposals are not in the interests of the health service in its area, a summary of the evidence considered, including any evidence of the effect or potential effect of the proposal on the sustainability or otherwise of the health service in the area.
- An explanation of any steps that the health scrutiny body has taken to try to reach agreement with the relevant NHS body or health service provider.
- Evidence that the health scrutiny body has complied with the requirements which apply where a recommendation has been made.
- Evidence that the health scrutiny body has complied with the requirements which apply where a recommendation has not been made, or where no comments have been provided on the proposal.

4.7.12 The terms of reference of the IRP, in assessing proposals and providing advice to the Secretary of State, are to consider whether the proposals will provide safe, sustainable and accessible services for the local population. Referrals to the Secretary of State and information provided by consulting bodies when consulting health scrutiny will, therefore be most helpful if they directly address each of these issues.

5. References and useful links

5.1 Relevant legislation and policy

- Department of Health (2013), *The NHS Constitution: the NHS belong to us all*: http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf

- Department of Health (2012), *The Mandate: A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015*: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213131/mandate.pdf

- Government guidance on consultation principles (2012): https://www.gov.uk/government/publications/consultation-principles-guidance

- Health and Social Care Act 2001, sections 7 – 10: http://www.legislation.gov.uk/ukpga/2001/15/contents

- Health and Social Care Act 2012, sections 190 – 192: http://www.legislation.gov.uk/ukpga/2012/7/contents

- Local Government Act 2000: http://www.legislation.gov.uk/ukpga/2000/22/contents

- The Localism Act 2011: http://www.legislation.gov.uk/ukpga/2011/20/contents/enacted

- National Health Service Act 2006, sections 244 – 245: http://www.legislation.gov.uk/ukpga/2006/41/contents

- Statutory Instrument No. 2013/218 The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013: http://www.legislation.gov.uk/uksi/2013/218/contents/made

5.2 Useful reading

- Centre for Public Scrutiny (2013): *Spanning the system: broader horizons for council scrutiny* (based on health scrutiny work on the health reforms in 14 local authority areas)*:* http://cfps.org.uk/domains/cfps.org.uk/local/media/downloads/L13_19_CfPSspanning_the_system__web.pdf

- Centre for Public Scrutiny (2012): *Local Healthwatch, health and wellbeing boards and health scrutiny: roles, relationships and adding value:* http://cfps.org.uk/domains/cfps.org.uk/local/media/downloads/L12_693_CFPS_Healthwatch_and_Scrutiny_final_for_web.pdf

- Centre for Public Scrutiny (2011), *Peeling the Onion,* learning, tips and tools from the DH-funded Health Inequalities Scrutiny Programme: http://politiquessociales.net/IMG/pdf/CfPSPeelingonionfin_1_1_.pdf

- Centre for Public Scrutiny (2007): *Ten questions to ask if you're assessing evidence:* http://www.cfps.org.uk/publications?item=209&offset=150

- Independent Reconfiguration Panel (2010): *Learning from Reviews:* http://www.irpanel.org.uk/lib/doc/learning%20from%20reviews3%20pdf.pdf

- Independent Reconfiguration Panel (2013): *Advice on* Safe and Sustainable *proposals for children's heart services*: http://www.irpanel.org.uk/lib/doc/000%20s&s%20report%2030.04.13.pdf

- Institute of Health Equity (2008), *Fair Society, Healthy Lives* (the Marmot report): http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

- LGA and ADSO (2012), *Health and wellbeing boards: a practical guide to governance and constitutional issues*: http://www.local.gov.uk/c/document_library/get_file?uuid=ca8437aa-742c-4209-827c-996afa9583ca&groupId=10171

- NHS England's guidance on the duty to involve (2013): *Transforming Participation in Health and Care* - http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid1.pdf

- NHS England (2013): *Planning and Delivering Service Change for Patients* - http://www.england.nhs.uk/wp-content/uploads/2013/12/plan-del-serv-chge1.pdf

Leeds CITY COUNCIL

Report author: Steven Courtney
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Report of Head of Scrutiny and Member Development

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

Date: 15 July 2014

Subject: Co-opted Members

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. For a number of years the Council's Constitution has made provision for the appointment of co-opted members to individual Scrutiny Boards. However, the appointment of co-opted members has not always been considered consistently across Scrutiny Boards.

2. This report provides guidance to the Scrutiny Board when seeking to appoint co-opted members. There are also some legislative arrangements in place for the appointment of specific co-opted members. Such cases are set out in Article 6 of the Council's Constitution and are also summarised within this report.

Recommendation

3. In line with the options available outlined in this report, Members are asked to consider the appointment of co-opted members to the Scrutiny Board.

1 Purpose of this report

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

2 Background information

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

3 Main issues

General arrangements for appointing co-opted members

3.1 It is widely recognised that in some circumstances, co-opted members can significantly aid the work of Scrutiny Boards. This is currently reflected in Article 6 (Scrutiny Boards) of the Council's Constitution, which outlines the options available to Scrutiny Boards in relation to appointing co-opted members.

3.2 In general terms, Scrutiny Boards can appoint:

- Up to five non-voting co-opted members for a term of office that does not go beyond the next Annual Meeting of Council ; and/or,

- Up to two non-voting co-opted members for a term of office that relates to the duration of a particular and specific scrutiny inquiry.

3.3 In the majority of cases the appointment of co-opted members is optional and is determined by the relevant Scrutiny Board. However, Article 6 makes it clear that co-option would normally only be appropriate where the co-opted member has some specialist skill or knowledge, which would be of assistance to the Scrutiny Board. Particular issues to consider when seeking to appoint a co-opted member are set out later in the report.

3.4 There are also some legislative arrangements in place for the appointment of specific co-opted members. Such cases are also set out in Article 6 (Scrutiny Boards) of the Council's Constitution and relate to Education representatives.

Issues to consider when seeking to appoint co-opted members

3.5 Currently, there is no overarching national guidance or criteria that should be considered when seeking to appoint co-opted members. As a result, there is a plethora of methods employed within Councils for the appointment of co-optees to Overview and Scrutiny Committees (Scrutiny Boards). For example, some

Council's use "job descriptions", some carry out formal interviews and some advertise for co-optees in the local press, with individuals completing a simple application form which is then considered by Members.

3.6 The Constitution makes it clear that 'co-option would normally only be appropriate where the co-opted member has some specialist skill or knowledge, which would be of assistance to the Scrutiny Board'. In considering the appointment of co-opted members, Scrutiny Boards should be satisfied that a co-opted member can use their specialist skill or knowledge to add value to the work of the Scrutiny Board. However, co-opted members should not be seen as a replacement to professional advice from officers.

3.7 Co-opted members should be considered as representatives of wider groups of people. However, when seeking external input into the Scrutiny Board's work, consideration should always be given to other alternative approaches, such as the role of expert witnesses or use of external research studies, to help achieve a balanced evidence base.

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

3.9 Historically, Scrutiny Boards that have considered issues across health and adult social care have tended to operate with standing co-opted members. In 2011/12, the Scrutiny Board (Health and Wellbeing and Adult Social Care) formally appointed four non-voting co-opted members to their membership, as follows:

- Alliance of Service Users and Carers – 1 co-opted member;
- Leeds Local Involvement Network – 2 co-opted members; and
- Equality representative – 1 co-opted member

3.10 In 2012/13, the Scrutiny Board retained these arrangements, however under the new arrangements created by the Health and Social Care Act 2012, Local Involvement Networks ceased to exist on 31 March 2013, with HealthWatch Leeds forming the local organisation responsible for gathering and representing the patient and public voice across the health and social care sector from 1 April 2013.

3.11 In 2013/14, the Scrutiny Board agreed not to appoint any standing non-voting co-opted members to its membership, but would review the appointment of non-voting co-opted members in relation to any particular and specific scrutiny inquiry during the 2013/14 municipal year. There was also a clear intention to continue to develop a close working relationship with HealthWatch Leeds, particularly in terms of gathering patient/ public views regarding specific work areas/ topics throughout the year. It is perhaps fair to say this approach had limited success.

3.12 It should also be noted that in a recent meeting between the Chair of the Scrutiny Board and the Chair and Director of HealthWatch Leeds, there was a positive discussion about appointing a representative from HealthWatch Leeds as a standing co-opted member to the Scrutiny Board, to help provide an opportunity for the views and intelligence gathered from service users and the wider public to be routinely brought to the attention of the Scrutiny Board.

3.13 This approach would note preclude any further appointment of co-opted members within the overall provision of the Council's Constitution.

4.0 Corporate Considerations

4.1 Consultation and Engagement

4.1.1 During 2010/11, the guidance surrounding co-opted members was discussed by the Scrutiny Chairs and it was agreed that individual Scrutiny Boards would consider the appointment of co-optees on an individual basis.

4.2 Equality and Diversity / Cohesion and Integration.

4.2.1 The process for appointing co-opted members should be open, effective and carried out in a manner which seeks to strengthen the work of the Scrutiny Board. In doing so, due regard should also be given to any potential equality issues in line with the Council's Equality and Diversity Scheme.

4.3 Council Policies and City Priorities

4.3.1 The Council's Scrutiny arrangements are one of the key parts of the Council's governance arrangements. Within the Council's Constitution, there is particular provision for the appointment of co-opted members to individual Scrutiny Boards, which this report seeks to summarise.

4.4 Resources and Value for Money

4.4.1 Where applicable, any incidental expenses paid to co-optees will be met within existing resources.

4.5 Legal Implications, Access to Information and Call In

4.5.1 Where additional members are co-opted onto a Scrutiny Board, such members must comply with the provisions set out in the Member's Code of Conduct as detailed within the Council's Constitution.

4.6 Risk Management

4.6.1 No specific implications to consider.

5.0 Conclusions

5.1 For a number of years the Council's Constitution has made provision for the appointment of co-opted members to individual Scrutiny Boards. However, the appointment of co-opted members has not always been considered

consistently across Scrutiny Boards. This report therefore sets out the legislative arrangements in place for the appointment of specific co-opted members and also provides further guidance when seeking to appoint co-opted members.

6.0 Recommendations

6.1 In line with the options available outlined in this report, Members are asked to consider the appointment of co-opted members to the Scrutiny Board.

7.0 Background documents[1]

7.1 None.

[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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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: 15 July 2014

Subject: Nomination to the Joint Health Overview and Scrutiny Committee (Yorkshire and Humber) in relation to the new review of Congenital Heart Disease services

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. At its meeting on 26 March 2014, Council considered recommendations put forward from the General Purposes Committee relating to confirming the mandate of a Joint Health Overview and Scrutiny Committee (Yorkshire and Humber) and delegating relevant functions in relation to the new review of Congenital Heart Disease services.

2. At that meeting, Council resolved:

   (a) That Council reconfirms its support for the establishment of a Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) in relation to NHS England's new review of Congenital Heart Disease services;

   (b) That Council delegates relevant functions, as set out in Appendix 1 of the submitted report to the General Purposes Committee[1], that shall be exercisable by the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber), subject to such terms and conditions therein, and ;

   (c) That Council asks the Scrutiny Board (Health and Wellbeing and Adult Social Care) to nominate a member from within its membership to sit on the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) in relation to the new review of Congenital Heart Disease services and, upon nomination, agrees to appoint such member to the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber).

[1] Attached at Appendix 1 for information.

3. Subsequently, at its meeting on 28 March 2014, the Scrutiny Board (Health and Wellbeing and Adult Social Care) nominated Cllr John Illingworth (as Chair of the Scrutiny Board) as Leeds City Council's representative to serve on the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) in relation to the new review of Congenital Heart Disease services

4. However, given the changed membership of the Scrutiny Board (Health and Wellbeing and Adult Social Care) agreed by Council at its Annual Meeting on 9 June 2014, it is now necessary for the Scrutiny Board to reconsider its previous nomination to ensure a member from within its current membership forms part of the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber), in relation to the new review of Congenital Heart Disease services.

Recommendations

5. That the Scrutiny Board (Health and Wellbeing and Adult Social Care) reconsiders its previous nomination and now nominates a member from within its current membership to sit on the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) in relation to the new review of Congenital Heart Disease services.

Background papers[2]

6. None used

[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.

SECTION 4 - JOINT ARRANGEMENTS

The **Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber)** is a joint committee appointed under Regulation 30 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013/218 and is authorised to discharge the following health overview and scrutiny functions of the authority[1], insofar as they relate to NHS England's new review of Congenital Heart Disease services:

a) To review and scrutinise any matter relating to the planning, provision and operation of the health service in its area, pursuant to Regulation 21 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

b) To make reports and recommendations on any matter it has reviewed or scrutinised, and request responses to the same pursuant to Regulation 22 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

c) To comment on, make recommendations about, or report to the Secretary of State in writing about proposals in respect of which a relevant NHS body or a relevant health service provider is required to consult, pursuant to Regulation 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

d) To require a relevant NHS body or relevant health service provider to provide such information about the planning, provision and operation of the health service in its area as may be reasonably required in order to discharge its relevant functions, pursuant to Regulation 26 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

e) To require any member or employee of a relevant NHS body or relevant health service provider to attend meetings to answer such questions as appear to be necessary for discharging its relevant functions, pursuant to Regulation 27 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

Member Authorities:

- Barnsley MBC
- Calderdale Council
- City of Bradford MDC
- City of York Council
- Doncaster MBC
- East Riding of Yorkshire Council
  Hull City Council
- Kirklees Council
- Leeds City Council
- North East Lincolnshire Council
- North Lincolnshire Council
- North Yorkshire County Council
- Rotherham MBC
- Sheffield City Council
  Wakefield Council

Reference to more specific details:
http://democracy.leeds.gov.uk/ieListMeetings.aspx?CId=793&Year=0

[1] In accordance with regulations issued under Section 244 National Health Service Act 2006 (the regulations)

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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: 15 July 2014

Subject: Leeds Teaching Hospitals NHS Trust: Care Quality Commission – Hospitals Inspection Outcome

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. The purpose of this report is to present s summary of the outcome of the Care Quality Commission (CQC) hospital inspection of services provided by Leeds Teaching Hospitals NHS Trust (LTHT).

2. Following a series of both announced and unannounced inspection visits across various hospital sites in March 2014; the Care Quality Commission (CQC) published its findings, recommendations and overall rating for LTHT on 1 July 2014. A summary report detailing the overall findings and recommendations is attached at Appendix 1.

3. The inspection was undertaken in accordance with the relatively new hospital inspection methodology. The full reports relating to the inspection can be accessed on the CQC's website using the following link: http://www.cqc.org.uk/provider/RR8

4. A summary of the overall ratings provided against the five key areas is provided in the table below:

Assessment area	Judgement
Overall rating for this trust	Requires improvement
Are acute services at this trust safe?	Requires improvement
Are acute services at this trust effective?	Good
Are acute services at this trust caring?	Good
Are acute services at this trust responsive?	Requires improvement
Are acute services at this trust well-led?	Requires improvement

5. In response to the areas of improvement identified through the inspection process, LTHT will be required to produce its associated action plan. This will subsequently be published and available on the CQC website. Clearly, the Scrutiny Board may wish to adopt an active role in monitoring LTHT's progress against its action plan. However, due to the timing of the Scrutiny Board meeting, the action plan is not yet available.

6. It is proposed to present LTHT's action plan to the September Scrutiny Board meeting and invite representatives from LTHT and the CQC to discuss the improvements with the Scrutiny Board.

Recommendations

7. The Scrutiny Board (Health and Wellbeing and Adult Social Care) is asked to:
    a. Note the content of this report and the outcome from Leeds Teaching Hospitals NHS Trust (LTHT) recent inspection.
    b. To note and agree the proposal to present LTHT's action plan to the Scrutiny Board meeting in September 2014 and invite representatives from LTHT and the Care Quality Commission (CQC) to discuss the inspection outcomes and improvement actions in more detail.
    c. Identify any specific matters that may require more detailed consideration at this time.

Background papers[1]

8. 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 Teaching Hospitals NHS Trust

Quality Report

Great George Street
Leeds
West Yorkshire
LS1 3 EX
Tel: 0113 2432799
Website: www.leedsth.nhs.uk

Date of inspection visit: 17-20 & 30 March 2014
Date of publication: 1 July 2014

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust	**Requires improvement**
Are acute services at this trust safe?	**Requires improvement**
Are acute services at this trust effective?	**Good**
Are acute services at this trust caring?	**Good**
Are acute services at this trust responsive?	**Requires improvement**
Are acute services at this trust well-led?	**Requires improvement**

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Overall summary

Letter from the Chief Inspector of Hospitals

Leeds Teaching Hospitals NHS Trust is one of the largest trusts in the United Kingdom and serves a population of about 752, 000 in Leeds and surrounding areas treating around 2 million patients a year. In total, the trust employs around 15,000 staff and provides 1785 inpatient beds across Leeds General Infirmary, St James's University Hospital, Leeds Children's Hospital and Chapel Allerton Hospital. Day surgery and outpatients' services are provided at Wharfedale Hospital and outpatients' services at Seacroft Hospital.

We carried out this comprehensive inspection because the Leeds Teaching Hospitals NHS Trust was initially placed in a high risk band 1 in CQC's Intelligent Monitoring System. Immediately prior to the inspection the intelligent monitoring bandings were updated and the trust was then placed in a low risk band 4, this was in the main due to an improved staff survey result.

We did not inspect Leeds Dental Institute as part of this review as this is a specialist service and outside the scope of the inspection. In addition, Leeds Teaching Hospital NHS Trust provides children's cardiac surgery services, which are also specialist services and therefore not included in this inspection.

We undertook an announced inspection of the trust on 17, 18, 19 and 20 March 2014. We also inspected Leeds General Infirmary and St James's University Hospital unannounced on the evening of 30 March 2014.

Our key findings were as follows:

Accident and Emergency services

Leeds General Infirmary and St James's University Hospital provided accident and emergency services for adults. Children's accident and emergency services were provided at Leeds General Infirmary.

At department level, the service was well led, staff felt engaged and involved in service improvement and redesign work. Staff worked well as a team.

The accident and emergency departments at both hospitals were clean and well maintained.

Nursing and medical staffing levels were safe as the trust was proactively managing the shortage of doctors by increased consultant cover and by developing advanced practioners and overseas emergency medicine training programmes.

Nursing handovers were comprehensive and thorough covering elements of general safety as well as patient specific information.

There was good ownership of risk and learning from incidents within the departments.

Not all staff had completed mandatory training particularly safeguarding children Levels 2 and 3 where appropriate.

Care and treatment was in accordance with nationally recognised best practice guidelines.

There was an effective Clinical Decisions Unit with access to a range of specialists 24 hours a day, including good access to mental health services, through the acute liaison psychiatry (ALP) service.

Patients were treated with dignity and respect and kept informed by staff about what was happening during the course of their stay in the department. The implementation of dignity rounds helped ensure that patients were as comfortable as possible, including ensuring that drinks and food was available.

The trust had been performing better than the national targets since June 2013 for 95% of patients waiting less than four hours to be admitted, transferred or discharged. Patient flow was maintained through the departments and was better than the national average.

The children's accident and emergency department was staffed by paediatric consultants and nurses, and the trust had recently recruited more staff. The service improvement team was reviewing staffing within the children's accident and emergency department as part of a wider piece of work looking at the effectiveness of the department. On most day shifts there was a nursery nurse on duty with one or two care support workers.

Summary of findings

Medical services

Both Leeds General Infirmary and St James's University Hospital provided medical services. Leeds General Infirmary provided specialist cardiology, neurology and stroke services for the region. It did not accept general medical patients (who were transferred to the St James's University Hospital).

Patients were admitted promptly to the appropriate ward, although some patients then had to be transferred to an 'outlying' ward once their acute phase of treatment was finished as there were some delays in transferring them back into the community.

There had been a concentration on improving the acute care pathway, which meant that the elderly care service had not developed as it should, particularly the care of patients living with dementia.

Medical wards at both hospitals were clean and well maintained.

Low numbers of nursing and medical staff in some areas, particularly out of hour's medical cover and anaesthetists meant that there was a risk that patients were not always protected from avoidable harm.

There was a good culture of reporting incidents among the nursing staff, but this was not seen as a priority for all clinical staff. The recent introduction of the 'safety board' on wards had been embraced by the staff and all spoke positively about it.

Not all staff had completed their mandatory training.

There was inconsistency with the quality and recording of the nursing and medical handovers, which meant important information may not always be passed on appropriately to the next shift.

Care was provided in line with national best practice guidelines and the trust performed well in comparison to other hospitals providing the same type of treatment. Although there was an annual clinical audit programme and a central Clinical Audit Database on which clinical audits should be recorded, this was still in its relative infancy and thus although audits were undertaken there lacked clarity over what was being audited, the outcomes and how this information was captured.

Multidisciplinary working was widespread and the trust had made significant progress towards seven-day working.

Patients were treated with kindness and respect and patients were complimentary and full of praise for the staff looking after them.

Surgical services

Surgical services were provided by Leeds General Infirmary, St James's University Hospital, Chapel Allerton Hospital and Wharfedale Hospital. Wharfedale Hospital only provided day case surgery. Staff reported a significant shift in culture in the organisation and the new management arrangements were working well, although the analysis and use of performance data was 'work in progress.

Wards and theatres were generally clean across all hospital sites and there was evidence of learning from incidents in most areas.

There were arrangements in place for the effective prevention and control of infection.

Not all staff had completed their mandatory training.

The operating theatres used the World Health Organisation safety checklist, although improvements were needed as not all aspects such as the debriefing were embedded in practice.

At Leeds General Infirmary and St James's University Hospitals, we found that there were inadequate levels of staff, both nursing and medical in some areas, particularly out of hours' medical cover and anaesthetist availability. In response to this the trust had increased the use of locums to minimise risk.

Trust policies were available, which incorporated best practice guidelines and quality standards to monitor performance. However, there was insufficient audit evidence and systematic monitoring to demonstrate these were implemented and effective.

Patients were positive about their care and treatment and were treated with dignity and respect.

There were systems in place to manage the flow of patients through the hospital and discharge dates and plans were discussed for most patients.

Summary of findings

Staff were aware of how to support vulnerable patients. However, mental capacity assessments were not always documented in accordance with the Mental Capacity Act (2005).

There was good multidisciplinary working with coordination of care between different staff groups, such as physiotherapists, nurses and medical staff.

Critical care

Critical care was provided at Leeds General Infirmary and St James's University Hospital. Staff were positive about the new leadership team and felt that communication had improved. However, staff were concerned about the increasing critical care bed pressures and increasing demands on the service.

We had concerns about the apparent 'us and them' culture between the two main hospital sites, the lack of engagement between senior medical staff and the limited planned cross-site working.

The critical care units were found to be clean with appropriate arrangements in place to prevent and manage infection, although there was some confusion over the use of some personal protective equipment.

Substantive nurse staffing levels were consistently below those required levels, which placed a reliance on nursing staff to work additional hours and a high use of agency staff. This was considered a risk by the permanent nursing team.

Mental capacity assessments and the deprivation of liberty safeguards were not embedded as part of the critical care process. Mandatory training completion was low and the mechanism in place for ensuring staff were up-to-date with their training appeared ad-hoc despite being co-ordinated by the Organisational Learning Department.

The critical care units followed a variety of national guidelines to determine best practice and we observed commonly used care tools such as care bundles.

We had concerns about the medical cover, the quality of the handover and support on the high dependency unit on Ward L39 at Leeds General Infirmary, which was overseen by the surgical services unit rather than the critical care service in accordance with the Critical Care Core Standards (2013).

Staff were caring and respected patients' privacy and dignity. Patient's families and carers were kept informed and involved and felt able to discuss concerns with staff.

Maternity and family planning

Maternity and family planning services were provided at Leeds General Infirmary and St James's University Hospital. There was consistency of leadership across the maternity services, regardless of the location.

Maternity service areas were clean and effective procedures were in place to monitor infection control.

Where incidents had been identified, staff had been made aware and action taken.

There was a shortfall in relation to midwifery and medical staffing; action had been taken to recruit midwifery staff and medical rotas were in place to cover the maternity services. Staff reported that despite the vacancies, systems were in operation to ensure safety at all times.

Women received care according to professional best practice clinical guidelines and audits were carried out to ensure that staff were following recognised national guidance.

Women were pleased with the quality and continuity of service and felt staff had treated them with dignity and respect. Women were involved in their care; this had included the development of their birth plan and aftercare.

The maternity service had several midwives who had specialist areas of expertise to meet the diverse needs of women in their care.

Children's and young people's services

The Children's Hospital was located within the buildings and facilities of the main hospital site of Leeds General Infirmary and was not easily identifiable as a dedicated service. There was no formal executive lead and oversight of children's services, which were provided across other clinical service units in addition to those in the Children's Hospital.

Nurse staffing levels on the children's wards were identified as a risk and regularly fell below expected minimum levels, which placed staff under increased

Summary of findings

stress and pressure. There were gaps at middle-grade and junior doctor level and some medical staff were covering paediatric specialties without any specific paediatric training.

Although Quality and Safety Matters briefings were issued to staff to encourage shared learning from serious incidents not all staff we spoke to were aware of recent serious incidents that had occurred within the trust.

Children's services were utilising national guidance, peer reviews and care pathways.

Nursing, medical and other healthcare professionals were caring and parents were positive about their experiences. Patients and their relatives were treated with compassion and felt involved in decisions about their care and treatment.

Apart from the teenage cancer unit, there were no dedicated areas for young people. Young people over the age of 16 were admitted to adult wards were not always assessed for their stage of development. Although there was work in place to look at the transition from children's to adult services, there was no policy for such transitions within the trust.

End of life care

The trust had recently introduced new 'care of the dying patient' care plans to replace the Liverpool Care Pathway (LCP). We were told that a future audit of the use of these was planned to assess their effectiveness.

Staff involved people in their care and treated them with compassion, kindness, dignity and respect.

Staff were committed to ensuring a rapid discharge for people receiving end of life care who wanted to go home or go to a hospice as their preferred place of care.

All the wards and departments we visited were led by managers who were committed to ensuring patients and their families received a high quality service.

Staff were positive about the management and support given with end of life care.

We saw some inconsistencies when assessing a patient's capacity when making decisions about whether a 'do not attempt cardiopulmonary resuscitation' was appropriate. The Mental Capacity Act 2005 was not being consistently applied or documented.

Outpatients

Outpatient services were provided by all the hospital sites inspected.

There was consistency in leadership and governance from the clinical service unit at all sites. Staff at all levels felt encouraged to raise concerns and problems.

Incidents were investigated appropriately and actions were taken following incidents to ensure that lessons were learned and improvements were shared across the departments and hospitals.

Clinics were generally clean and appropriately maintained. The infection control procedures were adhered to in clinical areas, which appeared clean and reviewed regularly.

Staffing levels were adequate to meet patients' needs.

The trust completed audits and had implemented changes to improve the effectiveness and outcomes of care and treatment.

Patients felt involved in their care and treatment and that staff supported them in making difficult decisions. The hospitals provided interpretation services and patients' privacy and dignity were respected.

A common theme from the analysis of patient feedback was that waiting times in clinics could be improved in terms of length of wait and patients being informed of why and how long they were expected to wait.

Medication

There were appropriate arrangements in place the safe storage, administration and disposal of medication.

Medication storage areas were well organised and administration appropriately recorded, including the handling and disposal of controlled medications.

There was inconsistent prescribing of oxygen, which did not adhere to trust policy.

Complaints management

When we carried out this inspection, colleagues from the Patients Association looked at how complaints were managed in the trust using the Patient's Association Good Practice Standards for Complaints Handling. A separate report has been provided to the trust with the outcome to this inspection.

Summary of findings

From April to November 2013, the top three themes of complaints were with regard to communication, medical care and attitude. The trust's Patient Advice and Liaison Service received 2895 concerns during the period April to November 2013. The highest number concerned head and neck, neurosciences and trauma services, mainly relating to administration, appointment or waiting time issues.

In January 2014, a revised Complaints Policy was implemented across the trust with the strategic intention of improving the management of complaints, attitude to complainants and to provide all those involved in the complaint handling with training.

A new team had been established and this was impacting positively on the receipt and handling of complaints.

The executive team was found to be committed to a cultural change in the handling of complaints and an improved response to patients concerns.

Work was progressing, but further areas for improvement included the increased capacity of the Patient Advice and Liaison Service, embedding the monitoring and auditing of complaints including performance information and better sharing of lessons learnt.

We saw areas of outstanding practice including:
The Macular Degeneration Clinic at St James's University Hospital and Seacroft Hospital had won a national patient award for exceptionally good practice in the care of people with macular degeneration.

The Disablement Service Centre at Seacroft Hospital had been voted the best centre for the third year by the Limbless Association Prosthetic and Orthotic Charity.

The geriatricians had worked with the community and the A&E department to try to help avoid unnecessary admissions in the elderly population. Elderly patients were seen early by a multidisciplinary team, which was led by a consultant geriatrician and had significantly reduced the number of admissions. They also provided telephone advice to GPs via the Primary Care Advice Line. This work had been acknowledged by the British Geriatric Society and the Health Service Journal.

Importantly, to improve quality and safety of care, the trust must:
Ensure there are sufficient qualified and experienced nursing and medical staff particularly on the medical elderly care wards children's wards and surgical wards, including anaesthetist availability and medical cover out of hours and weekends.

Ensure that staff attend and complete mandatory training, particularly for safeguarding and maintaining their clinical skills.

Ensure the appraisal process is effective and staff have appropriate supervision and appraisal.

Review the skill base of ward staff regarding care of patients discharged from the critical care units to ensure that they are appropriately trained and competent.

Ensure that staff are clear about which procedures to follow with relation to assessing capacity and consent for patients who may not have mental capacity to ensure that staff are clear about the Mental Capacity Act and implement and record this appropriately.

Ensure staff are aware of the Deprivation of Liberty Safeguards and apply them in practice where appropriate.

Ensure that there are effective systems in place to ensure that risk assessments are appropriately carried out on patients in relation to tissue viability and hydration, including the consistent use of protocols and appropriate recording practices.

Ensure that all staff report incidents and that learning including feedback from serious incident investigations is disseminated across all clinical areas, departments and hospitals.

Review the nursing and medical handover to ensure that the appropriate information is passed to the next shift of staff and recorded.

Review the practice of transferring patients to wards before the bed is ready for them, necessitating waits on trolleys in corridors.

Introduce a rolling programme to update and replace aging equipment particularly on the critical care units.

Review the arrangements over the oversight of L39 High Dependency Unit at Leeds General Infirmary to ensure

there is appropriate critical care medical oversight in accordance with the Critical Care Core Standards (2013). Ensure handovers are robust and consider introducing performance data for the area to assess and drive improvement.

Review the access and supervision of trainee anaesthetists and ensure that these provide the appropriate support to ensure care and treatment is delivered safely.

Review the clinical audit and auditing of the implementation of best practice, trust and national guidelines to ensure a consistent delivery of a quality service.

Review the information available on the guidance utilised across clinical service units to ensure the consistent implementation of trust policy, procedure and guidance.

However, there were also areas of practice where the trust should make improvements.

Review the effectiveness of the recruitment of staff processes to ensure delays to recruitment are kept to a minimum.

Ensure that there is medical ownership of patients in the emergency department, regardless of which speciality they have been referred to and accepted on.

Ensure that confidential patient information stored on computers in the minor injuries area is not accessible to unauthorised personnel.

Ensure that information about the Patient Advice and Liaison Service (PALS) and how to make a complaint is visible in patient areas.

Review the information available for people who have English as a second language and make written information more accessible including clinical decisions and end of life care.

Ensure that the provision of oxygen is appropriately prescribed.

Ensure that all staff involved in patient care are aware of the needs of people living with dementia and that the documentation used reflects these needs.

Ensure that all early warning score documentation is fully completed on each occasion used.

Consider displaying trend data over a period of time as part of the ward dashboards and that information is disseminated to staff.

Ensure that the windows on L26 are repaired and that the ventilation of the ward is appropriate to need.

Review the use of the Family and Friends Test results to improve consistency across departments.

Review the implementation of the guidance for the use of locum medical staff to ensure the effective induction and support of doctors.

Review the recruitment processes to ensure that they are efficient and timely.

Review the support and provision of the medical elderly care services with consideration of providing a seven day service and contribution to the monthly clinical service unit governance meetings.

Review the use of the World Health Organisation safety checklist for theatres to ensure that it includes all elements such as the team debrief.

Review the performance outcomes to ward safety thermometer dashboard results to ensure effective action planning to drive improvement.

Review the arrangements for surgery on the Clarendon Wing regarding their suitability and how performance, oversight and reporting were effective.

Review the bathing arrangements on Wards L24 and L50 to ensure that they meet health and safety standards and that there is accessible facilities for people with mobility problems.

Review the sterile supplies provision for sterile instruments and equipment in theatres to be assured that they deliver good quality in a timely manner.

Review the security of the hospital in general, but specifically with regard to access to theatre departments.

Ensure that risk registers are of a consistent quality and contain the appropriate details regarding actions taken or in progress.

Review the use of personal protective equipment on the critical care units to ensure consistent practice.

Implement a seven day a week critical care outreach team.

Summary of findings

Review the IT system to ensure that all necessary information such as that identifying if a social worker is involved when 'Looked After Children' arrive in the hospital.

Review the consent process to ensure that where appropriate the child or young person is involved in decisions and signatures are obtained.

Develop facilities and recreational activities for older children and young adolescents in children's services.

Appoint an executive lead for children's services to ensure that there is consistent oversight and shared learning across clinical areas.

Review the frequency and effectiveness of the surgical morbidity and mortality meetings so that there is a more effective use of lessons learnt to improve patient outcomes.

Introduce a robust patient tracking system for surgical patients so that there is continuity of care at all times.

Review the effectiveness and care of patients following surgery on Bexley Wing in relation to the transfer post operation to Geoffrey Giles Theatres in Lincoln Wing, and potential multiple moves to fit in with service operating times.

Consistently apply patient feedback processes across clinical support services.

Review the waiting times in the outpatient clinics and information given to patients to ensure these are kept to a minimum length and patients understand what to expect.

Review the condition of the facilities in the mortuary to ensure all areas are fit for purpose.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

The five questions we ask about trusts and what we found

We always ask the following five questions of trusts.

Are services safe?

Requires improvement

Overall, we rated the safety of services as requiring improvement. There were arrangements to assess, monitor and report risk with new governance and reporting structures in place. Areas visited were clean with systems to manage and monitor the prevention and control of infection. Attendance at mandatory training was low in some areas and staff did not always have access to the necessary training to maintain their skills. Not all clinicians involved in the care of children had undertaken appropriate children's safeguarding training. A safety culture was not yet fully embedded in the hospital. There was good reporting of incidents among the nursing staff, but this was not seen as a priority for all clinical staff. Lessons learnt from incidents were shared within departments or amongst the clinicians concerned, but there was limited sharing between clinical service units and other trust hospitals.

Nursing and medical staff shortages were experienced across a number of areas of the hospitals and meant that the necessary experience and skills mix did not always meet Royal College and national recommendations for best practice. Medical cover out of hours was a particular concern on the medical elderly care, children's and surgical wards. We had particular concerns over access to anaesthetists, particularly out of hours. The trust had taken a number of steps to address the shortfalls including increasing consultant cover. We found that mental capacity was not always being assessed in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberties Safeguards; where these were being undertaken, they were not consistently being recorded appropriately.

Are services effective?

Good

Overall, we rated the effectiveness of services as good. Care was provided in line with national best practice guidelines and the trust performed well in comparison to other hospitals providing the same type of treatment. We observed commonly used care tools such as care bundles for the care and treatment of specific medical conditions. Multidisciplinary working was widespread and the trust had made significant progress towards seven-day working.

Clinical audits were taking place, but although there was an annual clinical audit programme and a central Clinical Audit Database this was still in its relative infancy and therefore there was a lack of clarity over what was being audited, the outcomes and how this information was captured. Junior doctors in some areas reported no

Summary of findings

active involvement or encouragement to be involved in clinical audit or quality improvements. Further work was required to monitor and audit the implementation of trust policies, guidelines and best practice recommendations.

Are services caring?

Good

Overall, we rated caring in the trust as good. We observed that staff were kind, caring and ensured that the patients' privacy and dignity were respected when attending to individuals' personal needs. Patients told us they had been involved in decisions about their care and treatment. Nurses introduced themselves to their patients at all times. Doctors explained to patients their diagnosis and made them aware of what was happening with their care. We did however, have concerns over patients' and their families involvement in end of life decisions, as records did not consistently demonstrate that discussions had taken place.

Analysis of patient feedback information showed that generally patients were positive about their experience, particularly in the accident and emergency department. End of life support was reported to be good and a specialist team was available to advise and ensure that patients were given, were possible the opportunity to be cared for in their place of preference.

Are services responsive to people's needs?

Requires improvement

Overall, we rated the responsiveness of services as requiring improvement. Access to services was generally good; patients' needs were responded to appropriately and in a timely manner. The hospital had been performing better than the A&E national targets since July 2013, with 95% of patients waiting less than four hours to be admitted, transferred or discharged. The hospital was performing similar to hospitals in other trusts in both cancelled operations and delayed discharges. Generally, the hospital was performing well with access to appointments and waiting times, although there was an elevated risk with referral to treatment times under 18 weeks on the admitted pathway.

There was a focus on continuous quality improvement but further work was required on ensuring a consistent response to the needs of people living with dementia. Staff on the critical care units were concerned about the increasing bed pressures and increasing demands on the service, particularly because of the hospital's trauma centre status. Apart from the teenage cancer unit, there were no dedicated facilities including recreational for young people. Young people over the age of 16 were admitted to adult wards without an assessment of the appropriateness for their stage of development.

Summary of findings

Are services well-led?

Requires improvement

Overall, we rated the leadership within the trust as requiring improvement. The trust had recently introduced a new leadership and governance structure. Services were arranged within 19 clinical service units (CSUs) led by a senior doctor, nurse and manager. The clinical service unit structure crossed the different hospital sites and was yet to be fully established. There had been a change of leadership at trust level in 2013 and staff reported that there had been a shift in culture since this change. The Chief Executive in particular was visible and staff reported a positive lift in confidence within the hospital and trust as a whole.

At a local level, they felt supported by their managers. However, there were still areas that had not embraced the cross site ethos and different cultures were reported in some areas. Opportunities to improve the safety culture and quality of services were missed as good practice and learning from incidents was not consistently shared across clinical service units and reporting was not fully embedded across different staff groups. New systems and processes were still in their infancy and although improvements were being felt and reported by staff, there was still a need to embed these at local service level and within staff practices.

Vision and strategy for this service

- The trust had recently published a five year strategy consultation document for 2014, which sets out the trust's values, culture and vision.
- The vision aims to deliver five goals – to be patient centred, fair, collaborative, accountable and empowered with 10 corporate objectives. The values and objectives had been developed in consultation with staff across the trust.
- The work developing the trust vision and strategy was in its infancy and the executive team was working hard to act inclusively with staff across the trust.
- In many areas, the trust's objectives and vision were displayed on wards, together with the names of Trust Board members. We heard the phrase – "The Leeds way", which was being seen as a drive to create a high performing, patient centred organisation.

Governance, risk management and quality measurement

- There had been a significant change to the governance structure across the trust. The previous five divisions had been split into 19 smaller clinical service units.
- Each clinical support unit was led by a triumvirate of a medical, nursing and manager leads. It was evident from interviews and discussion with staff that this structure was in its infancy and although positively received, the benefits had yet to be realised.

Summary of findings

- Not all clinical service units were working across hospital sites effectively, there was a risk that 'silo working' would develop, for instance there was reported little 'joined up working' within and across the critical care units.
- The trust was in the process of re-developing risk management and assurance systems such as the Board Assurance Framework. However, it was too early to assess whether these would bring the robustness needed to ensure the timely and appropriate identification of risk. We found concerns such as the lack of appropriate mental capacity assessments, inconsistent application of the best practice guidance for 'do not attempt cardiopulmonary resuscitation' decisions, the lack of critical care oversight on the High Dependency Unit (L39) at Leeds General Infirmary and the lack of supervision for trainee anaesthetists had not been highlighted to the trust so that these issues could be addressed or mitigated against.
- There were systems in place for reporting incidents and events. However, lessons from the investigation of these had been in the main fed back to the clinicians concerned or the service involved. Staff reported that learning from lessons was improving, but that the some of the formal processes in place such as a trust-wide Learning Points Bulletin, and fortnightly Quality and Safety Matters briefing were still in their infancy. There was reporting to the Trust Board about incidents, but it was not clear that the information from reporting was robust, consistent and information was not always timely.
- There was good incident reporting by nursing staff, but this was not seen as a priority for all clinicians. Therefore, there was a missed opportunity to improve the safety and quality of services and meant that a safety culture was not yet fully embedded in the trust.
- Accountability was increasing across the services with the introduction of the clinical service units and new initiative such as the 'Ward Healthcheck'. This gave a three monthly oversight of individual ward performance against a multitude of performance measures, such as – staffing, the Friends and Family Test and safety measures such as the number of falls, pressure ulcers and infection rates.
- The Ward Healthcheck had only been in place one month prior to the inspection, as such it was too early to make any assessment of this initiative, but it was well received by staff and seen as an aid to drive improvement.
- There were regular governance meetings across the clinical service units. However, not all were fully attended. Notably,

elderly care was not always represented and it was acknowledged that there had been a concentration on improving the acute medical care processes and that attention was now needed on the elderly care wards.
- Mandatory training across many areas was not completed and the appraisal rate was poor in some areas.
- Staff shortages in some areas were a risk to patient care and the organisation. Recruitment was actively taking place and initiatives such as the emergency medicine practitioner programme had been introduced. However, recruitment processes were reported to be poor and lengthy. There had been investment in recruiting, but this was planned to take place over the next 30 months and consideration should be given to accelerating this process and ensure that there is a contingency plan if recruitment fails to provide the necessary skills.

Leadership of service

- The Chair and the Chief Executive were appointed in 2013.
- Staff reported that morale had improved with the new team, and that the Chief Executive was visible.
- Staff reported that the new leadership had made significant changes in communication, governance and was seen to be driving a quality experience for patients in the organisation.
- There were some areas that would benefit from some specific lead roles. For example, there was no executive lead at board level for the oversight of children's services across the trust.
- The Quality Committee had previously been chaired by a non-executive director who had now left. An interim arrangement had been put in place for the chair of the Trust to provide non-executive leadership for quality until the new non-executive director takes up their post.

Culture within the service

- Staff across the trust reported that there had been a significant change in culture with the commencement of the new executive and leadership team. Staff reported that the culture was more honest and open, that they felt well informed and involved.
- Many areas visited spoke of changes in culture putting the patient first and a drive for quality care.

Public and staff engagement

- Staff engagement had increased recently, with more consultation across a range of issues and strategies such as the

trust's vision and values. Staff reported that they felt better informed than previously and communication came in a range of forms including the staff Bulletin (staff magazine), weekly emails from the Chief Executive and newsletters.

- A Patient Experience Strategy had been produced in January 2014, but it was too early to assess whether the initiatives for consulting and engaging with the public would improve communication.
- The Trust Board had patient's stories as part of their meeting agendas.
- It was acknowledged that the patient engagement strategies are in the process of development and as such it was too early to make an assessment of their effectiveness.

Innovation, improvement and sustainability

- Innovation was encouraged from all staff members across all disciplines. Junior doctors and student nurses were involved in quality improvement projects. Staff were able to give examples of practice that had changed as a result.
- In recognition of the shortage of staff in some areas, the trust had developed training and development programmes such as the advanced practitioner programmes and the emergency medicine training programme for oversees medical students.
- There was a six-monthly 'innovation day', when staff displayed their recent projects.

Summary of findings

What people who use the trust's services say

The NHS Friends and Family Tests have been introduced to give patients the opportunity to offer feedback on the quality of care they had received. In October 2013, the trust scored about the same as the England average for inpatient tests, and significantly above for accident and emergency services, with a higher response rate for inpatient data.

Analysis of data from the Care Quality Commission's (CQC) Adult Inpatient Survey (2013) showed that the trust was rated as 'average' across all areas.

The Cancer Patient Experience Survey (CPES) 2012/13 - the trust performed 'better than other trusts' nationally for five of the 69 questions. The trust performed 'worse than other trusts' for 10 of the other questions in the survey.

CQC's Survey of Women's Experiences of Maternity services 2013 – Labour and Birth Data – the trust is performing the same as other trusts for two of the three areas of questioning. In comparison with the 2010 results, the trust is showing an upward trend in one of the eight questions asked.

Healthwatch shared their 2014 survey, where 183 people shared their views and experiences of services across all of the five hospitals at the trust. At trust level, approximately 44% rated the service outstanding, 24% were rated as good, 7% were rated as satisfactory and 26% were rated as requiring improvement.

Areas for improvement

Action the trust MUST take to improve

- Ensure there are sufficient qualified and experienced nursing and medical staff particularly on the medical, surgical and children's wards, including medical cover out of hours.
- Ensure that staff attend and complete mandatory training, particularly for the safeguarding of adults and children and maintaining their clinical skills.
- Ensure that doctors are able to attend teaching sessions and this includes specialist medication regimes and other clinical areas they cover for including children's services.
- Ensure the appraisal process is effective and staff have appropriate supervision and appraisal.
- Review the skill base of ward staff regarding care of patients discharged from the critical care units to ensure that they are appropriately trained and competent.
- Review the handover procedure for medical and nursing staff to ensure that the necessary information is communicated appropriately and effectively.
- Ensure that there is a coherent and clear auditing system in place for the participation of national clinical audits and auditing of trust guidelines and that there is an appropriate recording system in place to capture this. Review the involvement of junior doctors in the audit process.
- Introduce a rolling programme to update and replace aging equipment particularly on the critical care units.
- Review the arrangements over the oversight of L39 High Dependency Unit Leeds General Infirmary to ensure there is appropriate critical care medical oversight in accordance with the Critical Care Core Standards (2013). Ensure handovers are robust and consider introducing performance data for the area to assess and drive improvement.
- Review the access and supervision of trainee anaesthetists and ensure that these provide the appropriate support to ensure care and treatment is delivered safely.
- Ensure that staff are clear about which procedures to follow with relation to assessing capacity and consent for patients who may not have mental capacity to ensure that staff act in the best interests of the patient and this is recorded appropriately.
- Ensure staff are aware of the Deprivation of Liberty Safeguards and apply them in practice where appropriate.

Summary of findings

- Ensure that all staff report incidents and that learning including feedback from serious incident investigations is disseminated across all clinical areas, departments and hospitals.
- Ensure that there are effective systems in place to ensure that risk assessments are appropriately carried out on patients in relation to tissue viability and hydration, including the consistent use of protocols and appropriate recording practices.
- Review the practice of transferring patients to wards before the bed is ready for them, necessitating waits on trolleys in corridors.
- Review the information available on the guidance utilised across clinical service units to ensure the consistent implementation of trust policy, procedure and guidance.

Good practice

Outstanding practice

The Macular Degeneration Clinic at SJUH and Seacroft Hospital had won a national patient award for exceptionally good practice in the care of people with macular degeneration.

The Disablement Service Centre at Seacroft Hospital had been voted the best centre for the third year by the Limbless Association Prosthetic and Orthotic Charity.

The geriatricians had worked with the community and the A&E department to try to help avoid unnecessary admissions in the elderly population. Elderly patients were seen early by a multidisciplinary team, which was led by a consultant geriatrician and had significantly reduced the number of admissions. They also provided telephone advice to GPs via the Primary Care Advice Line. This work had been acknowledged by the British Geriatric Society and the Health Service Journal.

Leeds Teaching Hospital NHS Trust

Detailed findings

Hospitals we looked at
Leeds General Infirmary; Wharfedale Hospital; St James's University Hospital; Seacroft Hospital and Chapel Allerton Hospital

Our inspection team

Our inspection team was led by:

Chair: Dr Jane Barrett Consultant Radiologist

Head of Hospital Inspections: Julie Walton, Care Quality Commission (CQC)

The team included CQC inspectors and a variety of specialists: The team of 80 included CQC senior managers, inspectors and analysts, senior and junior doctors, nurses, midwives, a student nurse, a pharmacist, a paramedic, a theatre specialist, patients and public representatives, experts by experience and senior NHS managers.

Background to Leeds Teaching Hospital NHS Trust

Leeds Teaching Hospitals NHS Trust was formed in 1998 bringing together two smaller hospital trusts under a single management and direction for the first time. The trust treats around 2 million patients a year with a budget of around £1 billion per annum. The trust recognised it faces major financial challenges that will require significant action, particularly in improvements in performance.

There are approximately 86,000 attendances a year in the accident and emergency (A & E) department at St James's University Hospital and approximately 112,000 attendances in the A&E at Leeds General Infirmary, of which up to 31,000 are children (under 16 years old). Children are seen in the children's A&E, which is located next to the main A&E. The admission rate to a hospital ward at this site is about 33% for adults and 21% for children. At St James's University Hospital's A&E one emergency bay is equipped for children in case a child attended and not the children's A & E at Leeds General Infirmary.

Leeds General Infirmary provides cardiology, neurology and stroke services including percutaneous coronary intervention (for heart attacks) and thrombolysis (for strokes) service with a hyper-acute stroke unit. Ambulance services transport patients with suspected cardiological or neurological problems to this site. All other ambulance patients are taken to the St James's University Hospital

A&E. Any patient who walked into the A&E requiring medical input aside from cardiology or neurology would be stabilised first and then transferred to the other site under the care of the appropriate team.

St James's University Hospital provides acute and general medical care services. These include care of the elderly, respiratory, endocrine, infectious diseases, gastroenterology and acute medical wards. It also provides specialist oncology and renal wards, which were not inspected at this time.

Surgical services at Leeds General infirmary include trauma and orthopaedic surgery, ear, nose and throat (ENT), neurosurgery, spinal surgery, vascular, cardiac and plastic surgery. At St James's University Hospital there are a range of surgical services including general surgery, urological and gynaecological surgery, organ transplantation and day surgery. There is also a surgical admissions unit and a pre-assessment ward. Chapel Allerton Hospital provides orthopaedic and dermatology services and Wharfedale Hospital provides only day surgery services for general surgical, ENT, ophthalmology, gynaecology and vascular conditions.

Adult critical care services are provided across Leeds Teaching Hospitals NHS Trust, with 131 beds. The beds are split across two sites with three units at Leeds General Infirmary for general, cardiac and neuro-surgery and two units at St James's University Hospital for general intensive care and high dependency care. Critical care at St James's University Hospital comprise of 34 high dependency beds and 15 intensive care beds. There are 14 additional high dependency beds at St James University Hospital and six at Leeds General Infirmary, which sit outside the management of the critical care clinical service unit.

The trust provides obstetric/midwifery care at the St James's University Hospital and Leeds General Infirmary site, along with community midwifery care. It is a tertiary centre and therefore provides care for and advice to clinicians caring for women with complex needs. The service included pre conceptual care, early pregnancy care, antenatal, intra partum and postnatal care. The trust also had a tertiary Neonatal Intensive Care Unit at both sites, which provided medical neonatal care. At Leeds General Infirmary the service is for babies under 27 weeks gestation and high risk pregnancies, and they had a total of 27 neonatal cots. At St James's University Hospital the service is for babies above 27 weeks gestation and with a total of 34 neonatal cots.

End of life care services are provided throughout the trust. The Specialist Palliative Care Team is located at the Robert Ogden Centre at St James's University Hospital. The team comprises of consultant medical staff, speciality doctors, matrons, specialist palliative care nurses, a palliative care discharge facilitator, end of life care facilitators, a social worker and a pharmacist.

The trust provided a range of outpatient clinics with nearly one million patients attending each year. At St James University Hospital over 390,000 patients attended outpatient clinics in 2012-2013, 307,000 patients attended Leeds General infirmary and 51,000 patients attended Seacroft Hospital. The trust has dedicated outpatient departments with dedicated outpatient staff. The trust employs 220 nursing staff (Registered and Unregistered) who are supported by approximately 350 administrative and reception staff to provide and support outpatient services.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection team always inspects the following core services at each inspection, if they are provided by the hospital:

- Accident and emergency (A&E)
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Services for children and young people
- End of life care

Detailed findings

- Outpatients.

We inspected and reported on the following-

Leeds General Infirmary, which provided all eight core services. The Children's Hospital is located within the buildings and facilities of Leeds General Infirmary, and therefore the findings of the inspection of this hospital are reported in the children's and young people's core service of the Leeds General Infirmary report.

We inspected the outpatients' services located at Seacroft Hospital and the findings of this inspection are contained within the hospital report for St James's University Hospital.

St James's University Hospital, which provided seven core services – children's and young people's services were not provided at this hospital.

Wharfedale Hospital and Chapel Allerton Hospital only provide surgery and outpatients' core services.

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew about the hospital. This included the clinical commissioning group, local area team, NHS Trust Development Authority, Health Education England and Healthwatch. We carried out announced visits over a period of four days on 17, 18, 19 and 20 March and we undertook an unannounced visit to St James's University Hospital and Leeds General Infirmary on 30 March 2014.

During the visits we held focus groups with a range of hospital staff, including support workers, nurses, midwives, doctors (consultants and junior doctors), physiotherapists, occupational therapists and student nurses. We talked with patients and staff from all areas of the trust, including the wards, theatres, critical care unit, outpatients, and A&E department. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' personal care or treatment records.

We held two listening events on 11 March 2014 to hear people's views about care and treatment received at the hospitals. We used this information to help us decide what aspects of care and treatment we looked at as part of the inspection. We also held a community focus group with the support of Regional Voices (through Involve Yorkshire and Humber) who was working with Voluntary Action Leeds so that we could hear the views of harder to reach members of public.

Facts and data about this trust

Safety

The trust had five Never Events between December 2012 and November 2013. Three related to swabs being left inside a patient after surgery, one was due to a small piece of equipment being left in a patient and one was a result of a misplaced nasogastric tube.

Between December 2012 and January 2014, 38 Serious Incidents occurred at the trust and were reported to the Strategic Executive Information System (STEIS). Ward areas accounted for 44% with the remaining split across nine separate areas.

Leeds General Infirmary accounted for 50% of serious incidents between December 2012 and November 2013, with St James's University Hospital having the second highest.

Medical specialities had the highest number of patient incidents reported to the National Reporting and Learning System (NRLS) with 43%. Incidents with a moderate degree of harm were the most common at 51%. Death incidents accounted for 9% of incidents reported to the NRLS, but 0.001% of all incidents reported by the trust.

The trust's infection rates for Methicillin Resistant Staphylococcus Aureus were within statistically acceptable range for the size of the trust. However, there was an elevated risk for Clostridium difficile.

Medication errors were within statistically acceptable limits.

There were no concerns for this trust in the Schedule 5 (formerly Coroner's Rule 43) report.

New pressure ulcers – from November 2012 to November 2013 the trust had performed well above the national average for all patients and patients over 70 years acquiring a pressure ulcer after admission.

New Venous Thromboembolism (VTE) – The trust's performance of new VTE was significantly higher than the national average from November 2012 to March 2013. From April to September 2013 the trust's performance rapidly decreased to below the average by 0.6%.

Catheters and new Urinary Tract Infections (UTI) – The trust performed higher than the national average 10 months

between November 2012 and November 2013. For all patients the trust was below the national average in October 2013 by 0.3%. For patients over the age of 70 years the trust was below the average by 0.5% in October 2013.

Falls with harm – The trust's performance was higher than the national average for 10 months of the year for all patients between November 2012 and November 2013. In September 2013 the trust was below the national average by 0.4%. For patients over 70 years the trust was below the national average by 0.7% in September 2013.

Tier 1 Indicators

For maternity and women's health - there was no evidence of risk for elective Caesarean Section, emergency Caesarean Section, Puerperal Sepsis and other puerperal infections.

For re-admissions there was no evidence of risk for maternal readmissions, neonatal readmissions, emergency readmissions following elective admission or emergency readmissions following emergency admissions.

PROMs - there was no evidence of risk for groin hernia surgery, hip replacement surgery, knee replacement surgery or varicose vein surgery.

Audit – there was no evidence of risk for the number of cases assessed as achieving compliance with all nine standards of care measured within the National Hip Fracture Database, the number of patients scanned within one hour of arrival at hospital, the number of potentially eligible patients' thrombolysed.

For Mortality trust level – there was no evidence of risk with the Summary Hospital-level Mortality Indicator or the Dr Foster: Composite of Hospital Standardised Mortality Ratio indicators.

Responsive

A&E Waiting Times – since June 2013 the trust has consistently been above the 95% target for the four hour waiting time. The percentage of emergency admissions via A&E waiting 4-12 hours from the decision to admit until being admitted, the trust is better than the national average. The trust scored worse than expected in the percentage of patients leaving A&E without being seen. The trust is tending towards better than expected for ambulance handovers.

Cancelled Operations – The trust is performing similar to other trusts in both cancelled operations and delayed discharges.

Referral to treatment time under 18 weeks: admitted pathway showed an elevated risk. For all other access to treatment measures, there was no evidence of risk.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 (1) (a) (b) (i) (ii) (1)The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of – (a)The carrying out of an assessment of the needs of the service user; and (b)The planning and delivery of care and, where appropriate, treatment in such a way as to – Meet the service user's needs, Ensure the welfare and safety of the service user Nursing and medical handovers were not consistently ensuring that the appropriate information was passed to the next shift of staff and recorded, which put service users at risk. There was no oversight of the practice of transferring patients to wards before the bed is ready for them, necessitating waits on trolleys in corridors. Systems to ensure that risk assessments were appropriately carried out on patients in relation to tissue viability and hydration, including the consistent use of protocols and appropriate recording practices were not effective. There was a risk to patients due to a lack of anaesthetic staff, which had resulted in unsupervised trainees anesthetising patients. There was no peripatetic anaesthetist available to oversee trainees or provide emergency cover.

Regulated activity	Regulation

This section is primarily information for the provider

Compliance actions

Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, Regulation 10: Assessing and monitoring the quality of service Provision

(1) The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to –

(a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations; and

(b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

Reporting mechanism for incidents were not effective across all staff groups and lessons learnt from serious incident investigations were not shared across all clinical areas, departments and hospitals.

There was no critical care clinical oversight and support of L39 High Dependency Unit in accordance with the Critical Care Core Standards (2013). Handovers were not robust and there was no performance data for the area to assess and drive improvement.

There was no rolling programme for the replacement and upgrade of equipment in the critical care units.

There was no robust system in place for clinical audits or the audit of the implementation of best practice, trust and national guidelines to ensure a consistent delivery of a quality service.

There was a lack of information available on the guidance utilised across clinical service units to ensure the consistent implementation of trust policy procedure.

Regulated activity	Regulation
	Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

This section is primarily information for the provider

Compliance actions

The registered person must have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in

relation to the care and treatment provided for them.

Staff were not always assessing the mental capacity of service users to ensure that the ability to consent was appropriately ascertained.

Regulated activity	Regulation
	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing. Appropriate steps had not been taken to ensure that there were sufficient numbers of suitably qualified, skilled and experienced nursing and medical staff working in the hospital to carry out the activity of TDDI, particularly on medical elderly care, children's services and surgical wards, including the availability of anaesthetists and medical cover out of hours and at weekends, in order to safeguard the health safety and welfare of service users.

Regulated activity	Regulation
	Regulation 23 (1) (a) & (b) HAS 2008 (Regulated Activities) Regulations 2010 Supporting workers. There were not suitable arrangements in place to ensure that staff were supported to enable them to deliver care and treatment to service users safely and to the appropriate standard. Not all staff had completed their mandatory training or had the opportunity to attend training to enhance or maintain their skills or obtain further qualifications appropriate to the work they perform. Not all staff had received an appraisal or had appropriate supervision.

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: 15 July 2014

Subject: The report of the investigation into matters relating to Savile at Leeds Teaching Hospitals NHS Trust

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. The purpose of this report is to present an overview of the findings and recommendations arising from the external investigation (commissioned by Leeds Teaching Hospitals NHS Trust (LTHT)) into matters around Jimmy Savile and his relationship the Trust (and its predecessor bodies).

2. In December 2012, the Board of Leeds Teaching Hospitals NHS Trust commissioned an external team to investigate matters relating to Jimmy Savile and the Trust (and its predecessor bodies). Led by Dr Susan Proctor, the investigation team started its work in January 2013 and continued for approximately 18 months to fulfil the terms of reference of the investigation.

3. On 26 June 2014, the report and recommendations of the investigating team were published. A copy of the Executive Summary of the report is attached at Appendix 1: This provides a summary of findings and recommendations from the investigating team. The full report and other details relating to the investigation can be accessed on LTHT's website using the following link: http://savilereport.leedsth.nhs.uk/

4. Members of the Scrutiny Board should note that it is planned to present the report findings and recommendations to a joint meeting of Leeds Children's and Adult's Safeguarding Boards in September 2014. It is planned that both Safeguarding Boards will jointly oversee action against the recommendations and monitor progress. In order to avoid duplication and make best use of resources, such proposals should be taken into account when considering any future scrutiny activity in this area.

5. It is equally important to take into account any potential interest from the Scrutiny Board (Children and Families) and consider working collaboratively should there be any future scrutiny activity/ consideration in this area.

Recommendations

6. The Scrutiny Board (Health and Wellbeing and Adult Social Care) is asked to:
    a. Note the content of this report and, in particular, the attached Executive Summary of the investigating team's findings and recommendations.
    b. To note the proposed role of the Leeds' Safeguarding Boards for Children and Adults in receiving the report findings and recommendations and monitoring progress.
    c. Consider what, if any, future scrutiny activity is required at this juncture.
    d. Agree to work collaboratively with the Scrutiny Board (Children and Families), should there be any agreed future scrutiny activity/ consideration around this matter.

Background papers[1]

7. 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.

The report of the investigation into matters relating to Savile at Leeds Teaching Hospitals NHS Trust

Executive Summary

The report of the investigation into matters relating to Savile at Leeds Teaching Hospitals NHS Trust

Executive Summary

Authors: Susan Proctor; Ray Galloway; Rebecca Chaloner; Claire Jones; David Thompson

Contents

Executive summary

Leeds General Infirmary is part of the Leeds Teaching Hospitals NHS Trust. Originally the city's teaching hospital, it dates back to the 1700s. The Trust now administers seven hospitals in Leeds and the surrounding area. It is one of the largest teaching hospitals in Europe, with an annual turnover of £1 billion. It employs over 15,000 staff and each year treats almost 1.5 million patients in its wards and departments. Many departments are regional or supra-regional centres of clinical excellence, and many also excel in teaching, research and clinical innovation.

James Wilson Savile was born in Leeds in 1926. He died in Leeds aged 84 in 2011. During his lifetime he was a radio disc jockey, television presenter, media personality and charity fundraiser. For over 50 years he had a close association with the Infirmary and its associated hospitals. Over the years, the nature of this association evolved through his roles as a volunteer, celebrity advisor to the hospital radio service, volunteer porter and significant fundraiser.

He was awarded an OBE in 1972, an Honorary Doctorate in Law from Leeds University in 1986, a Knighthood in 1990 and a Papal Knighthood in the same year.

Initially highlighted in an ITV *Exposure* documentary first shown in October 2012, and then through subsequent investigations including Operation Yewtree led by the Metropolitan Police, it is now known that Savile was also a prolific sexual predator, paedophile and rapist. He operated across the country through his work at the BBC, and in a number of NHS hospitals, including the Infirmary in Leeds.

Following the broadcast of the ITV documentary, Leeds Teaching Hospitals NHS Trust received a number of calls from former patients, staff and others. These callers reported accounts of verbal, physical and sexual abuse at the hands of Savile. The incidents took place throughout his association with the hospital, with greater frequency during the 1960s and 1970s. Over subsequent weeks, many more victims alleging abuse by Savile, including at the Infirmary, came forward to inform the police and health authorities.

The Trust's immediate response was to conduct an urgent internal review of key areas of risk pertinent to Savile's alleged offences. Its Internal Audit department assessed a range of relevant current policies and practices and recommended a series of actions to address deficiencies.

In October 2012, Kate Lampard was invited by the Secretary of State for Health to oversee independent investigations in the NHS organisations with which Savile was closely associated. These are: Leeds Teaching Hospitals NHS Trust; Buckinghamshire Healthcare NHS Trust, which runs Stoke Mandeville Hospital; and West London Mental Health NHS Trust, which runs Broadmoor Hospital. The Department of Health is also conducting a joint investigation with West London Mental Health NHS Trust as part of this process.

In December 2012, the Board of Leeds Teaching Hospitals NHS Trust commissioned an external team to investigate matters relating to Jimmy Savile and the Trust (and its predecessor bodies). Led by Dr Susan Proctor, the investigation team started its work in January 2013 and has continued over the last 18 months to fulfil the terms of reference of the investigation.

The terms of reference for the investigation are as follows:

1 Thoroughly examine and account for Jimmy Savile's association with Leeds Teaching Hospitals NHS Trust (LTHT) and its predecessor bodies, including approval for any roles and the decision-making process relating to these.

2 Identify a chronology of his involvement with LTHT and its predecessor bodies.

3 Consider whether Jimmy Savile was at any time accorded special access or other privileges, and/or was not subject to usual or appropriate supervision and oversight.

4 Consider the extent to which any such special access and/or privileges and/or lack of supervision and oversight resulted from Jimmy Savile's celebrity or fundraising role within the organisation.

5 Review relevant policies, procedures and practices throughout the time of Jimmy Savile's association with LTHT and its predecessor bodies and compliance with these.

6 Review past and current complaints and incidents concerning Jimmy Savile's behaviour at any of the hospitals owned or managed by LTHT and its predecessor bodies, including:

- where the incident(s) occurred;
- who was involved;
- what occurred; and
- whether these incidents were reported at the time and whether they were investigated and appropriate action taken.

The investigation does not have the power to impose disciplinary sanctions or make findings as to criminal or civil liability. Where evidence is obtained of conduct that indicates the potential commission of criminal offences, the police will be informed. Where such evidence indicates the potential commission of disciplinary offences, the relevant employers will be informed.

7 Where complaints or incidents were not previously reported or investigated, or where no appropriate action was taken, consider the reasons for this, including the part played, if any, by Jimmy Savile's celebrity or fundraising role within the organisation.

8 Review Jimmy Savile's fundraising activities and any issues that arose in relation to the governance, accountability for and use of funds raised by him or on his initiative/with his involvement.

9 Review LTHT's current policies and practice relating to the matters mentioned above, including employment checks, safeguarding, access to patients (including that afforded to volunteers and celebrities) and fundraising in order to assess their fitness for purpose. Ensure safeguards are in place to prevent any recurrence of matters of concern identified by this investigation and identify matters that require immediate attention.

10 Identify recommendations for further action.

Summary of findings

Based on the analysis of over 200 witness interviews, and the analysis of over 1,300 documents, the evidence we have obtained (quoted in the main body of the report) supports the following summary conclusions:

- Savile's relationship with Leeds General Infirmary started in 1960. During the 1960s he would regularly visit the hospital as a celebrity, on occasion as a voluntary porter and also in connection with fundraising activities. He also supported the development of the hospital radio service. In 1968, he formally offered his services as a voluntary porter to the Board of Governors and this was considered and approved by the Chairman of the Board of Governors, enabling Savile to commence his sanctioned role as a volunteer porter.
- Savile was most active in his role as porter from the late 1960s to the mid-1970s. He continued in this role, albeit on a more sporadic basis, well into the 1990s. He was a regular presence at the hospital and worked largely with the porters serving the X-ray and Accident and Emergency departments.
- Throughout his association with the Infirmary, Savile successfully sought publicity using the local press and national media to promote various fundraising and other campaigns about services in Leeds or on behalf of other hospitals.

Fundraising and publicity

- Over the years Savile was associated with raising £3.5 million for services at the Infirmary. He successfully maintained an almost continual presence in the local press associated with his charitable fundraising.
- During the 1980s, he would use the Infirmary as a base for fundraising activity for the Stoke Mandeville Spinal Injuries Unit. With the press in attendance, he would host publicity meetings in the Infirmary boardroom, where he would receive donations for this campaign from hospital and community organisations and members of the public in Leeds.
- He continued to be associated with fundraising activities on behalf of services at Leeds Teaching Hospitals NHS Trust and its predecessor bodies throughout his years of association with the Infirmary. In later years, this activity was less frequent, but continued to successfully attract publicity through local media.

Access and influence

- Savile regularly visited wards and departments, both as a porter and as a celebrity. These visits occurred throughout his association with the Infirmary, but particularly from the 1960s to the 1980s. Generally, these would be unannounced visits, at any time of the day or night, and he would chat to patients and staff alike. He was considered to be very popular with patients, and his visits were seen by many as a boost to morale.
- During the late 1960s and 1970s, Savile had wide-ranging access across the Infirmary. There was little evidence of challenge to or controls on his whereabouts during this period, or in later years when he spent comparatively less time at the hospital. In addition to duties as a porter, and his ward visits, he sometimes attended consultant ward rounds, assisted in the delivery of intimate care such as giving bed baths to patients, and regularly visited the mortuary.
- He had access to offices, to on-site residences and to other restricted areas via his relationships with the Head Porter and other senior managers in the late 1960s. This access remained unchallenged for the entirety of his association with the Infirmary. This included a regular allocation of car parking spaces for his vehicles, including the overnight parking of his campervan.

- Savile had three offices allocated to him in succession from 1992 to 2011. Prior to this, he used the Head Porter's office as an informal base. Up to the early 1980s, he used the Infirmary as his postal base for personal mail and media correspondence, which was dealt with by a member of staff on his behalf. This arrangement was then reinstated in the 1990s when he was first allocated a dedicated office.

The abusive encounters

- We are aware that many who read this report will want to discover what happened to the victims. There is no substitute for reading this section of the report (chapter seven), and therefore we include only brief summary information here.
- As part of this investigation 64 people came forward to share accounts of abuse or inappropriate encounters at the hands of Savile. Sixty of these accounts concerned abuse in premises run by the Trust or its predecessors, and four related to other healthcare organisations in either Leeds or other parts of West Yorkshire. Of the victims from the Leeds Teaching Hospitals NHS Trust or its predecessor bodies, ages ranged from five years to 75 years. Nineteen children and 14 adults were patients at the time of their abuse. In addition, 19 members of staff reported abusive or inappropriate encounters with Savile. We heard eight further accounts from victims who were external to the Infirmary, but whose abusive encounters had a connection with it.
- The majority of Savile's victims were in their late teens or early twenties at the time of the encounter. The earliest case was in 1962, when Savile was 36 years old; the most recent in 2009, when he was 82. In terms of patient victims specifically, the earliest case was in 1962 and the most recent in 1999.
- Mostly, his assaults were opportunistic, and many took place in public areas such as wards and corridors. However, eight cases suggest an element of premeditation: in some instances, this included the grooming of victims and their families over a period of months. Mostly Savile worked alone, but on occasion he was assisted in his abusive behaviour by others.
- Encounters ranged from lewd remarks and inappropriate touching to sexual assault and rape. These encounters took place on wards, in lifts, in corridors, in offices and off site in a local café, in his mother's house and in his campervan.
- Only four children and five adults reported their experiences at the time to staff or a colleague. The subsequent individual responses are examined.

Corporate responses

- Consideration is also given to the response of the organisation as a whole, and in particular to that of the senior management during Savile's association with the Infirmary.
- Different levels of the organisation held disparate views of Savile and his value to them. Among staff in the wards and departments he was tolerated because of his celebrity and popularity with patients. He was, however, seen by many as a nuisance, a disruptive presence in the clinical areas and, towards female staff, a sex pest.
- Among the Board of Governors before 1974 and in the opinion of some senior managers in post during the 1960s to 1980s, he was mostly regarded as a force for good, a great and positive publicist for the Infirmary, a morale booster and a welcome fundraiser. Later on, the senior managers in the 1990s and 2000s paid him little attention and were largely indifferent to his (albeit relatively less frequent) presence in the organisation. Occasionally he would attend the launch of a new service, or help to publicise a new initiative, but was rarely courted or in receipt of attention from the contemporary senior managers.

- Recognising the extensive changes in healthcare delivery, NHS governance and other legislative changes that impact on corporate policies and practices today, we assess and critique the current pertinent corporate policies in the Trust.

Governance and internal assurance

A local oversight panel chaired by a Trust Non-Executive Director was set up in January 2013. Its role was to oversee the development, scope, pace and progress of the investigation and to report to the Trust Board. Membership comprised the Chairs of the Leeds Adult and Child Safeguarding Boards; senior representation from the NSPCC, Leeds Local Involvement Network (LINk, now Healthwatch), Victim Support and the University of Leeds; and the Trust Executive Director Lead for Safeguarding. The local oversight panel received legal advice from the Trust's legal advisors.

Co-ordination with the other two principal NHS investigations has been consistent and regular liaison has been maintained. Productive relationships were also established with both the Metropolitan Police Service and West Yorkshire Police.

Recommendations

We have made 31 recommendations for the Trust Board, which are grouped into six themes:

- leadership, organisational values and executive accountability;
- patient-centred drivers and safeguarding;
- board and ward coherence;
- security and controls on the physical access to hospital premises;
- policy development and implementation; and
- fundraising.

These aim to build on current good practice in the Trust and to ensure that the Trust Board strengthens its systems of assurance and internal control to minimise the risk of anything similar happening in the future.

Recommendations

Recommendations

As part of this investigation we have reviewed numerous reports of inquiries and studies considering failings in healthcare services, the safeguarding of children and young people, and the safeguarding of adult patients (Francis, 2013; Keogh, 2013; Erooga et al, 2012; Laming, 2003; Laming, 2009). When we consider these reports alongside our investigation concerning Savile's abusive behaviour in Leeds, there is a resonance in our mutual findings on the factors associated with organisational weaknesses and safeguarding standards. From this process of review and the learning from our own investigation, we have found that the following characteristics are invariably associated with healthcare organisations striving to be safer:

- strong, visible, credible and accessible Board leadership;
- clearly defined and commonly agreed organisational values and behaviours;
- executive accountability for the safeguarding of children, young people and adults;
- leadership that fosters a culture of curiosity, scrutiny and constructive challenge, with processes to underpin these behaviours;
- clearly defined, patient-centred drivers for all internal policies and practices;
- a commitment to lead and safeguard patients on a 24 hours, seven days a week basis;
- coherence and connection between the Board and wards/departments;
- a secure environment with regulated access to care settings;
- effective and well-understood policies for staff and patients to raise concerns;
- robust systems of employment checks for staff, volunteers and contractors;
- effective processes of induction, training, review and management of performance; and
- zero tolerance of the abuse, harassment or victimisation of staff or patients.

Our recommendations are therefore derived from the evidence, our consideration of these characteristics, and a prescription of actions necessary to strengthen the relevant corporate systems and processes that, when optimal, will contribute significantly to making the organisation safer. We do recognise that in recent years there has been considerable improvement in many of the corporate systems and processes, but there is still much to do. We have also made some specific recommendations on the Trust's fundraising governance processes and its relationship with the Charitable Trustees, and some specific points about corporate policies.

Our recommendations are presented below in a way that links them to the characteristics of a safer organisation set out above, and to our findings. They should be taken forward by the Chief Executive and their progress monitored by the Board.

Leadership; organisational values; executive accountability

Under the leadership of the new Chief Executive and Board, the Trust has recently embarked on a major organisational development programme to refresh and strengthen its core values and behaviours. We welcome this, and recommend that the following matters are addressed as part of this programme during 2014.

11 The organisational development programme should incorporate the following:

- the safety of patients, staff, volunteers and visitors as a central priority (source: chapters six, seven and eight);
- the promotion of enquiring leadership at all levels in the organisation. It should value a culture of curiosity and questioning, and behaviours that enable all staff and volunteers to have the courage to challenge any inappropriate behaviour witnessed in the Trust (source: chapters four, six, seven, eight and nine);
- a review of existing policies, knowledge and understanding about how staff and volunteers can effectively raise concerns, and a new approach that empowers them to speak out (source: chapters seven, eight and nine); and
- a review of the effectiveness of current approaches to the management of, and responses to, complaints from patients and visitors (source: chapters six, seven and eight).

Patient-centred drivers; safeguarding patients

We believe that the quality of patient services is a central priority for the Trust's new leadership team, and for the Board. These recommendations are therefore intended to strengthen current approaches, and in particular to improve the inclusivity of all patient contact services in their continual quest for improvement in quality. Because of the central importance of safeguarding patients, these recommendations should be addressed by September 2014.

12 The Executive Director with responsibility for safeguarding patients, and the Executive Director with responsibility for facilities and estates, should jointly assure the Board on how support services (including porters, security and mortuary services) contribute to safeguarding patients, particularly in the following areas:

- that the Trust's safeguarding policies extend explicitly to the care and transportation of deceased patients (source: chapters six and nine);
- that there are policies and controls in place covering security at the mortuary, and that these are regularly audited (source: chapters six and nine);
- on the quality of the Trust's safeguarding compliance in respect of adult and child patients, and its duty to protect staff. Working with the Safeguarding Boards for Children and Adults in the city, an audit programme should include a review of the safeguarding of adults and children in in-patient areas; staff training; and employment checks (source: chapters four, six, seven, eight and nine);
- that current Disclosure and Barring Service (DBS) checks are in place for all relevant employees, volunteers and, where appropriate, contractors as a matter of urgency, and that this position is reviewed to inform each Board meeting (source: chapters eight and nine);

- on the quality of the complaints system; the Board should monitor full adherence to the recommendations of the 2013 Clwyd/Hart Review (source: chapters six, seven, eight and nine); and
- on the robustness of the Trust's processes for staff and others to raise concerns, and on how such matters are responded to and addressed. Particular attention should be given to allegations of sexual impropriety (source: chapters six, seven and eight).

13 There should be a Trust-wide campaign to raise awareness of the safeguarding duty to patients across all patient contact staff and volunteer groups (source: chapters six, seven and eight).

14 All safeguarding promotional material, educational material or information used in the Trust should be explicit in the inclusion of all patient contact and support services (source: chapters six and eight).

15 The quality of work carried out by porters should include reference to patient experience and safeguarding, in addition to the measurement of time to complete tasks (source: chapter six).

16 Porters should receive training and support about the transportation and handling of deceased patients. De-briefing and counselling should be available for porters who are adversely affected by carrying out this duty (source: chapters six and nine).

17 The Trust Quality Committee should commission a specific project on the care, transportation and storage of the bodies of deceased patients to give wider assurance that the matters raised by Savile's association with the hospital mortuary could not happen again (source: chapter six).

18 Guidance and active support on interacting with VIP patients should be developed and issued to consultants and senior clinicians, and its use monitored through the appraisal process (source: chapters four, five and six).

More broadly, the following recommendations look to the role of the Board in corporate and system-wide assurance regarding the safety of patients. We believe that these actions should be in place as a matter of urgency by July 2014.

19 A sanctioned visitor policy should be established and implemented across all sites of the Trust with some urgency. It should set clear boundaries regarding the role of celebrities, VIPs and media contractors in the Trust, including their access to hospital premises. This policy should include robust processes for Board assurance and information about the rules of engagement with media, celebrity visitors and other VIP or non-essential visitors to the hospital (source: chapters four, six, seven, eight and nine).

20 The Trust should conduct a review to ensure that the support, advice and care it provides to victims of sexual assault and statutory rape are consistent with current best practice (source: chapters six and seven).

21 The Trust should conduct an audit of placements of children and young people on adult in-patient areas to ensure that this no longer happens (source: chapters six, seven and eight).

22 The Trust should put in place a safe and confidential counselling service for all staff, patients, visitors and volunteers affected by the content of this report (source: chapter seven).

23 The Trust should establish a confidential helpline and referral service for victims of Savile, including those who have not yet come forward (source: chapter seven).

Board/ward coherence

Strengthening the connection between the Board and the rest of the organisation across its multiple sites is an important, but challenging, matter to address. Current approaches we endorse include a weekly electronic newsletter from the Chief Executive, dedicated time for visits to wards and departments, and the work connected to the organisational development programme. The momentum created by these initiatives should be maintained, and by October 2014 the following should be in place.

24 Development of strategies and actions should continue to improve the visibility of executive and non-executive directors across the organisation (source: chapters four, six, eight and nine).

25 As part of their Board responsibility, directors should foster a culture of curiosity, internal scrutiny and constructive challenge, particularly on matters that have a major impact on public confidence in Trust services (source: chapters eight and nine).

26 The Board should develop an understanding of how it feels to be a patient in the Trust and identify methods of communication to share good practice and celebrate success, in addition to ensuring that concerns are addressed promptly (source: chapters six, seven and eight).

Security and controls on the physical access to hospital premises

Keeping its premises accessible and yet safe is an important challenge for the Trust. Providing services on multiple sites and from premises that range from Victorian to modern is a further logistical challenge, and we are aware of the Trust's commitment to minimising the risk to patients and staff by its investments in effective security systems. The following recommendation should be addressed by October 2014.

27 The Trust should review security across all sites, including on-call residences and decommissioned areas in its estate, to develop a comprehensive strategic security plan. The Board should seek regular assurance that all restricted areas are secure, including high-risk areas (source: chapters six and eight).

Policy development and implementation

We reviewed a number of policies directly connected to issues arising from Savile's impact on the Trust. We note and welcome the Trust Board's initiation of a review of all corporate policies through the creation of a Corporate Policy Review Group. The following recommendations should be implemented by December 2014.

28 A unified HR system should be established across the Trust that fulfils the recruitment and employment requirements for all employees, volunteers and contractors in a consistent manner (source: chapters eight, nine and ten).

29 The Trust should review its policy on gifts and hospitality and seek assurance that all staff (including volunteers and non-executive directors) are aware of their responsibilities and comply with the policy. Compliance should be reviewed at least annually by Internal Audit (source: chapters five and ten).

30 The Trust should develop with some urgency a volunteer policy. This should cover volunteers' employment checks, induction, training, access to the Trust and clarity about the boundaries of their roles (source: chapters four, six, eight and nine).

31 The Trust should develop a major strategic plan for the management of potentially catastrophic issues where public confidence in the organisation may be at stake in the light of unprecedented events. This will enable greater clarity and consistency in matters of communication, accountability and action (source: chapters eight and nine).

32 The Trust should work with the Leeds Teaching Hospitals Charitable Trust to develop and implement a policy for the management of large financial donors, specifically setting out how to deal with requests for favours from them (source: chapter five).

33 The Trust Dignity at Work policy has been in place since 2011, but does not explicitly mention sexual harassment in its definition of what constitutes harassment or unwanted behaviour. This should be reviewed and sexual harassment clearly defined, with examples given. Following review, this policy should be audited: in particular, to gain assurance that staff who have line management responsibility for others are fully conversant with the required actions to take when faced with allegations of sexual harassment or unwanted behaviour (source: chapters six, seven, eight, nine and ten).

34 All policies should be reviewed to ensure that they comply with statutory obligations about the retention of records (source: chapters nine and ten).

35 All Trust policies should extend in their scope to the broader community, including volunteers, non-executive directors and, where appropriate, contractors; and, in time, to governors (source: chapters eight, nine and ten).

36 The Trust should review how it seeks the views of a wider range of stakeholders in developing policies, and should ensure that all policies are patient centred. In doing so, it should draw best practice from other organisations within and outside the NHS (source: chapter ten).

37 All policies should be succinct, clearly set out in plain language, and identify the points that people need to know in order to implement them safely (source: chapter ten).

38 There should be mandatory compliance with policies designed to protect patients and staff. The role of the Trust's Internal Audit should be reviewed as part of this (source: chapters nine and ten).

Fundraising

Owing to the nature of Savile's activities as a fundraiser for numerous charities, we considered historical and current practice with regard to the priority-setting, governance and leadership of charitable funds connected with the Infirmary. The following recommendations should be addressed by December 2014.

39 A baseline review of the range of projects supported by the Leeds Teaching Hospitals Charitable Trust should be undertaken to assess consistency with the current priorities of the Trust (source: chapter five).

40 The Charitable Trustees should work closely with the Leeds Teaching Hospitals NHS Trust Executive Team to establish priority-setting and decision-making processes that reflect the needs of the patients of the hospital and the services provided to them (source: chapter five).

41 Assurance that charitable funds are channelled appropriately should be gathered on a systematic and ongoing basis and reported to both the Charitable Trustees and the Trust Board Audit Committee to ensure that the mechanisms in place to do this continue to be effective (source: chapter five).

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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: 15 July 2014

Subject: Sources of work for the Scrutiny Board

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. Scrutiny Boards are responsible for ensuring that items of scrutiny work come from a strategic approach as well as a need to challenge service performance and respond to issues of high public interest.

2. This report provides information and guidance on potential sources of work and areas of priority within the Board's terms of reference. In consultation with the relevant Director and Executive Board Members, the Scrutiny Board is requested to consider and confirm the areas of Scrutiny for the forthcoming municipal year.

Recommendation

3. Members are requested to use the attached information and the discussion with those present at the meeting to confirm the areas of Scrutiny for the forthcoming municipal year.

1.0 Purpose of this report

1.1 To assist the Scrutiny Board in effectively managing its workload for the forthcoming municipal year, this report provides information and guidance on potential sources of work and areas of priority within the Board's terms of reference.

2.0 Background information

2.1 Scrutiny Boards are responsible for ensuring that items of scrutiny work come from a strategic approach as well as a need to challenge service performance and respond to issues of high public interest.

2.2 The alignment of the Scrutiny Boards to the City Priorities continues to promote a more strategic and outward looking scrutiny function that focuses on the "Best City for…" priorities, as set out within the City Priority Plan 2011 to 2015. This city-wide partnership plan summarises the key outcomes and priorities to be delivered by the Council and its partners.

3.0 Main issues

Best Council Plan

3.1 A refresh of the Best Council Plan was agreed at Executive Board in March 2014, to reflect the progress made over the past year and the significant changes to the context in which the council is working, and to fully align it with the approved 2014/15 budget. The resulting 'Best Council Plan – Plan on a Page' is attached as Appendix 1.

Leeds' Joint Health and Wellbeing Strategy (2013- 2015)

3.2 As set out within its terms of reference, this Scrutiny Board is authorised to review or scrutinise the performance of the Health and Wellbeing Board. In doing so, the Scrutiny Board may review performance and progress against the outcome and priority areas detailed in the Leeds' Joint Health and Wellbeing Strategy (JHWS) (2013-2015) – attached at Appendix 2.

3.3 In determining items of scrutiny work this year, the Scrutiny Board is encouraged to explore how it can add value to the work of the Health and Wellbeing Board in delivering the priorities identifies in the JHWS (2013-2015). In addition, in line with the Scrutiny Board Procedure Rules, the Scrutiny Board will also act as a 'critical friend' to the Health and Wellbeing Board through an annual assessment of how well the Board is working in practice.

3.4 It is also likely that a revised/ refreshed Joint Health and Wellbeing Strategy will be developed beyond 2015 (i.e. the lifecycle for the current strategy).

Other sources of Scrutiny work

3.5 The Scrutiny Boards' terms of reference are also determined by reference to Directors' delegations. As such, Scrutiny Boards have always challenged service directorates across the full range of council activities and the Scrutiny Board may

therefore undertake pieces of scrutiny work in line with its terms of reference, as considered appropriate.

3.6 The Scrutiny Board may also wish to consider and define the performance management information that it receives in order to discharge part of its performance monitoring role, which itself can often lead to the identification of areas for more detailed scrutiny. The Scrutiny Board considered limited performance information during the previous municipal year (i.e. 2013/14).

3.7 Other common sources of work include pre-decision scrutiny, requests for scrutiny and other corporate referrals. Members' may also wish to routinely consider outcomes (through the minutes of meetings) from the Executive Board and the Health and Wellbeing Board.

3.8 Scrutiny Boards have always sought to work in partnership with one another – if and/or where appropriate; in particular in cross-cutting areas which span more than one Scrutiny Board's terms of reference. In setting the work programme for the coming year, the Board is encouraged to consider areas of work which may benefit from a partnership approach.

3.9 As outlined elsewhere on the agenda, the Scrutiny Board also has a specific role in discharging the Council's Health Scrutiny role/ function. This should be taken into account when determining the work programme and the adopted methodology. Nonetheless, draft terms of reference relating to the re-establishment of the Health Service Developments Working Group are presented elsewhere on the agenda for consideration.

3.10 It should also be noted that given the current footprint of NHS commissioners and service providers, they may be time where a joint approach with other local authorities may be appropriate and/or required. Further work to establish an agreed approach in relation to joint scrutiny is likely to be needed.

Areas of Scrutiny work brought forward from the previous year

3.11 The Scrutiny Board was engaged in a number of work areas during the previous municipal year (2013/14). A summary of the recommendations that the Scrutiny Board may wish follow-up during the current municipal year is attached at Appendix 3. The Scrutiny Board is specifically requested to consider any areas it wishes to pursue.

3.12 The review of Homecare was a specific request for scrutiny received in the previous municipal year. Draft terms of reference relating to this area are presented elsewhere on the agenda for consideration.

3.13 In the previous year it was also proposed for the Scrutiny Board to consider the performance around Reducing Smoking and the general approach to tobacco control – considering the outcome of the peer review completed in March/ April 2014. However, the completion of the finalised peer review report did not coincide with the final scheduled Scrutiny Board for 2013/14. Provisional plans are in place for this to be considered in September 2014, however the Scrutiny Board is specifically requested to consider if it wishes to continue with this scrutiny activity.

4.0 Corporate Considerations

4.1 Consultation and Engagement

4.1.1 It is recognised that in order to enable Scrutiny to focus on strategic areas of priority, each Scrutiny Board needs to establish an early dialogue with the relevant Executive Board Members and Directors.

4.1.2 The Executive Members for Adult Social Care and Health and Wellbeing along with the Director of Adult Social Services and the Director of Public Health have been invited to attend the meeting to discuss priority areas of work with the Scrutiny Board.

4.2 Equality and Diversity / Cohesion and Integration.

4.2.1 The Scrutiny Board Procedure Rules state that, where appropriate, all terms of reference for work undertaken by Scrutiny Boards will include ' to review how and to what effect consideration has been given to the impact of a service or policy on all equality areas, as set out in the Council's Equality and Diversity Scheme'.

4.3 Council Policies and City Priorities

4.3.1 The terms of reference of the Scrutiny Boards promote a strategic and outward looking Scrutiny function that focuses on the City Priorities. This particular Scrutiny Board is authorised to review or scrutinise the performance of the Health and Wellbeing Board. In doing so, the Scrutiny Board will review outcomes, targets and priorities within the Business Plan and "Best City….for business" priorities, as set out within the City Priority Plan and the Leeds' Joint Health and Wellbeing Strategy (2013-2015).

4.4 Resources and Value for Money

4.4.1 Over the last few years of Scrutiny Board work, experience has shown that the process is more effective and adds greater value if the Board seeks to minimise the number of substantial inquiries running at one time and focus its resources on one key issue at a time.

4.4.2 Before deciding to undertake an inquiry, the Scrutiny Board is advised to consider the current workload of the Scrutiny Board and the available resources to carry out the work.

4.5 Legal Implications, Access to Information and Call In

4.5.1 This report has no specific legal implications.

4.6 Risk Management

4.6.1 There are no risk management implications relevant to this report.

5.0 Conclusions

5.1 Scrutiny Boards are responsible for ensuring that items of scrutiny work come from a strategic approach as well as a need to challenge service performance and respond to issues of high public interest. This report provides information and guidance on potential sources of work and areas of priority within the Board's terms of reference. In consultation with the relevant Director and Executive Board Members, the Scrutiny Board is requested to consider and confirm the areas of Scrutiny for the forthcoming municipal year.

6.0 Recommendations

6.1 Members are requested to use the attached information and the discussion with those present at the meeting to confirm the areas of Scrutiny for the forthcoming municipal year.

7.0 Background papers[1]

7.1 None

[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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Our ambition and approach

Our Ambition is for Leeds to be the best city and Leeds City Council to be the best council in the UK: fair, open and welcoming with an economy that is both prosperous and sustainable so all our communities are successful.

Our Approach is to adopt a new leadership style of **civic enterprise**, where the council becomes more enterprising, businesses and partners become more civic, and citizens become more actively engaged in the work of the city.

Our best council outcomes

- Improve the quality of life for our residents, particularly for those who are vulnerable or in poverty;
- Make it easier for people to do business with us; and
- Achieve the savings and efficiencies required to continue to deliver frontline services.

Our best council objectives and priorities for 2013 to 2017

Supporting communities and tackling poverty – *involving people in shaping their city and tackling the challenges of poverty, deprivation and inequality*
With a focus on:
- Supporting healthy lifestyles and getting people active
- Tackling domestic violence and abuse
- Helping people out of financial hardship and into work
- Strengthening local accountability and being more responsive to the needs of local communities
- Providing accessible and integrated services

Promoting sustainable & inclusive economic growth– *improving the economic wellbeing of local people and businesses*
With a focus on:
- Meeting the skills needs of business to support growth
- Boosting the local economy
- Maximising housing growth to meet the needs of the city in line with the Core Strategy
- Providing a good and efficient transport and digital infrastructure
- Developing a low carbon, resilient energy infrastructure for the city
- Playing our full role within the combined authority and city region to make the most of devolution opportunities
- Maximising the impact of our cultural infrastructure

Building a child-friendly city – *improving outcomes for children and families.*
With a focus on:
- Ensuring the best start in life
- Reducing the number of looked after children
- Improving school attendance
- Reducing NEETs
- Raising educational standards
- Ensuring sufficiency of school places

Delivery of the Better Lives programme – *helping local people with care and support needs to enjoy better lives.*
With a focus on:
- Helping people to stay living at home
- Joining up health and social care services
- Providing choice by creating the right housing, care and support
- Promoting and supporting enterprise in the care market to increase capacity and choice

Dealing effectively with the city's waste – *minimising waste in a growing city.*
With a focus on:
- Ensuring a safe, efficient and reliable waste collection service
- Providing a long-term solution for disposing of our waste
- Increasing recycling and reducing the use of landfill

Becoming a more efficient and enterprising council – *improving our organisational design, developing our people and working with partners to effect change.*
With a focus on:
- Getting services right first time and improving customer satisfaction
- Improving how we're organised and making the best use of our assets
- Creating flexibility and the right capacity and skills in our workforce
- Becoming more enterprising
- Generating income for the council

Our values: underpinning all that we do

Working as a team for Leeds	Being open, honest and trusted	Working with communities	Treating people fairly	Spending money wisely

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Leeds Joint Health and Wellbeing Strategy 2013-2015

Our Vision:

Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest

Foreword
... and welcome

Leeds is a magnetic city and has a vision to be the best city in the UK by 2030. As part of this vision to create a thriving liveable city, Leeds aspires to be the best city for health and wellbeing. Like many other cities, Leeds is facing huge challenges including a widening inequalities gap, an increasing population of young and older people, as well as reductions in public sector funding.

Of course, for Leeds to be the best city for health and wellbeing, it means making sure that the people can access high quality health and social care services: but it also means that Leeds is a Child Friendly city, a city that creates opportunities for business, jobs and training; a city made up of sustainable communities and of course a great place to live. In short, our vision is that Leeds will be a healthy and caring city for all ages, where people who are the poorest, improve their health the fastest.

To achieve this vision, we have come together as the Leeds Health and Wellbeing Board to make sure that we make the best use of our collective resources. We are committed to using the 'Leeds pound' and 'Leeds assets' wisely on behalf of the people of Leeds. This means that we will work together when spending public money, to make sure we are maximising the impact of each pound we have. Together we will make sure that more services are joined up and that people find them easier to use.

To help us to decide how best to use our collective resources in future, we will do two things. First, we will make decisions based on good information. We all have information about people and places and by looking at this information together; we can make decisions based on a more complete picture of Leeds. We have committed to improve how we collect and use this information and after extensive consultation, we have published this as the Joint Strategic Needs Assessment. Second, we will make decisions about how we spend the 'Leeds pound' together. Using jointly agreed principles we will make a plan for how we spend our collective resources, called the Joint Health and Wellbeing Strategy. Following widespread engagement, this document sets out the Joint Health and Wellbeing Strategy for Leeds for 2012-2015. It will provide the framework for how we use resources throughout the city and enable us to be accountable to local people. It will help the council and the NHS in Leeds, working with local communities and partner organisations, to make improvements to the health and wellbeing of local people.

The Health and Wellbeing Board will oversee how we continue to improve the health and wellbeing of the people of Leeds and this document is vital to how we will work together to make it happen. We would expect everyone to use the Joint Health and Wellbeing Strategy when making decisions about spending money and planning services over the next few years, and in doing so we can truly make Leeds the best city for health and wellbeing.

Cllr Lisa Mulherin,
Chair of the Leeds Health and Wellbeing Board

What is the Leeds Joint Health and Wellbeing Strategy?

Leeds City Council, Leeds North Clinical Commissioning Group, Leeds South and East Clinical Commissioning Group and Leeds West Clinical Commissioning Group have a new shared legal duty to prepare and publish a Joint Health and Wellbeing Strategy (JHWS) through the Health and Wellbeing Board. This document discharges that responsibility.

The JHWS is the result of commissioners coming together to provide the strategic direction and sets out how we will make the best use of our collective resources. It will be the 'framework' for all commissioners to use, and will help us to decide how we might bring into line the right level of resources for different needs across the city.

The JHWS spans the NHS, social care and public health across all ages and considers wider issues such as housing, education and employment. It provides a short summary of how we will address the health and wellbeing needs of Leeds and will help us to measure our progress.

It will help us to live our ambition to be the best city in the UK: a healthy and caring city for all ages where people who are the poorest improve their lives the fastest.

Leeds JHWS overview

Vision for health and wellbeing
Leeds will be a healthy and caring city for all ages

Principle in all outcomes
People who are the poorest, will improve their health the fastest

Overarching Indicator
Reduction in the differences in life expectancy between communities

The five outcomes

1. People will live longer and have healthier lives
2. People will live full, active and independent lives
3. People will enjoy the best possible quality of life
4. People are involved in decisions made about them
5. People will live in healthy and sustainable communities

How was the Leeds JHWS developed?

The Leeds JHWS has been developed from:

- Leeds JSNA including public opinion and research
- National guidance from the Secretary of State, including the NHS Mandate
- National Outcome Frameworks
- National data profiles
- Financial modelling

The JHWS has been created by focusing on a number of principles, including that it should:

- Be simple, unambiguous and measurable
- Guide strategic decision making
- Have indicators which measure one thing and that relate primarily to the outcome
- Have a wider set of local plans which sit beneath it
- Apply to all ages and be a consensus
- Include things capable of change locally
- Promote equality and meet the Public Sector Equality Duty
- Be the right thing to do

Why do we need one?

The Health and Wellbeing Board will use the JHWS to influence partners across the city to reduce inequalities and to improve the health and wellbeing of the people of Leeds. It will:

- Achieve better health and wellbeing outcomes for the people of Leeds
- Ensure partners on the Health and Wellbeing Board agree the outcomes we want to achieve and how they will contribute to the long term vision for Leeds 2030
- Provide the framework for commissioning plans for children, young people and adults healthcare, social care and public health
- Promote integration and partnership working between the NHS, social care, public health and other local services
- Inform the business plans of service provider organisations
- Promote more effective and efficient actions across the partnership
- Help to measure progress in making Leeds a healthy and caring city for all ages

Where are we starting from?

Leeds is the UK's third largest city with a population of around 750,000, expected to rise to around 840,000 by 2021. It is also one of the greenest cities in the UK with 20 major parks and two thirds of the district is classified as rural.

The most recent census (2011) indicates that the Leeds population has grown 5% since 2001. Leeds is a truly diverse city with over 140 ethnic groups including black, Asian and other minority ethnic populations representing almost 19% of the total population. In the coming years, Leeds is also expecting to see an increase in the numbers of children of primary school age as well as the numbers of those aged over 75 and over 85.

Despite the economic downturn, the city's economy is considered to be one of the most resilient in the UK. It has changed from being dominated by industry to now being a key centre for finance, business, retail, healthcare, creative industries and legal services as well as a continued strength in manufacturing. The current employment rate is 69%. Leeds remains a major centre for development with £4.3 billion worth of schemes completed in the last decade.

Leeds is also home to one of the largest teaching hospitals in Europe and to the new NHS England, HealthWatch England and five other national NHS bodies.

However, the health of people in Leeds is generally lower than the England average. It is strongly associated with the high levels of deprivation experienced by the 150,000 people in Leeds who are living in the most deprived neighbourhoods nationally. Although overall life expectancy has been increasing for all Leeds residents, the life expectancy for a man living in a deprived Leeds neighbourhood is 12 years lower than a man living in an affluent part of Leeds.

It is estimated that adult healthy eating, smoking and obesity levels are worse than the England average, with smoking-related and alcohol-related hospital admission rates above average. The high prevalence of smoking in people with low incomes, compared to the rest of Leeds, is the biggest preventable cause of ill health and early death in the city.

Some of the major issues identified in the Leeds JSNA include: deprivation, mental health, smoking, alcohol, obesity, health conditions such as cancer and cardio vascular disease and dementia, children and young people's health, financial inclusion, housing, social isolation and older people, equality groups and Issues for localities.

The JHWS will enable Leeds to turn the issues where there is deprivation and inequality into plans for action to enable Leeds to be the best city for health and wellbeing.

How will the JHWS make a difference?

It will enable us all to make better decisions about how we:

- Commission and decommission services by informing the plans of CCGs, Leeds City Council and NHS England
- Re-design services
- Use existing assets and resources of partners, including workforce, communities, buildings and information.
- Encourage service providers to work together to deliver services and act in ways that meet agreed priorities
- Influence the wider determinants of health and wellbeing through other partnerships and organisations

What is happening already?

Publishing the JHWS is a really important step to set the future direction and focus for reducing inequalities and improving the health and wellbeing of the people of Leeds. There is already a great deal of work underway in the city which is helping to change lives. We will build on the successes of this work, learn from others both nationally and internationally and use the JHWS to drive forward improvements to the outcomes we have agreed.

There is extensive work already being carried out in a range of areas linked to JHWS. These examples are just a snapshot of work underway:

(1) The Leeds Let's Change programme provides information and signposting on a range of issues to help people make healthy lifestyle choices including losing weight and stopping smoking.

(2) The Infant Mortality demonstrator sites in Chapeltown and Beeston & Holbeck are already helping families to reduce sudden infant death, smoking in pregnancy and improve access to maternity services.

(3) The NHS Health Check helping people reduce and manage their risk of heart disease, stroke, kidney disease and diabetes, and the COPD early diagnosis programme is improving prognosis for a condition far more prevalent within deprived areas of Leeds.

(4) Twelve new integrated health and social care teams are now live across the city. The teams, made up of community nursing, social care and other staff, will work closely with GPs, hospitals, the voluntary sector and patients themselves to plan care jointly.

(5) Intermediate Care teams and the reablement service are working closely together to provide support to people to ensure that they have the best possible chance of recovering from ill health.

(6) The Pudsey Wellbeing Centre has a group of volunteers helping people to cope better with managing their conditions by organising health walks, arranging social events, providing transportation so that patients can get around the area, providing one-one-one or group training sessions and leading health support groups.

(7) The NHS, council and third sector are already working together across the city and improving access to mental health services for minority groups.

(8) The "Got a cough? Get a check" campaign has already led to 2000 people from Inner East and Inner South Leeds to receive a screening x-ray and has identified 25 people with lung cancer enabling them to start treatment early.

(9) The NHS and council are working together to provide a single point of urgent referral. This improves access to services for patients in need of an urgent response from a community service.

(10) Neighbourhood network schemes are locally led organisations that enable older people to live independently and pro-actively participate within their own communities by providing services that reduce social isolation; provide opportunities for volunteering; act as a "gateway" to advice, information, and services; and promote health and wellbeing.

(11) Warm Homes Service grants are helping people who suffer from illness or have disability aggravated by cold and damp conditions to keep warm by insulating their properties.

(12) Support is available across the city which is helping people to claim the benefits which they are entitled to, leading to better finances for many people especially in poorer households.

(13) The Working Well Action Plan is supporting individuals into work and improving the health and wellbeing of employees within businesses across the Leeds economy.

What will we do next?

We will use the JHWS to review all the existing plans and strategies across the city to make sure that we are focusing our efforts and resources on the right things. This will help us to strengthen our action plans and make sure that we have not left any gaps.

The Health and Wellbeing Board has identified four 'commitments' which we believe will make the most difference to the lives of people in Leeds. If we make progress on these four commitments, then it is also likely that we will make progress with many of our other priorities too.

Our commitments

- Support more people to choose healthy lifestyles
- Ensure everyone will have the best start in life
- Improve people's mental health and wellbeing
- Increase the number of people supported to live safely in their own home

How will we measure progress?

We will measure our progress by focusing on the impact that the strategy will have on people's lives: these are the outcomes that we want to achieve. We have chosen a number of indicators for each outcome, which will help us to measure our progress. During the first year of the strategy we will develop these indicators to ensure we can measure progress accurately and that we can compare our progress with other areas. We will use an approach called Outcomes Based Accountability, which is known to be effective in bringing about whole system change. The Leeds JHWS has chosen to focus on some really tough areas that will make a sustainable difference to people's lives. We acknowledge that bringing about these major changes, will not happen overnight, so we expect to see gradual improvements over time rather than radical quick wins. The Health and Wellbeing Board will use its strategic influence to ensure that progress is made by partners across the city through:

- Regular performance reports as part of our city priority plans
- Local level reports in partnership with CCGs
- Outcome based accountability events to focus closely on particular issues.
- An annual report from the Health and Wellbeing Board

Leeds Joint Health and Wellbeing Strategy 2013-2015

Vision for health & wellbeing: Leeds will be a healthy and caring city for all ages

Principle in all outcomes: People who are the poorest, will improve their health the fastest

Indicator: Reduce the differences in life expectancy between communities

Outcomes	Priorities	Indicators
People will live longer and have healthier lives	1. Support more people to choose healthy lifestyles 2. Ensure everyone will have the best start in life 3. Ensure people have equitable access to screening and prevention services to reduce premature mortality	1. Percentage of adults over 18 that smoke 2. Rate of alcohol related admissions to hospital 3. Infant mortality rate 4. Excess weight in 10-11 year olds 5. Rate of early death (under 75s) from cancer. 6. Rate of early death (under 75s) from cardiovascular disease
People will live full, active and independent lives	4. Increase the number of people supported to live safely in their own home 5. Ensure more people recover from ill health 6. Ensure more people cope better with their conditions	7. Rate of hospital admissions for care that could have been provided in the community 8. Permanent admissions to residential and nursing care homes, per 1,000 population 9. Proportion of people (65 and over) still at home 91 days after discharge into rehabilitation 10. Proportion of people feeling supported to manage their condition
People's quality of life will be improved by access to quality services	7. Improve people's mental health & wellbeing 8. Ensure people have equitable access to services 9. Ensure people have a positive experience of their care	11. The number of people who recover following use of psychological therapy 12. Improvement in access to GP primary care services 13. People's level of satisfaction with quality of services 14. Carer reported quality of life
People will be involved in decisions made about them	10. Ensure that people have a voice and influence in decision making 11. Increase the number of people that have more choice and control over their health and social care services	15. The proportion of people who report feeling involved in decisions about their care 16. Proportion of people using NHS and social care who receive self-directed support
People will live in healthy and sustainable communities	12. Maximise health improvement through action on housing 13. Increase advice and support to minimise debt and maximise people's income 14. Increase the number of people achieving their potential through education and lifelong learning 15. Support more people back into work and healthy employment	17. The number of properties achieving the decency standard 18. Number of households in fuel poverty 19. Amount of benefits gained for eligible families that would otherwise be unclaimed 20. The percentage of children gaining 5 good GCSEs including maths & English 21. Proportion of adults with learning disabilities in employment 22. Proportion of adults in contact with secondary mental health services in employment

Partnership members:

Cllr Lisa Mulherin - *Chair of the Health and Wellbeing Board, Leeds City Council*
Cllr Judith Blake - *Executive Member for Children's Services, Leeds City Council*
Dr Jason Broch - *Chair, Leeds North Clinical Commissioning Group*
Susie Brown - *CEO Zest Health for Life for Third Sector Leeds*
Andy Buck - *Director (West Yorkshire), NHS England*
Dr Ian Cameron - *Director of Public Health, Leeds City Council*
Cllr Stewart Golton - *Leeds City Council*
Dr Andy Harris - *Chief Clinical Officer, Leeds South & East Clinical Commissioning Group*
Sandie Keene - *Director of Adult Social Care, Leeds City Council*
Rob Kenyon - *Chief Officer Health Partnerships, Leeds City Council*
Cllr Graham Latty - *Leeds City Council*
Cllr Adam Ogilvie - *Executive Member for Adult Social Care, Leeds City Council*
Linn Phipps - *Chair, Healthwatch Leeds*
Nigel Richardson - *Director of Children's Services, Leeds City Council*
Dr Gordon Sinclair - *Chair, Leeds West Clinical Commissioning Group*

This publication can also be made available in large print, Braille, on audio tape, audio cd and on computer disk.

For further details please email:
healthandwellbeingboard@leeds.gov.uk

APPENDIX 3

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

WEDNESDAY, 31 JULY 2013

1. Aspiring NHS Foundation Trusts in Leeds

RESOLVED –

(a) That an overview of progress to be maintained, and progress be considered at a future meeting, with particular focus on:
- Clinical Audit
- Complaints
- Patient Confidentiality
- Preventative medicine

(b) That LTHT to provide a written update/ position statement on Seacroft Hospital.

(c) That the NHS TDA provide an outline of the role of the Director of Communications (including number of staff, budget and main stakeholders)

2. Request for Scrutiny – Men's Health in Leeds

RESOLVED –

(a) To incorporate the request for scrutiny into the work schedule for 2013/14 (precise timing to be determined), as part of the broad theme of 'Narrowing the Gap'.

(b) To present draft terms of reference and an outline timetable to a future meeting for consideration.

3. Request for Scrutiny – Children's Epilepsy Surgery

RESOLVED –

(a) To incorporate the request for scrutiny into the work schedule for 2013/14 (precise timing to be determined) and to invite NHS England to be to provide a written briefing/ update on the Safe and Sustainable review of Children's Neurosurgical Services for consideration at a future meeting.

(b) For the Chair of the Scrutiny Board to advise the Yorkshire and Humber network of Health Scrutiny Chairs of the concerns raised and the proposed actions.

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

4. Request for Scrutiny – Dermatology

RESOLVED –

(a) To form a working group of the Scrutiny Board and incorporate the request for scrutiny into the work schedule for 2013/14.
(b) That the scope of the working group would include consideration of proposed changes around medical rotas for other specialities (i.e. not just dermatology).
(c) Recognising the need to act swiftly, that a working group meeting be arranged as soon as practicable, with all relevant parties invited to participate in that meeting.

5. Urgent and Emergency Care Review

RESOLVED –

(a) That the Chair of the Scrutiny Board, in conjunction with the Principal Scrutiny officer, work towards drafting a response to Stage 1 of the public engagement activity, associated with the national review of Urgent and Emergency Care in England, ahead of 11 August deadline.
(b) That the Chair of the Scrutiny Board, in conjunction with the Principal Scrutiny officer, discuss the Scrutiny Board's general approach with Chair of Leeds' Health and Wellbeing Board and HealthWatch Leeds.
(c) That the Chair of Leeds Urgent Care Board to be invited to a future meeting of the Scrutiny Board (possibly October 2013) to outline the work of the Leeds Urgent Care Board.
(d) That further consideration be given to the on-going national review of Urgent and Emergency Care in England, at a future meeting (possibly October 2013).

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

WEDNESDAY, 25 SEPTEMBER 2013

6. Better Lives for the People of Leeds – The Future of Day Services for Older People

RESOLVED –

(a) To note that the concerns highlighted by the request for scrutiny, insofar as it relates to the decisions about residential care for older people, would be considered as part of the separate call-in meeting.
(b) To note the concerns highlighted by the request for scrutiny, insofar as it relates to the decisions about day services for older people.
(c) That the request for scrutiny be declined and no further consideration be given to the Executive Board decisions relating to day services for older people, at this time.
(d) That an report be presented to a future meeting of the Scrutiny Board that includes:
    i. A progress update on the implementation of the Executive Board's decisions relating to day services for older people;
    ii. Details of the community facilities, services and support available to older people across the City;
    iii. An update on the actual financial implications / savings associated with implementing the Executive Board decisions, compared to the details presented in the report that informed the decision.

Following conclusion of the item, there was a short adjournment at 11:05am. The meeting recommenced at 11:15am.

7. Fundamental Review of NHS Allocations Policy

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) To give further consideration to the matter at a future meeting – inviting input from a range of bodies representing the local health and social care sector. The aim of further discussions being to consider issues raised during the discussion, including (but not restricted to):
    i. The current financial plans and commissioning activity of local CCGs;
    ii. The potential implications of the proposed allocations on local CCGs and their associated commissioning activities;
    iii. The potential impact on the aspirations and target set out in the Leeds Joint Health and Wellbeing Strategy;
    iv. The potential implications for the work of the Leeds Health and Social Care Transformation Board.
(c) In consultation with the Chair, information to be presented to future meetings of the Scrutiny Board to be initially determined by the Principal Scrutiny Adviser.

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

WEDNESDAY, 25TH SEPTEMBER, 2013 (CALL-IN MEETING)

8. Better Lives for People in Leeds: report on the future of Residential Care for Older People and responses to Deputations to Leeds City Council by supporters of residents of Manorfield House and Primrose Hill care home – outcome of Call In

Following the vote to release the decision for implementation, reassurance was sought that further consideration would be given to the issues around respite care and intermediate care discussed at the meeting, which would not prejudice the Executive Board decision now released. The Director of Adult Social Services committed to undertaken further work in this regard.

RESOLVED – To release the decision for implementation.

(Under the provisions of Council Procedure Rule 16.5, Councillor S Lay required it to be recorded that he voted against releasing the decision for implementation)

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

WEDNESDAY, 30 OCTOBER 2013

9. Care Quality Commission Hospital Inspection Programme: Intelligent Monitoring

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) Following the inspection of Leeds teaching Hospitals NHS Trust, to formally consider the CQC's inspection report and any associated implications.

10. Fundamental Review of NHS Allocations Policy

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) To give further consideration to the matter at a future meeting – inviting input from a range of bodies representing the local health and social care sector. The aim of further discussions being to consider issues raised during the discussion, including (but not restricted to):
    i. The current financial plans and commissioning activity of local CCGs;
    ii. The potential implications of the proposed allocations on local CCGs and their associated commissioning activities;
    iii. The potential impact on the aspirations and target set out in the Leeds Joint Health and Wellbeing Strategy;
    iv. The potential implications for the work of the Leeds Health and Social Care Transformation Board.
(c) In consultation with the Chair, information to be presented to future meetings of the Scrutiny Board to be initially determined by the Principal Scrutiny Adviser.

11. NHS England: Call to Action

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) To consider further progress and developments associated with NHS England's 'Call to Action' at a future meeting
(c) To consider proposals to access the integration transformation fund (ITF) prior to the final submission in February 2014.

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

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

THURSDAY, 28 NOVEMBER 2013

12. Fundamental Review of NHS Allocations Policy

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) That the Principal Scrutiny Adviser draft a formal response to the NHS Funding Allocation proposals published by NHS England, taking account of the information due to be published ahead of the NHS England Board meeting (scheduled for 17 December 2013).

13. GP Services at Woodlands Surgery, Chapeltown

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) That the Scrutiny Board revisit the matter at a future meeting to consider any 'lessons learned' and also consider the West Yorkshire Area Team's assurance role in relation to GPs and primary care services in general.

14. Leeds Health And Social Care Transformation Board

RESOLVED –

(a) To note the information presented and discussed at the meeting.

15. NHS England: Call to Action

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) To seek a formal response from NHS England (West Yorkshire Area Team) in the letter from the Chair of the Scrutiny Board (dated 16 October 2013).
(c) To seek a formal response from Leeds Clinical Commissioning Groups regarding the engagement event, including the number of attendees and outcomes from the event.

Councillor Lay left the meeting at 11:30am during consideration of the above item.

16. Government Mandate to NHS England: 2014-15 Refresh

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) To seek a joint report from NHS England (West Yorkshire Area Team) and Leeds Clinical Commissioning Groups (CCGs) detailing the local implications of the NHS Mandate on the planning, commissioning and provision of local health services.

17. Consultation on Future Public Health Quality Standards and Guidance – Proposed Topic List

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) That the Principal Scrutiny Adviser, in conjunction with the Chair of the Scrutiny Board, should provide the Director of Public Health with the comments made at the meeting to inform an overall consultation response from the Council.
(c) That a copy of the overall consultation response from the Council (referred to in (b) above) be provided to members of the Scrutiny Board.

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

WEDNESDAY, 18 DECEMBER 2013

18. Minutes – 28 November 2013

In considering the minutes from the previous meeting, the following points were raised:

Fundamental review of NHS Allocations Policy (minute 60 refers)

- The Chair confirmed that at its meeting on 17 December 2013, the NHS England Board had considered a report setting out the outcome of the review, alongside a range of options regarding the allocation of NHS funding for 2014/15 and 2015/16.
- Members expressed concern around the timing of the release of information and the lack of detail currently available in terms of specific allocations for Clinical Commissioning Groups.
- The Principal Scrutiny Adviser confirmed that, due to the timing of the release of the above information, it had not been possible to implement resolution (b) as detailed in the minutes, i.e.

  That the Principal Scrutiny Adviser draft a formal response to the NHS Funding Allocation proposals published by NHS England, taking account of the information due to be published ahead of the NHS England Board meeting (scheduled for 17 December 2013).

- The Chair confirmed that this was a matter that the Scrutiny Board should return to at a future meeting.

RESOLVED –

(a) That the minutes of the meeting held on 30 October 2013 be approved as a correct record.
(b) That further consideration be given to the outcome of the Fundamental review of NHS Allocations Policy and NHS England's decisions in relation to the allocation of NHS funding for 2014/15 and 2015/16 – specifically in relation to the implications for Leeds.

19. Urgent and Emergency Care Review

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) That further consideration be given to the necessary re-design of the local urgent and emergency care system, and in particular the current arrangements and operation of the '111' service.

20. Our Children Deserve Better: Prevention Pays. Annual Report of the Chief Medical Officer 2012

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) To consider a 6-month update report on the issues presented in the report and discussed at the meeting, specifically including:
  - The mapping of children and young people's need for physical activity against current provision and the delivery of various programmes of work.
  - How the 'member lead member' roles around health and wellbeing and children are working together across the child heath agenda.

21. Progress report on Adult Social Care Better Lives Programme

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) To accept the request to undertake some work around the Future of Homecare and incorporate this into the work schedule.
(c) To invite Leeds and York Partnerships NHS Foundation Trust to a future meeting to report on the concerns raised around the provision of Mental Health service, reported delays in accessing services and the need to access services out of area.

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

WEDNESDAY, 29 JANUARY 2014

22. Minutes – 18 December 2013

In considering the minutes from the previous meeting, the following points were raised:

Progress report on Adult Social Care Better Lives Programme (minute 75 refers)

- It was confirmed that a report on a proposed staff-led mutual for the provision of Learning Disability Community Support service was scheduled to be presented to the Executive Board at its meeting on 14 February 2014. The Scrutiny Board may wish to consider any proposals presented for consultation in more detail.

RESOLVED –

(a) That the minutes of the meeting held on 18 December 2013 be approved as a correct record.
(b) That, following the outcome of the Executive Board meeting in February 2014, further consideration be given to any proposals for a staff-led mutual for the provision of Learning Disability Community Support service.

23. Shakespeare Medical Practice: Provision of General Practice (GP) and Walk-in Services

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) That a scoping meeting be convened with appropriate NHS representatives to consider the Scrutiny Board's consideration of general matters relating to the development of Primary Care services in Leeds and, in particular, any specific matters in relation to:
    i. The closure of Woodlands GP Surgery (considered at the meeting in November 2013)
    ii. The provision of General Practice (GP) and Walk-in Services at Shakespeare Medical Practice

NB *Cllr J Lewis joined the meeting at 1:50pm during the Scrutiny Board's consideration of this item.*

24. Better Care Fund – Developing Proposals in Leeds

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) The need to consult service users on draft proposals and undertake meaningful equality impact assessments be highlighted to Leeds' Health and Wellbeing Board.

(c) To consider a further update on the draft proposals at the next meeting of the Scrutiny Board, scheduled for February 2014.

25. Director of Public Health Annual report 2013

RESOLVED –

(a) To note the report as presented and the issues discussed at the meeting.

26. Work Schedule

The Scrutiny Board discussed the report and information highlighted at the meeting. A number of specific points were made, including:

- A proposal that the following items and associated activity be removed from the Board's work schedule for the current year (2013/14):
  - 'Quality Accounts' and 'Health Service Developments' working groups;
  - Request for scrutiny – Men's Health;
  - Request for Scrutiny – Children's epilepsy surgery;
  - Information flows/ data sharing.
- Proposals to incorporate the following areas / items into the work schedule for the current year (2013/14):
  - To hold a dedicated meeting focusing on mental health;
  - To hold a scoping meeting with NHS England and CCG representatives around Primary Care (during February / March 2014);
  - To review the partnership arrangements of the Health and Wellbeing Board through a working group meeting in April 2013 (date to be agreed/ confirmed);
  - To request a report on the proposals to review homecare provision in Leeds, including timescales and the proposed approach, in order to specifically consider the role of the Scrutiny Board.
- To consider convening and additional Scrutiny Board meeting in May 2014.
- To consider current trends in patient referral patterns in Leeds across each CCG.

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) Subject to the issues discussed during consideration of this item, the revised draft work schedule as presented be agreed.

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

FRIDAY, 28 FEBRUARY 2014

27. Leeds and York Partnership Foundation Trust – Care Quality Commission Inspection Reports

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) To receive the Trust's initial action plan produced at the conclusion of the inspection visits.

28. Fundamental Review of NHS Allocations Policy – Update on NHS England's Decisions and Associated Implications

RESOLVED –

To note the information presented and discussed at the meeting.

29. Better Care Fund Proposals

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) To maintain an overview of developments and to consider a further update on the proposals at a future meeting of the Scrutiny Board.

30. Review of Homecare Services in Leeds

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) That, in consultation with the Deputy Director, the Principal Scrutiny Adviser produce some draft Terms of Reference for consideration at a future meeting.
(c) That HealthWatch Leeds be approached to identify and nominate two, non-voting co-opted members for this specific aspect of the Scrutiny Board's work and duration of the review.

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

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

FRIDAY, 21 MARCH 2014

31. Minutes – 28 February 2014

The Scrutiny Board considered the draft minutes of the meeting held on 28 February 2014.

Reference was made to Care Quality Commission inspections in respect of services provided by Leeds and York Partnership Foundation Trust (LYPFT) and the request for the Trust's initial action plan produced at the conclusion of the inspection visits (minute 95 refers). It was confirmed this had been received and circulated to members of the Scrutiny Board.

RESOLVED –

That the minutes of the meeting held on 28 February 2014 be approved as a correct record.

32. Leeds Teaching Hospitals NHS Trust – Draft 5-Year Strategy

RESOLVED –

(a) To note the information presented and discussed at the meeting.

(b) That, in consultation with the Chair, the Principal Scrutiny Adviser drafts a formal response on behalf of the Scrutiny Board.

(c) That the Trust's changing funding landscape, particularly in relation to its 'teaching hospital' status, be the subject of further discussion at a future meeting of the Scrutiny Board.

(d) That the final 5-year strategy be presented to the Scrutiny Board following submission in June 2014.

(e) That further and more detailed action plans, detailing how the priorities would be achieved, be reported to a future meeting of the Scrutiny Board for more detailed consideration.

NB *Cllr J Lewis left the meeting at 1:10pm immediately after the Scrutiny Board's consideration of this item.*

33. Aspiring NHS Foundation Trusts – Leeds Teaching Hospitals NHS Trust Progress Update

RESOLVED –

(a) To note the update and progress reported in respect of Leeds Teaching Hospitals NHS Trust progress towards NHS Foundation Trust status.

(b) To express concern in respect of the update provided by the NHS Trust Development Authority around Leeds Community Healthcare NHS Trust; specifically the departure of the Chief Executive and the outcome of the Care Quality Commission inspection of services delivered at the South Leeds Independence Centre (reported in December 2013) – matters which had not been brought to the attention of the Scrutiny Board.

(c) That, on behalf of the Scrutiny Board, the Chair and Principal Scrutiny Adviser explores the circumstances around the information flows to the Scrutiny Board in this specific instance, and more generally across the local Health and Social Care system.

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

FRIDAY, 28 MARCH 2014

34. Creation of a Social Enterprise to deliver the Council's Learning Disability Community Support Service – Consultation on Proposals

RESOLVED –

(a) To note the information presented and discussed at the meeting, including the outline of the proposals and progress to date.
(b) That a further report, detailing progress and outcome of the consultation processes, be presented to the Scrutiny Board prior to any future Executive Board report and/or decision.

35. Joint Health Overview and Scrutiny Committee (Yorkshire and Humber)

RESOLVED –

To nominate the Chair, Cllr John Illingworth, as Leeds City Council's representative to serve on the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) in relation to the new review of Congenital Heart Disease services.

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

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

WEDNESDAY, 30 APRIL 2014

36. NHS Specialised Services: Impact assessment of proposed changes to specific service specifications

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) That, based on the information presented and discussed, the Principal Scrutiny Adviser draft a formal response to the current consultation around NHS Specialised Service specification, and consult members of the Scrutiny Board on its content ahead of the 21 May 2014 deadline.
(c) That the Scrutiny Board maintain an overview of progress and, subject to the revised specification for Paediatric Critical Care (Level 2) being adopted, that a further report detailing the precise implications be presented to the Scrutiny Board at a future date.

At the conclusion of the discussion, the Chair thanked those in attendance for their contributions to the meeting.

37. Children's Epilepsy Surgery

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) To request a copy of the letter from the North East Paediatric Neurosciences Network to NHS England seeking a review of service provision within Yorkshire and Humber / the North of England.
(c) To maintain an overview of the existing provision of Children's Epilepsy Surgery services, as necessary.

At the conclusion of the discussion, the Chair thanked those in attendance for their contributions to the meeting.

38. Urgent and Emergency Care

RESOLVED –

(a) To note the information presented and discussed at the meeting.
(b) To maintain an overview of the ongoing review of urgent and emergency care across the City and to receive further update reports in the new municipal year (i.e. 2014/15).

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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: 15 July 2014

Subject: Work Schedule

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 Further to the discussions already held during today's meeting, Members are now requested to translate any chosen topics for Scrutiny into a work schedule for the forthcoming municipal year.

2.2 A work schedule that will include any traditional 'business items' – such performance monitoring, recommendation tracking and Budget and Policy Framework Plans – will be presented to a future Scrutiny Board meeting.

2.3 In addition, as detailed elsewhere on the agenda, it is proposed to establish two formal working groups of the Scrutiny Board, as follows:

- **Health Service Developments Working Group** – to help the Board discharge its health scrutiny function/ role, specifically in relation to NHS service changes and/or developments. The draft terms of reference is attached at Appendix 1. A revised pro-forma to be used when presenting significant/ substantial service changes is provided at Appendix 2.

- **Review of Homecare Working Group** – to help the Board consider and contribute to the city-wide review (as previously agreed in 2013/14). The draft terms of reference is attached at Appendix 3.

2.4 Relevant stakeholders have been provided with draft copies of the terms of reference for both working groups, for comment. Any specific comments/ observations will be report to the Scrutiny Board at the meeting. .

3. Recommendations

3.1 Members are asked to:

a) Prioritise the topics identified for Scrutiny and incorporate these into its work schedule for the forthcoming municipal year.
b) Amend/ agree the draft terms of reference in relation to the Health Service Developments Working Group, including the proposed pro-forma to be used when presenting significant/ substantial service changes to the working group.
c) Determine the membership of the Health Service Developments Working Group.
d) Amend/ agree the draft terms of reference in relation to the Review of Homecare Working Group.
e) Determine the membership of the Review of Homecare Working Group.

4. Background papers[1]

4.1 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)
HEALTH SERVICE DEVELOPMENTS WORKING GROUP

TERMS OF REFERENCE

1.0 Background

1.1 The Health and Social Care Act (2012) reinforced the duty of NHS Commissioners and Service Providers to make arrangements to involve and consult patients and the public in:

- Planning service provision;
- The development of proposals for changes; and,
- Decisions about changes to the operation of services.

1.2 The requirement to consult on service changes and/or developments, also includes a duty to consult local authorities (through the health overview and scrutiny function) where any proposal is under consideration for:

- a substantial (major) development of the health service; or,
- a substantial (major) variation in the provision of such a service in the local authorities area.

1.3 Leeds City Council currently discharges its health overview and scrutiny function through the Scrutiny Board (Health and Wellbeing and Adult Social Care).

2.0 Scope

2.1 The levels of service variation and/or development are not specifically defined in legislation and it is widely acknowledged the term 'substantial variation or development of health services' is subjective, with proposals often open to interpretation.

2.2 To help achieve some degree of consistency, the Centre for Public Scrutiny (CfPS) published a scrutiny guide, *Major Variations and Developments of Health Services*[1]. Based on this guidance, and through discussions with local NHS partners, locally developed definitions and stages of have been agreed. These are detailed in Annex A and summarised in Table 1 (below).

Table 1: Summary of levels of change

Degree of variation	Colour code	Contact with Scrutiny
Category 4 –substantial variation (e.g. introduction of a new service)	**Red**	**Consult**
Category 3 – significant change (e.g. changing provider of existing services)	**Orange**	**Engage**
Category 2 – minor change (e.g. change of location within same hospital site)	**Yellow**	**Inform**
Category 1 – ongoing improvement (e.g. proposals to extend or reduce opening hours)	**Green**	**No**

[1] Published in December 2005 and available from the publications section of the CfPS website: http://www.cfps.org.uk/

2.3 The overall purpose of the working group is to provide an environment that allows local NHS commissioners and service providers to have an on-going dialogue with the Scrutiny Board, regarding proposed developments and changes to local health services and associated progress.

2.4 The role of the working group can be summarised as follows:

- To consider, at an early stage, any future proposals for new service changes and/or developments of local health services.
- To consider and agree the proposed level of change, including the proposed level of public engagement and involvement, for new service changes and/or developments of local health services.
- To determine whether or not relevant plans for public engagement and involvement are appropriate and appear satisfactory[2] for new service changes and/or developments of local health services.
- To consider whether or not any proposals for substantial changes/ developments are in the interests of the local health service.
- To maintain an overview of progress associated with ongoing service change proposals and associated public engagement and involvement activity, including details of any stakeholder feedback and how this is being used to further develop the proposals.
- To review the implementation of any agreed service change and/or development, including any subsequent service user feedback.
- To refer any matters of significant concern to the full Scrutiny Board (Health and Wellbeing and Adult Social Care), for further consideration.

2.5 It should be recognised that the statutory duty to consider any substantial service changes or developments remains the responsibility of the Scrutiny Board (Health and Wellbeing and Adult Social Care). As such, any substantial service changes and/or developments identified (i.e. category 4) will automatically be referred to the Scrutiny Board (Health and Wellbeing and Adult Social Care) for consideration.

2.6 Where a substantial service change and/or development is identified, the view of the working group will usefully inform the deliberation of the Scrutiny Board (Health and Wellbeing and Adult Social Care) when considering such matters.

3.0 Frequency of meetings

3.1 It is proposed that the working group will meet on a regular bi-monthly basis.

3.2 However, due to the nature of the work and the potential timing of proposed service changes and/or developments, it is recognised that the working group will adopt a flexible approach and additional meetings may be arranged as necessary.

3.3 It should also be recognised that the purpose of meeting on a bi-monthly basis is not only to ensure the early engagement of members of the Scrutiny Board with regard to emerging service changes and/or developments, but to ensure the continued involvement in relation to ongoing developments, alongside maters following implementation.

[2] This early engagement with Scrutiny will allow the working group to discuss and agree the proposed degree of variation, prior to the commencement of any patient and public engagement and involvement activity

4.0 Membership

4.1 The membership of the working group will be drawn from the membership of the Scrutiny Board (Health and Wellbeing and Adult Social Care).

4.2 The quorum of any working group meetings will be the Chair (or the Chair's nominee) plus a minimum of three other members from the Scrutiny Board (Health and Wellbeing and Adult Social Care). There will be a minimum of two political groups represented at any working group meeting.

5.0 Key stakeholders

5.1 The following key stakeholders have been identified as likely contributors to the working group:

- Leeds North Clinical Commissioning Group
- Leeds South and East Clinical Commissioning Group
- Leeds West Clinical Commissioning Group
- NHS England (West Yorkshire Area Team)
- NHS England (South Yorkshire and Bassetlaw Area Team)
- West and South Yorkshire and Bassetlaw Commissioning Support Unit
- Leeds Teaching Hospitals NHS Trust (LTHT)
- Leeds and York Partnership NHS Foundation Trust (LYPFT)
- Leeds Community Healthcare NHS Trust (LCH)
- Director of Adult Social Services (or nominee)
- Director of Public Health (or nominee)

6.0 Monitoring arrangements

6.1 The Scrutiny Board (Health and Wellbeing and Adult Social Care) will be kept fully appraised of the activity of the working group, with regular updates, reports and minutes provided as appropriate.

June 2014

Definitions of reconfiguration proposals and stages of engagement/consultation

Definition & examples of potential proposals	**Stages of involvement, engagement, consultation**			
	Informal Involvement	Engagement		Formal consultation
Substantial (major) variation or development Substantial service reconfiguration – changing how/where and when large scale services are delivered. Examples: urgent care, community health centre services, introduction of a new service.				**Category 4** Formal consultation required (minimum twelve weeks) **(RED)**
Significant variation or development Change in demand for specific services or modernisation of service. Examples: changing provider of existing services, pathway redesign when the service could be needed by wide range of people			**Category 3** Formal mechanisms established to ensure that patients/service users/ carers and the public are engaged in planning and decision making **(ORANGE)**	Information & evidence base
Minor change Need for modernisation of service. Examples: Review of Health Visiting and District Nursing (Moving Forward Project), patient diaries		**Category 2** More formalised structures in place to ensure that patients/ service users/ carers and patient groups views on the issue and potential solutions are sought **(YELLOW)**	Information & evidence base	
Ongoing development Proposals made as a result of routine patient/service user feedback. Examples: proposal to extend or reduce opening hours	**Category 1** Informal discussions with individual patients/ service users/ carers and patient groups on potential need for changes to services and solutions **(GREEN)**	Information & evidence base		

OSC involved

OSC may be involved

Note: based on guidance within the Centre for Public Scrutiny *Major variations and developments of health services, a guide*

Proposals for Change
Scrutiny Board - Health Services Development Group

Name of scheme/ project

Date:

SECTION A: THE PROPOSAL

1	*Detail the proposed level of service change: Substantial; Significant; Minor Change; Ongoing development (colour code accordingly)*
2	**Summary**
	Single paragraph to summarise the proposals.
3	**Details and purpose of proposed changes**
	Background *Briefly detail any background to the proposals.*
	The Proposal *Expand on the summary provided in section 2.*
	Contingency Plans *Detail any proposed contingencies during implementation (e.g. phased implementation; dual provision during shift to a new service model etc.).*

SECTION B: KEY QUESTIONS

1	**What is the current level of service usage/ demand?**
2	**What planning assumptions have been used to predict future service usage/ demand?**
3	**What are the financial implications of the proposals?**
4	**What are the intended benefits of the proposal?**
5	**What is the clinical evidence on which the proposals are based?**

6	**What other considerations have been taken into account when developing the proposals?**
7	**What are the health and equality impacts associated with the proposal? If appropriate, how will these be addressed and/or mitigated?**
8	**How will the proposals improve and contribute to joint working / service integration?**
9	**How will the proposals impact on the workforce? What are the implications?**
10	**What (if any) will be the impact on other partners within the local health system?**
11	**How will the proposals impact on service user access and choice?**

12	**How have services users, local people and groups been kept informed and involved in developing the proposal?**
13	**How will services users, local people and groups remain engaged in the development of the proposal?**
14	**What (if any) relevant evidence/ intelligence is held by HealthWatch Leeds in relation to these proposals?**
	To be provided by HealthWatch Leeds
15	**What are the timescales for any public consultation and when does the Scrutiny Board need to formally respond to the proposals?**
16	**What (if any) additional relevant information do NHS commissioners and/or providers wish to draw to the attention of the Scrutiny Board?**

SCRUTINY BOARD (HEALTH AND WELLBEING AND ADULT SOCIAL CARE)
FUTURE PROVISION OF HOMECARE SERVICES

TERMS OF REFERENCE

1.0 Background

1.1 In December 2013, the Executive Board Member (Adult Social Care) highlighted work underway around the 'Future of Homecare' and requested the Scrutiny Board's involvement in co-producing a solution. It was highlighted that a cross-party Members Advisory Board had also been established.

1.2 To help consider the overall role of the Scrutiny Board in relation to the 'Future of Homecare', in February 2014 the Scrutiny Board considered a report on the proposals to help scope any future work of the Scrutiny Board – including timescales and the proposed approach.

1.3 Key information presented to the Scrutiny Board included:

- Adult Social Care (ASC) has a statutory duty to provide services/support to people who have 'eligible' needs.
- The current eligibility level in Leeds is 'substantial and critical' – as defined in 'Prioritising need in the context of Putting People First', Dept. of Health (2010).
- The current expenditure by ASC on home care is in the region of £27m.
- Support to people with eligible needs in Leeds is provided in their homes by a variety of services including:
  - Reablement services;
  - ASC's Community Support Service; and,
  - Independent sector home care.
- The Community Home Care Framework Agreement is the main method by which ASC contract with independent sector home care providers.
- 33 independent sector providers have a contract with ASC through the Framework Agreement.
- 13 of these independent sector providers – mostly national or regional companies – provide city-wide coverage.

2.0 Scope

2.1 The overall aim of the ASC project is to create, implement and evaluate a new purchasing solution and service delivery model for independent sector home care provision in Leeds by April 2016.

2.2 The role of the working group can be summarised:

- To maintain oversight of the ASC project in terms of overall progress.
- To consider, review and make recommendations on any draft proposals/ solutions identified by ASC.

- To identify any opportunities and/or examples of good practice around the potential purchasing solution and service delivery model for independent sector home care provision in Leeds.
- To identify the overall financial envelop available for the future delivery of services and to assess the financial stability of any draft proposals/ solutions identified by ASC.
- To consider any opportunities for greater collaboration and value for money issues associated with the Leeds pound (£).
- To determine whether or not relevant plans for public (service user) engagement and involvement are appropriate and appear satisfactory
- To maintain an overview of any public (service user) engagement and involvement activity, including details of any feedback and how this is being used to further develop the proposals.
- To identify any specific recommendations and, via the Scrutiny Board (Health and Wellbeing and Adult Social Care), make reports to the appropriate decision-making body (e.g. Leeds City Council's Executive Board)

3.0 Timescales and frequency of meetings

3.1 In February 2014, it was outlined that the project would be delivered in 3 phases, as follows:

Phase	Description	Provisional Timescales
1	Development of the Home Care Commissioning Strategy for 2015 - 2020, Options Appraisal and Purchasing Strategy	July 2013 to April 2014
2	Procurement and implementation of the Purchasing Strategy, purchasing solution and service delivery model.	April 2014 to Sept 2015
3	Evaluation of the purchasing solution, services and project including benefits realisation,	Sept 2015 to March 2016

3.2 The timescales were identified as provisional and subject to change depending upon the outcome of the options appraisal, pricing review and other key aspects of the project.

3.3 The working group will adopt a flexible approach while aiming to meet on a regular basis: However, the frequency of meetings will largely be determined by the progress of the overall project.

3.4 It will be important for ASC to identify any key dates as soon as possible, to allow for sufficient time for the working group to consider and respond to relevant information.

3.5 The overall timetable will be kept under review as part of this scrutiny review.

4.0 Membership

4.1 The membership of the working group will be drawn from the membership of the Scrutiny Board (Health and Wellbeing and Adult Social Care).

4.2 The quorum of any working group meetings will be the Chair (or the Chair's nominee) plus a minimum of three other members from the Scrutiny Board (Health and Wellbeing and Adult Social Care). There will be a minimum of two political groups represented at any working group meeting.

5.0 Key stakeholders

5.1 The following stakeholders have been identified as likely contributors to the working group:

- Adult Social Care (Leeds City Council)
- Adult Social Care (other areas)
- Independent sector service providers
- Service user representatives and/or service user groups.
- Leeds Clinical Commissioning Groups
- Leeds Teaching Hospitals NHS Trust (LTHT)
- Leeds and York Partnership NHS Foundation Trust (LYPFT)
- Leeds Community Healthcare NHS Trust (LCH)
- Public Health (Leeds City Council)

6.0 Monitoring arrangements

6.1 The Scrutiny Board (Health and Wellbeing and Adult Social Care) will be kept fully appraised of the activity of the working group, with regular updates, reports and minutes provided as appropriate.

June 2014

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