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SCRUTINY BOARD (ADULT SOCIAL SERVICES, PUBLIC HEALTH AND NHS)

Meeting to be held in Civic Hall, Leeds, LS1 1UR on Tuesday, 23rd June, 2015 at 2.00 pm

(A pre-meeting will take place for ALL Members of the Board at 1.30 p.m.)

MEMBERSHIP

Councillors

C Anderson	Adel and Wharfedale;
B Flynn	Adel and Wharfedale;
P Gruen (Chair)	Cross Gates and Whinmoor;
A Hussain	Gipton and Harehills;
G Hussain	Roundhay;
S Lay	Otley and Yeadon;
C Macniven	Roundhay;
B Selby	Killingbeck and Seacroft;
A Smart	Armley;
E Taylor	Chapel Allerton;
S Varley	Morley South;

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

Agenda compiled by:
Kirsty Ware
Scrutiny Support Unit
Tel: 22 43094

Principal Scrutiny Adviser:
Steven Courtney
Tel: 24 74707

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 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 - 14 MAY 2015** To confirm as a correct record, the minutes of the Scrutiny Board (Health and Well-being and Adult Social Care) meeting held on 14 May 2015.	1 - 4
7			**TERMS OF REFERENCE** To receive a report from the Head of Scrutiny and Member Development presenting the Board's terms of reference	5 - 14
8			**CO-OPTED MEMBERS** To receive a report from the Head of Scrutiny and Member Development on the appointment of coopted Members to Scrutiny Boards	15 - 20
9			**SOURCES OF WORK** To receive a report of the Head of Scrutiny and Member Development on potential sources of work for the Scrutiny Board.	21 - 116

Item No	Ward/Equal Opportunities	Item Not Open		Page No
10			**LOCAL AUTHORITY HEALTH SCRUTINY** To consider a report from the Head of Scrutiny and Member Development introducing the Department of Health guidance around Local Authority Health Scrutiny and proposals to establish an associated Working Group of the Scrutiny Board.	117 - 154
11			**DATE AND TIME OF NEXT MEETING** Tuesday, 28 July 2015 at 2.00pm (pre meeting for all Board Members at 1.30pm) **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 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.	

Item No	Ward/Equal Opportunities	Item Not Open		Page No
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SCRUTINY BOARD (HEALTH AND WELL-BEING AND ADULT SOCIAL CARE)

THURSDAY, 14TH MAY, 2015

PRESENT: Councillor D Coupar in the Chair

Councillors J Akhtar, B Anderson, B Flynn, M Harland, K Maqsood, E Taylor and S Varley

Non-voting co-opted member: Dr J Beal (HealthWatch Leeds)

106 Chair's Opening Remarks

The Chair opened the meeting and welcomed those in attendance.

The Chair reminded all those in attendance of the Council's Third Party Recording code of practice, copies of which were available at the meeting.

107 Late Items

In accordance with powers under Section 100B(4)(b) of the Local Government Act 1972, the Chair agreed to accept the following late information:

Scrutiny Inquiry: Leeds' Child and Adolescent Mental Health Services and Targeted Mental Health in Schools – draft final report (minute 111 refers)

- Draft inquiry report of the Scrutiny Board

The above information was not available at the time of agenda despatch and was subsequently made available on the Council's website. Copies of the draft report were available at the meeting.

108 Declaration of Disclosable Pecuniary Interests

There were no disclosable pecuniary interests declared to the meeting.

However, in relation to the item on Leeds' Child and Adolescent Mental Health Services (CAMHS) and Targeted Mental Health in Schools (TAMHS), Dr Beal drew members' attention to the fact that his daughter was currently employed in the delivery of Leeds CAMHS services (minute 111 refers).

109 Apologies for Absence and Notification of Substitutes

Apologies for absence were received and recorded on behalf of:

- Councillor Ghulam Hussain

- Councillor Graham Latty (Councillor Barry Anderson in attendance as a substitute member)
- Councillor James Lewis
- Councillor Janette Walker (Councillor Mary Harland in attendance as a substitute member)

110 Minutes - 24 February, 24 March and 21 April 2015

The Board considered the draft minutes presented members. In relation to the minutes from the meeting held on 21 April 2015, the Principal Scrutiny Adviser highlighted the following matters to more fully describe the outcome of the discussion in relation to minutes 104:

Members noted and discussed the recent reference from the Licensing Committee regarding Legal Highs, along with issues raised around Air Quality. Members agreed both matters should be considered as potential areas of inquiry in the new municipal year.

Members also discussed the annual Quality Accounts that provider Trusts are required to produce. It was noted that Trusts are required to provide the Scrutiny Board the opportunity to comment on the draft publication. Due to the timing of production and the Board's capacity to make a meaningful contribution, members agreed the Board would not make any formal comments on any draft Quality Accounts for 2014/2015.

Subject to the inclusion of the above matters, the Board agreed (as an accurate record) the minutes of the previous meetings presented.

RESOLVED –

(a) That the draft minutes, as presented, from the meetings held on 24 February 2015 and 24 March 2015 be approved as an accurate record.
(b) That the draft minutes from the meeting held on 21 April 2015 be approved as an accurate record, subject to the amendments to minute 104 highlighted and discussed at the meeting.

111 Scrutiny Inquiry: Leeds' Child and Adolescent Mental Health Services and Targeted Mental Health in Schools - draft final report

The Head of Scrutiny and Member Development submitted a report introducing the draft final scrutiny inquiry report in relation to Leeds' Child and Adolescent Mental Health Services and Targeted Mental Health in Schools.

The Chair invited the Principal Scrutiny Adviser to talk through the draft report and recommendations.

The Principal Scrutiny Adviser went through and gave a brief overview of each section of the draft report, including each of the proposed recommendations and supporting rationale.

The Chair invited comments from members of the Scrutiny Board, who discussed the draft report and made a number of comments. These included:

- The report succinctly highlighted some of the previous failures to children and young people in need of emotional support and mental health services.
- The inquiry had identified communication issues across the system.
- The need for a future Scrutiny Board to consider a response to the recommendations and monitor progress.
- Any future consideration might usefully consider the impact of services from the ground, up.

It was proposed that an additional recommendation (recommendation 9) be included within the report in relation to the appropriate Scrutiny Board to consider the outcome of the Care Quality Commission inspection of Leeds Community Healthcare NHS Trust and the associated issues identified in the report. Members agreed to the inclusion of the additional recommendation.

Subject to the additional recommendation and necessary formatting of the final report, the Chair proposed the draft report should be agreed. Members of the Scrutiny Board agreed the report unanimously.

RESOLVED –

(a) That, subject to the inclusion of an additional recommendation (as outlined above) and the necessary formatting of the final version, the report be agreed.
(b) That, on completion of the agreed amendment and necessary formatting, the final report be shared with the appropriate organisations for a formal response to be presented at a future meeting of the appropriate Scrutiny Board.

112 Date and Time of the Next Meeting

The Chair confirmed this as the last meeting of the Scrutiny Board during the current municipal year (i.e. 2014/15) and that any future arrangements would be subject to the outcome of the Council's Annual Meeting scheduled for 21 May 2015.

The Chair thanked all members of the Scrutiny Board for their attendance and contributions throughout the year. Members of the Scrutiny Board thanked the Chair for all her efforts during the course of the year and the manner in which the Board's business had been conducted.

The Chair and other members of the Scrutiny Board thanked the Principal Scrutiny Adviser for all the support throughout the year.

(The meeting concluded at 10:45am)

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Adult Social Services, Public Health, NHS)

Date: 23 June 2015

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 Scrutiny Board (Adult Social Services, Public Health, NHS) 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 Scrutiny Board (Adult Social Services, Public Health, NHS).

2.0 Background information

Scrutiny Board's terms of reference

2.1 Each year, the Scrutiny Officer conducts a review of scrutiny arrangements to ensure that they are fit for purpose. This year, the focus of the review has been to consider the Board's terms of reference.

2.2 In the light of changes to the Council's key partnerships, Council resolved that the terms of reference for Scrutiny Boards be drafted to mirror the executive functions of the Council's directorates. This would provide clarity over the respective remit of each Scrutiny Board.

2.3 This Board's terms of reference are related to functions delegated to the Assistant Chief Executive (Adult Social Services, Public Health, NHS). The terms of reference are shown as Appendix 1 and the relevant officer delegations as Appendix 2.

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

- **Councillor L Mulherin (Executive Member for Health, Wellbeing and Adults)** – The lead for improving health and the quality of adult social care, reducing health inequalities through healthy lifestyles and integrating health and social care.
  - Social services so far as they relate to adults
  - Arrangements to protect and promote the welfare of vulnerable adults, including vulnerable young children moving into adulthood.
  - 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 the weighing and measuring of 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 health function of the Secretary of State (or functions exercisable in connection with those functions)
    - which the authority is required by regulations 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 It should be noted that the Director of City Development maintains decision-making oversight for following area of Executive Member responsibility, which therefore falls outside the direct Terms of Reference for the Scrutiny Board (Adult Social Services, Public Health, NHS):

- Sport and active lifestyles (including community sports facilities (excluding golf courses and outdoor pitches in parks))

2.6 Cross directorate working is encouraged and there will potentially be occasions when other directors or Executive Members may be asked to contribute to a Scrutiny inquiry should their portfolio responsibilities be relevant.

3.0 Corporate Considerations

3.1 Consultation and Engagement

3.1.1 These terms of reference were formally considered and approved by Council on 21st May 2015.

3.2 Equality and Diversity / Cohesion and Integration.

3.2.1 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.

3.3 Council Policies and the Best Council Plan

3.3.1 The terms of reference of the Scrutiny Board will continue to promote a strategic and outward looking Scrutiny function that focuses on the Best Council Plan.

3.4 Resources and Value for Money

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

3.5 Legal Implications, Access to Information and Call In

3.5.1 This report has no specific legal implications.

3.6 Risk Management

3.6.1 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.

Scrutiny Board (Adult Social Services, Public Health, NHS)

The Scrutiny Board (Adult Social Services, Public Health, NHS) 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 receive and consider requests for Scrutiny from any source;

c) to review or scrutinise the performance of such Trust / Partnership Boards as fall within its remit

d) to act as the appropriate Scrutiny Board in relation to the Executive's initial proposals for a relevant plan or strategy within the Budget and Policy Framework which falls within its remit;[3]

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

f) to make such reports and recommendations as it considers appropriate and to receive and monitor formal responses to any reports or recommendations made.

2. the following functions of the authority:[4]

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.[5]

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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] In accordance with Budget and Policy Framework Procedure Rules.

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

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

The Director of Adult Social Services[1]

With the exception of those matters where an appropriate Executive Member[2], has directed that the delegated authority should not be exercised and that the matter should be referred to the Executive Board for consideration,[3] the Director of Adult Social Services[4] is authorised to discharge any function[5] of the Executive in relation to:

(a) social services so far as those functions relate to adults[6];and

(b) arrangements to protect and promote the welfare of vulnerable adults[7], including vulnerable young people moving into adulthood.

[1] Appointed under Section 6 Local Authority Social Services Act 1970

[2] An "appropriate Executive Member" is the Leader or other appropriate portfolio-holding Member of the Executive Board

[3] The Director of Adult Social Services may consider in respect of any matter that the delegated authority should not be exercised and that it should be referred to the Executive Board for consideration

[4] The fact that a function has been delegated to the Director does not require the Director to give the matter his/her personal attention and the Director may arrange for the delegate authority to be exercised by an officer of suitable experience and seniority. However the Director remains responsible for any decision taken pursuant to such arrangements.

[5] "Function" for these purposes is to be construed in a broad and inclusive fashion and includes the doing of anything which is calculated to facilitate or is conducive or incidental to the discharge of any of the specified functions. The delegation also includes the appointment of the Director of Adult Social Services as "proper officer" for the purpose of any function delegated to him/her under these arrangements.

[6] That is, do not relate to:
(i) children or
(ii)young people leaving care under sections 23C and 24D of the Children Act 1989, so far as not falling within (i).

[7] So far as not falling within (a) above. See also footnote 6 above

Director of Public Health[1]

With the exception of those matters where an appropriate Executive Member[2] has directed that the delegated authority should not be exercised and that the matter should be referred to the Executive Board for consideration[3], the Director of Public Health[4] is authorised to discharge any function of the Executive in relation to:

a) taking appropriate steps to improve the health of the people in the authority's area[5];

b) dental public health[6];

c) joint working with the prison service[7];

d) the medical inspection of pupils and the weighing and measuring of children[8];

e) research, obtaining and analysing data or other information, and obtaining advice from persons with appropriate professional expertise [9];

f) planning for, or responding to, emergencies involving a risk to public health;

g) co-operating with arrangements for assessing risks posed by violent or sexual offenders[10];

h) any public health function of the Secretary of State (or functions exercisable in connection with those functions)

- which the authority is required by regulations to exercise[11]; or

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[1] Appointed under Section 73A National Health Service Act 2006 (" the 2006 Act")
[2] An "appropriate Executive Member is the Leader or other appropriate portfolio-holding Member of the Executive Board
[3] The Director of Public Health may consider in respect of any matter that the delegated authority should not be exercised and that it should be referred for consideration by the Executive Board.
[4] The fact that a function has been delegated to the Director of Public Health does not require the Director to give the matter his/her personal attention, and he/she may arrange for such delegation to be exercised by an officer of suitable experience and seniority. However, the Director remains responsible for any decision taken pursuant to such arrangements.
[5] Section 2B of the 2006 Act. Steps that may be taken include: providing information and advice; providing services or facilities designed to promote healthy living; providing services or facilities for the prevention, diagnosis or treatment of illness; providing financial incentives to encourage individuals to adopt healthier lifestyles; providing assistance (including financial assistance) to help individuals to minimise any risks to health arising from their accommodation or environment; providing or participating in the provision of training for persons working or seeking to work in the field of health improvement; making available the services of any person or any facilities; and providing grants or loans
[6] As prescribed by the Secretary of State under Section 111 of the 2006 Act
[7] In relation to improving the way in which the authority's functions are exercised to secure and maintain the health of prisoners - Section 249 of the 2006 Act
[8] Under Schedule 1 of the 2006 Act
[9] For any purposes in connection with the authority's functions in relation to the health service – paragraph 13 of Schedule 1 of the 2006 Act
[10] Under Section 325 Criminal Justice Act 2003
[11] Section 6C(1) and (3) of the 2006 Act

- in respect of which arrangements have been made[12];

i) any other function prescribed by the Secretary of State as the responsibility of the Director of Public Health; and

j) the oversight of clinical governance arrangements.

[12] Under Section 7A of the 2006 Act

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74553

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Adult Social Services, Public Health, NHS)

Date: 23 June 2015

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.

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.

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 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.

3.6 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.

3.7 When considering the appointment of a standing co-opted member for a term of office, Scrutiny Boards should be mindful of any potential conflicts of interest that may arise during the course of the year in view of the Scrutiny Boards' wide ranging terms of reference. To help overcome this, Scrutiny Boards may wish to focus on the provision available to appoint 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.

3.8 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.

Co-opted members and health scrutiny

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 In 2014/15, the Scrutiny Board again reviewed its approach to co-opted members and appointed a standing non-voting co-opted member representative from Healthwatch Leeds for 2015/16. The overarching aim of that appointment was 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 There is a general consensus that the 2014/15 arrangements worked well and, if invited to do so, HealthWatch Leeds would welcome similar arrangements for the municipal year 2015/16.

3.14 However it should be noted that, on occasion, due to the availability of the nominated representative, HealthWatch Leeds was not always represented at all Scrutiny Board meetings. The Council's current arrangements for substitute members attending Scrutiny Board meetings do not extend to co-opted members. As such, the Scrutiny Board may wish to consider seeking more than one nomination from HealthWatch Leeds.

3.15 It should also be noted this approach would not preclude any further appointment of co-opted members within the overall provision provided by 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 Best Council Plan

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 As stated in paragraph 3.7 above, when Scrutiny Boards are considering the appointment of a standing co-opted member for a term of office, they should be mindful of any potential conflicts of interest that may arise during the course of the year in view of the Scrutiny Boards' wide ranging terms of reference.

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. This report 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.

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Adult Social Services, Pubic Health, NHS)

Date: 23 June 2015

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. The vision for Scrutiny, agreed by full Council on 21st May 2015 (Appendix 1) also recognises that resources to support the Scrutiny function are, (like all other Council functions), under considerable pressure and that requests from Scrutiny Boards cannot always be met. Consequently, when establishing their work programmes Scrutiny Boards should:

   - Ensure any Scrutiny undertaken has clarity and focus of purpose and will add value and can be delivered within an agreed time frame;
   - Avoid pure "information items" except where that information is being received as part of a policy/scrutiny review;
   - Seek the advice of the Scrutiny officer, the relevant Director and Executive Member about available resources;
   - Avoid duplication by having a full appreciation of any existing forums already having oversight of, or monitoring a particular issue;
   - Balanced in terms of the workload across the Scrutiny Boards and as to the type of Scrutiny taking place;
   - Remain sufficiently flexible to enable the consideration of urgent matters that may arise during the year.

3. 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 Directors and Executive Board Members, the Scrutiny Board is requested to consider areas of Scrutiny for the forthcoming municipal year.

4. The Executive Board Member for Health, Wellbeing and Adults, the Director of Adult Social Services and the Director of Public Health have each been invited to the meeting to help inform the Scrutiny Board's discussions. Representatives from Leeds three Clinical Commissioning Groups (CCGs) have also been invited to attend the meeting.

Recommendations

5. Members are requested to;

   - Use the attached information and the discussion with those present at the meeting to draw up a list of areas for potential Scrutiny for the forthcoming municipal year.
   - Request that, in line with the agreed Vision for Scrutiny, the Chair and the Scrutiny Officer consult with the relevant Directors and Executive Board Member regarding resources and report back to the next meeting with a draft work programme.

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.

3.0 Main issues

Best Council Plan

3.1 A refresh of the Best Council Plan was agreed at Executive Board in March 2015, to reflect the progress made over the past year and the significant changes to the context in which the council is working. The resulting 'Best Council Plan – Update 2015/16' is attached as Appendix 2.

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 such Trust/ Partnership Boards as fall within its remit. The Health and Wellbeing Board is the main Partnership Board within the Scrutiny Board's remit and the Scrutiny Board may wish to review areas of performance and progress against specific outcome and priority areas detailed in the Leeds' Joint Health and Wellbeing Strategy (JHWS) (2013-2015) – attached at Appendix 3.

3.3 In considering aspects of Leeds' Joint Health and Wellbeing Strategy (JHWS) (2013-2015), it should be recognised that a review/ refresh process is currently underway to develop priorities beyond 2015 (i.e. the current lifecycle for the strategy). The Scrutiny Board may wish to consider its role in this process.

3.4 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 to acting as a 'critical friend' to the Health and Wellbeing Board..

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. To assist the Scrutiny Board, a summary of Leeds' Adult Social Care profile and Leeds' Health Profile – both compiled by Public Health England – are attached at Appendix 4 and 5, respectively.

3.6 Other common sources of work include pre-decision scrutiny, requests for scrutiny and other corporate referrals. The Board is also required to be formally consulted during the development of key policies which form part of the council's budget and policy framework.

Scrutiny of the NHS

3.7 The Scrutiny Board is also tasked with discharging the Council's health scrutiny function (as set out in its terms of reference). This includes being consulted on (and responding to) any proposed substantial changes and/or developments of local NHS services. Proposals to consider NHS service changes are detailed elsewhere on the agenda.

3.8 However, the Scrutiny Board may also review and scrutinise any matter relating to the planning, provision and operation of the health services in its area. The significant challenges faced by the NHS are well documented. In helping to address these challenges, NHS England published its 5-Year Forward View in October 2014 (Appendix 6). The Scrutiny Board may wish to consider the impact / implementation of the national forward view locally.

3.9 In considering scrutinising any matter relating to the planning, provision and operation of local health services, the Scrutiny Board may also wish to consider those areas already identified by commissioners for review. This was specifically highlighted by the previous Scrutiny Board in its report on *The Provision of Emotional Wellbeing and mental Health Support Services for Children and Young People in Leeds* (agreed in May 2014), through the following recommendation:

Recommendation 1

(a) In order to minimise any potential duplication, at the beginning of each municipal year, all commissioners across Leeds' health and social care economy identify and report to the appropriate Scrutiny Board any specific service areas currently under review and/or planned to be under review in the immediate future.

(b) Throughout each municipal year, commissioners across Leeds' health and social care economy ensure the appropriate Scrutiny Board is undated regarding the progress of any current service reviews and appraised of any in-year changes to future areas of review.

3.10 Service commissioners attending the meeting have specifically been reminded of this recommendation.

Areas of Scrutiny work brought forward from the previous year

3.11 Throughout the previous municipal year (2014/15), the Scrutiny Board (Health and Wellbeing and Adult Social Care) identified a range of matters for potential scrutiny that were unable to be commenced or completed during that year.

- Oversight of Savile report findings and recommendations and the respective roles of Leeds' Adults and Children's Safeguarding Boards (**July 2014**)
- Better Care Fund – respective roles of the Health and Wellbeing Board and the Scrutiny Board (**September 2014**)

- Consider quality assurance processes, including roles and responsibilities, across NHS/ health services in Leeds (**September 2014**)
- Overview of the impact and implementation of the requirements of the Care Act 2014 (**September 2014**)
- The Director of Public Health's Annual Report (**October 2014**)
- Outcome of the Health and Wellbeing Board's consideration of the 'Due North' report (**October 2014**)
- The Regional Oral Health Needs Assessment (**November 2014**)
- Regular reports on the development and provision of Primary Care Services in Leeds (**November 2014**)
- The contribution of Primary Care in addressing health inequalities (**November 2014**)
- Leeds' Oral Health Strategy (**November 2014**)
- Use of Council resources in the delivery of a range of Adult Social Care services (request for scrutiny agreed in **December 2014**)
- Review of the work of Leeds' Health Protection Board (**December 2014**)
- Proposed next steps for delivering the Leeds' Better Lives Strategy (request from Executive Board (November 2014) and agreed in **December 2014**)
- Leeds Draft Maternity Strategy (delayed from **February 2015**)
- Further updates on the development and implementation of the Leeds' mental Health Framework (**February 2015**) and equality impact assessments associated with the provision of mental health services in Leeds (**October 2014**)
- Leeds and York Partnership NHS Foundation Trust – a report from the Trust in relation to its approach to broader engagement (**January 2015**).
- Yorkshire Ambulance Service NHS Trust (YAS) – outcome of CQC inspection and overview of performance improvement plans (**January 2015**)
- Leeds Community Healthcare NHS Trust (LCH) – CQC inspection report outcomes/ recommendations and formal action plans (delayed from **February 2015**)
- The operation of the City's integrated health and social care teams (identified in the Board's statement on *The Future Provision of External Home Care Services* (**April 2015**)).
- Quarterly performance and progress of the areas identified in Leeds' Local Account of Adult Social Care 2014/15 – including available benchmarking data from other areas (**April 2015**).
- Approaches to addressing social isolation through actions agreed by Community Committee (**April 2015**)
- Impact of Legal Highs (reference from the Licensing Committee (**April 2015**))
- Air Quality in Leeds (**April 2015**)
- Continue to monitor the outcomes of Care Quality Commission inspections and associated improvement plans (**April 2015**))

3.12 In addition, as part of the Scrutiny Inquiry report into *The Provision of Emotional Wellbeing and mental Health Support Services for Children and Young People in Leeds* (agreed in May 2014), the previous Scrutiny Board agreed the following recommendation:

Recommendation 9
That as part of its work schedule for 2015/16, the appropriate Scrutiny Board:

(a) Continues to monitor the outcome of Care Quality Commission inspections and the associated improvement plans developed by NHS Trusts in Leeds.
(b) Specifically considers and reports on any matter that might suggest an underlying system-wide issue, including those areas identified in this report *[i.e. identification of potential ligature points* and *premises identified as 'unsuitable'].*
(c) Considers and reports on the adequacy of the quality assurance processes across Leeds' Clinical Commissioning Groups and other service commissioners, where appropriate.

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 Directors and Executive Board Members holding the relevant portfolios. The Vision for Scrutiny, agreed by full Council in May 2015 also states that Scrutiny Boards should seek the advice of the Scrutiny officer, the relevant Director and Executive Member about available resources prior to agreeing items of work.

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 the Best Council Plan

4.3.1 The terms of reference of the Scrutiny Boards promote a strategic and outward looking Scrutiny function that focuses on the best council objectives.

4.4 Resources and Value for Money

4.4.1 Experience has shown that the Scrutiny 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 The Vision for Scrutiny, agreed by full Council also recognises that resources to support the Scrutiny function are, (like all other Council functions), under considerable pressure and that requests from Scrutiny Boards cannot always be met. Consequently, when establishing their work programmes Scrutiny Boards should:

- Seek the advice of the Scrutiny officer, the relevant Director and Executive Member about available resources;
- Avoid duplication by having a full appreciation of any existing forums already having oversight of, or monitoring a particular issue;
- Ensure any Scrutiny undertaken has clarity and focus of purpose and will add value and can be delivered within an agreed time frame.

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 Directors, Executive Board Members and Scrutiny Officer, the Scrutiny Board is requested to consider 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 draw up a list of areas for Scrutiny for the forthcoming municipal year.

- Request that the Chair and the Scrutiny Officer consult with the relevant Director and Executive Board Members regarding resources in line with the agreed Vision for Scrutiny and report back to the next meeting with a draft work programme.

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.

APPENDIX 1

Vision for Scrutiny at Leeds

"To promote democratic engagement through the provision of an influential scrutiny function which is held in high regard by its many stakeholders and which achieves measurable service improvements which add value for the people of Leeds through a member led process of examination and review"

To achieve this Scrutiny will follow the nationally agreed 'Four Principles of Good Scrutiny';

1. Provide 'critical friend' challenge to decision makers, through holding them to account for decisions made, engaging in policy review and policy development;

2. Promote Scrutiny as a means by which the voice and concerns of the public can be heard;

3. Ensure Scrutiny is carried out by 'independent minded' Board members;

4. Improve public services by ensuring reviews of policy and service performance are focused.

To succeed Council recognises that the following conditions need to be present;

- Parity of esteem between the Executive and Scrutiny
- Co-operation with statutory partners
- Member leadership and engagement
- Genuine non-partisan working
- Evidence based conclusions and recommendations
- Effective dedicated officer support
- Supportive Directors and senior officer culture

Council agrees that it is incumbent upon Scrutiny Boards to recognise that resources to support the Scrutiny function are, (like all other Council functions), under considerable pressure and that requests from Scrutiny Boards cannot always be met. Therefore Council agrees that constructive consultation should take place between the Executive and Scrutiny about the availability of resources prior to any work being undertaken.

Consequently, when establishing their work programmes Scrutiny Boards should

- Seek the advice from the Scrutiny officer, the relevant Director and Executive Member about available resources

- Avoid duplication by having a full appreciation of any existing forums already having oversight of, or monitoring a particular issue (e.g. Plans Panel, Housing Advisory Board, established member working groups, other Scrutiny Boards)

- Ensure any Scrutiny undertaken has clarity and focus of purpose and will add value and can be delivered within our agreed time frame.

Leeds
CITY COUNCIL

BEST COUNCIL PLAN 2015-20

UPDATE 2015-16

FOREWORD

We have a positive and distinctive vision for the future of Leeds City Council: where the council becomes more enterprising; businesses and partners more civic; and the public more engaged. We will meet our responsibilities in a way that serves our communities even better, reducing inequalities and achieving our ambitions of Leeds being the UK's best council and best city: a city that is great for all ages; where people are earning, learning, safe, healthy and engaged.

The last five years have seen major changes across local government and the public sector, with increased demand for services and a significantly decreased central budget. Leeds is no different. What has set us apart is the way we have worked with our partners to face these challenges and continued to deliver real progress for people in the city.

ABOUT LEEDS

Leeds is the **2nd largest** metropolitan **local authority** in England covering an area of 552 km²

Latest estimated population of Leeds is **775,666**, up 3.2% since 2011 census, **8.4% growth** since 2001 census

Around **10,000 births** a year, up one third since 2001

We provide the **largest** local authority-run **museum** service in England

Leeds has **272** state funded **schools**

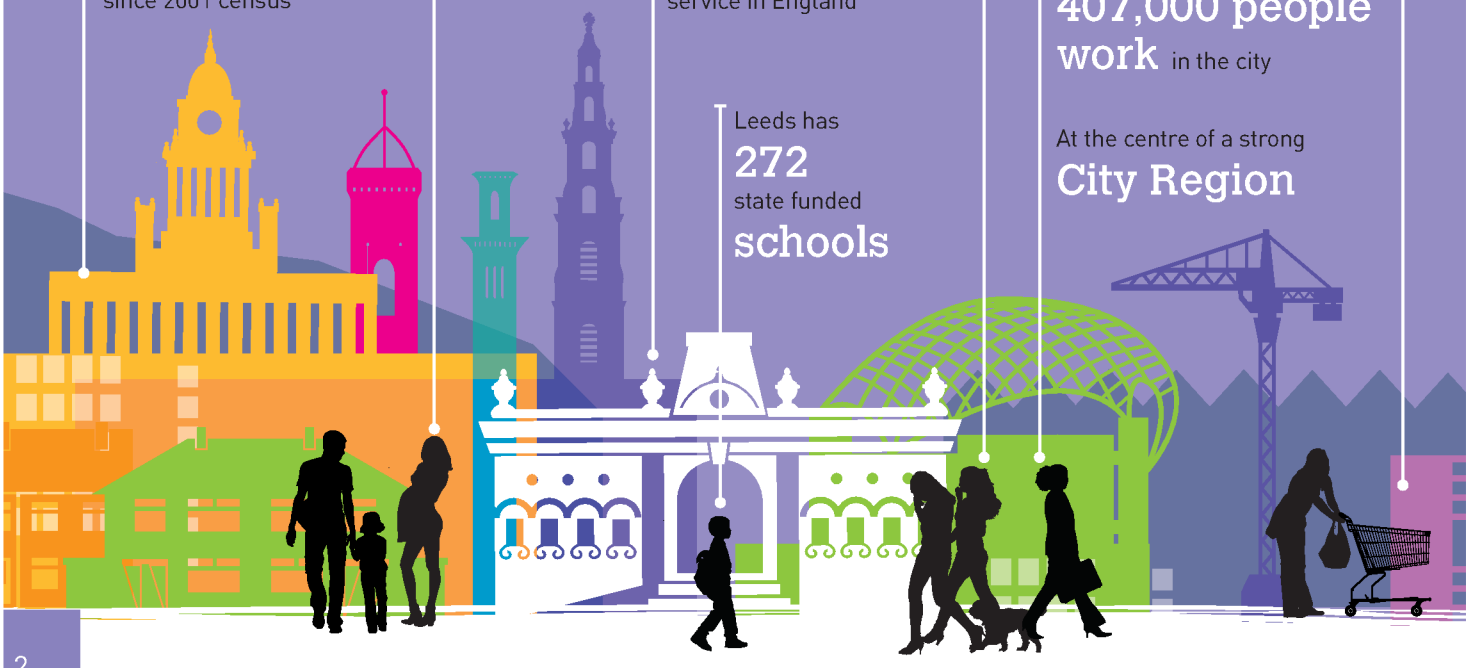
Leeds is increasingly diverse with over **140 ethnic groups** representing almost **19%** of the total population compared to 11% in 2001

Leeds has over **24,000** VAT registered **businesses**

407,000 people work in the city

Leeds is by far the largest centre of economic activity in the region, with the total value of the **economy** estimated at **£21bn** per annum (GVA)

At the centre of a strong **City Region**



We know that local government and public services remain vital to communities in helping them shape their health and wellbeing. At a time when the public consistently trusts local government much more than central government, we will continue to make the case for greater freedoms from Whitehall. Real and meaningful devolution is the key to transforming Leeds, opening up opportunities and improving the lives of people in the city.

These are big ambitions and we need big changes to make them a reality. We have clear plans with our partners, such as the children and young people's plan, the housing strategy, and the health and wellbeing strategy. We have set out here what our focus will be for the next twelve months; and how we will work differently over the next five years.

Our five council values continue to underpin everything we do: working as a team for Leeds; being open, honest and trusted; working with communities; treating people fairly; spending money wisely.

We are again asking our colleagues to do more with less, and continue to find new ways of delivering the very best for Leeds. We value their commitment and would like to share our sincere thanks for all that's been achieved so far, and the continuous hard work that is going to be needed over the coming months and years.

Tom Riordan

Chief Executive of
Leeds City Council

Cllr Keith Wakefield

Leader of Leeds City Council

The council employs around **13,500 people** and spends almost **£2 billion** each year delivering hundreds of different services

We are one of six councils that make up the West Yorkshire **Combined Authority**

Leeds City Council has **99 councillors**

We look after **4,000 hectares of parks** and green spaces, the equivalent of 5,600 football pitches

We support more than **114,000 residents** in **57,000 council houses** with more being built

More than **180,000 children and young people** aged 0-19 live in the city, with just under **1,300** in care

Our social care services provide support to around **23,600** people aged **over 65**

We maintain over **92,000** streetlamps

We clean and maintain **3,000 km** of roads – that's enough road to get from Leeds to Greenland

We empty almost **two million bins** each month

INTRODUCTION

Over the coming years, the projected growth and changes in the Leeds population continue to present a complex range of challenges, from ensuring enough school places are available to meeting the needs of an ageing population. Inequalities persist: for example, 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. The skills that local employers need from their workforce are evolving, particularly in the projected growth areas of innovative manufacturing and financial and professional services. We must meet our responsibilities in these areas within the context of a continued reduction in budget.

For Leeds, funding from government was reduced by £129m between 2010/11 and 2014/15 but, in addition, the council has also faced significant cost pressures particularly within adult and children's social care, as well as reductions in income due to the economic

KEY ACHIEVEMENTS 2014/15

Construction began on the city centre **Victoria Gate** development

Our Better Lives programme continues to **reduce the time** older people spend in residential and **nursing care homes**

We've introduced ten **Community Committees** to include more local people in decision making

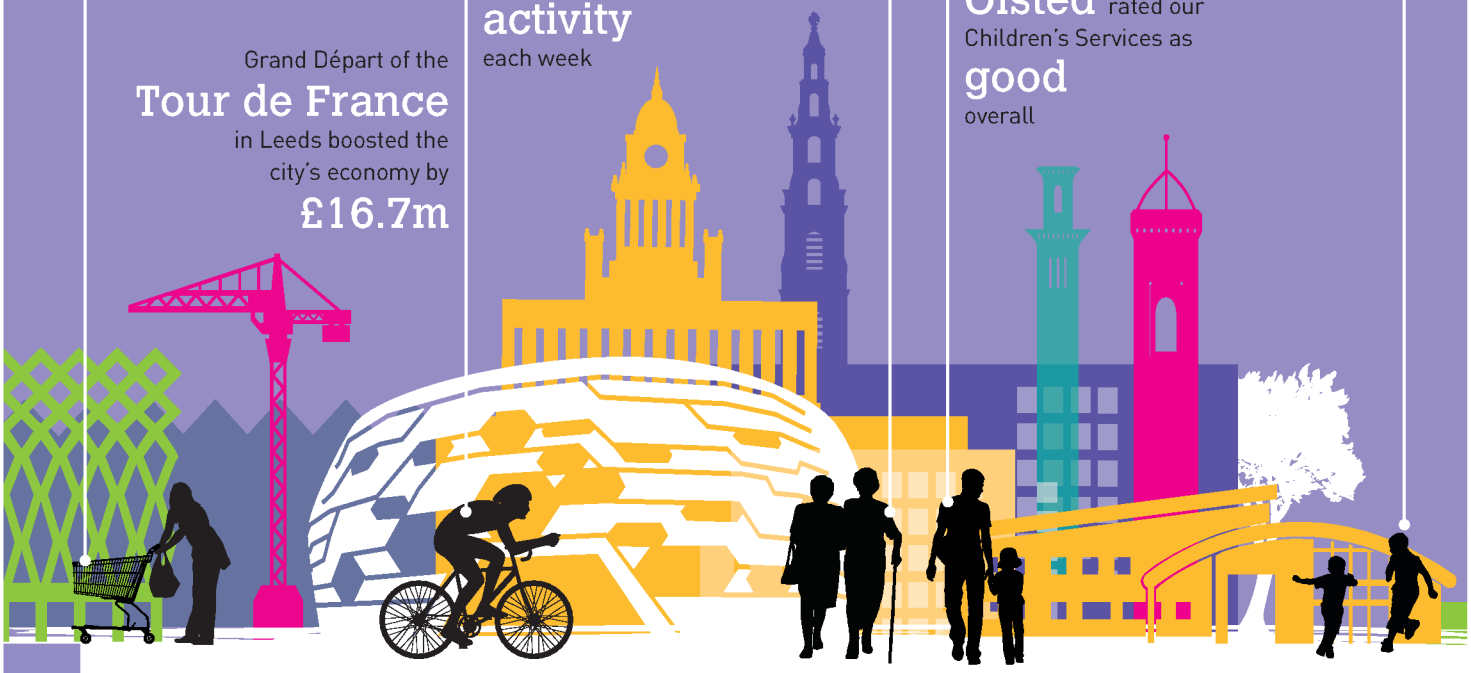
£8m secured for Leeds to deliver **cycle schemes** over the next 3 years

Over **2,000** previously **inactive people** now participate in **physical activity** each week

School attendance the **highest ever** recorded in the city

Grand Départ of the **Tour de France** in Leeds boosted the city's economy by **£16.7m**

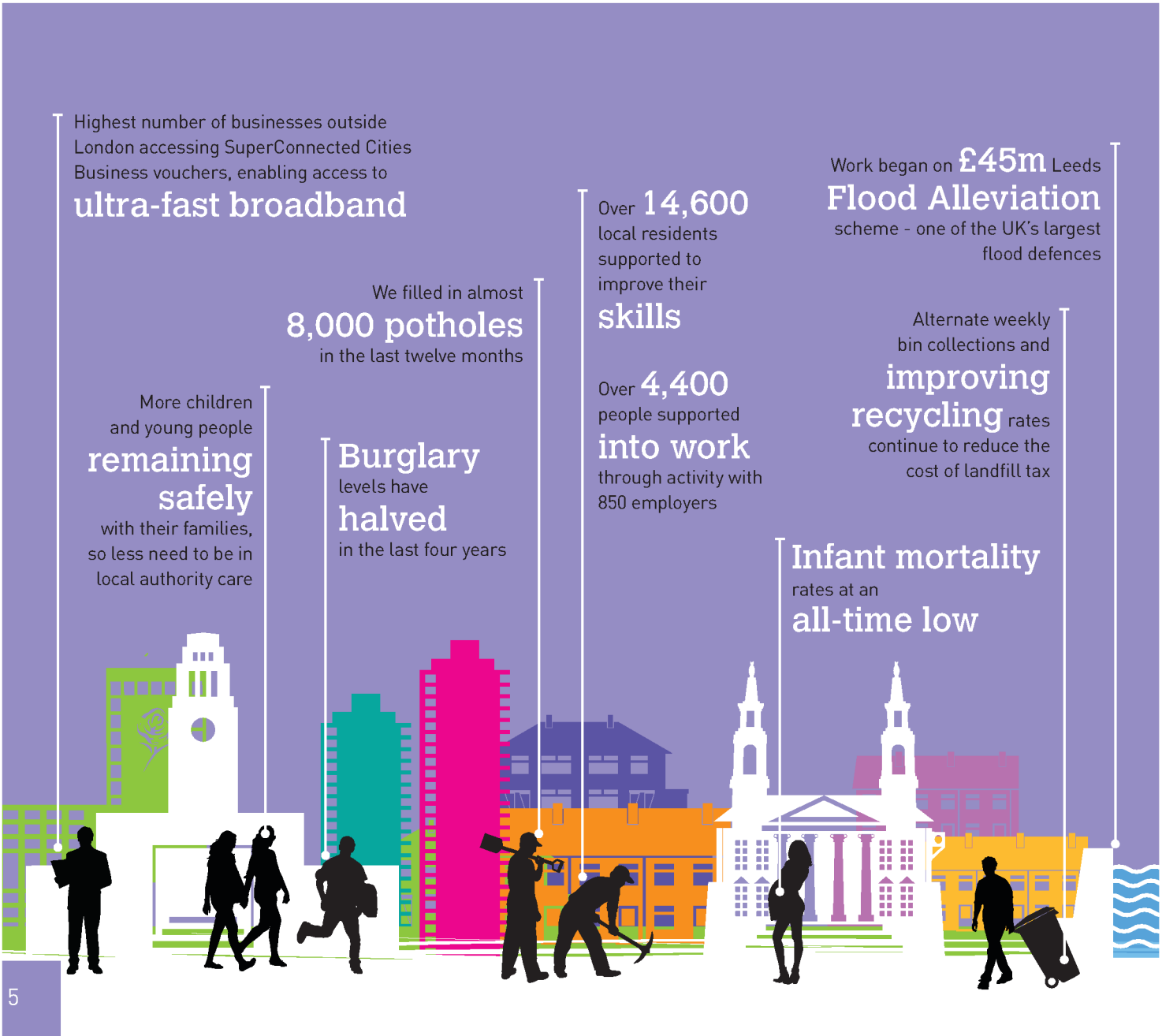
Ofsted rated our Children's Services as **good** overall



climate. This has meant that savings of around £250m have had to have been found over the last four years.

For 2015/16, our net budget has been reduced by £44m, with less core funding from the government being the main element of that. Further reductions will fundamentally challenge the services provided by the council and change the way we work.

This is the context for this Best Council Plan to take us to 2020. The impact of these cuts cannot be underestimated but our 2015/16 budget demonstrates our firm focus on countering disadvantage and inequality in Leeds. This will remain central to all our work in the next five years. What will help us rise to these challenges is the way we work together and engage with our partners and with the public to understand and respond to their needs and demands. We will adapt to survive – and we want to do more than survive. We intend to continue to play our part in making Leeds thrive.



THE NEXT TWELVE MONTHS: 2015/16

In last year's Best Council Plan update, we shared our priorities and objectives. We outlined our continued focus on a values-based approach to deliver change, investing significantly in our workforce. We described the difference that a civic enterprise approach is making. The objectives will continue to be important for the next year, with our budget showing how our spending will help to achieve them. The objectives are supported by a set of plans that use the performance management methodology 'outcomes based accountability', detailing outcomes, priorities and key performance indicators. The most significant of these indicators form a set to help measure progress on the Best Council Plan as a whole. These are set out in the Appendix.

The six objectives for 2015/16 remain as:

1. **Supporting communities and tackling poverty**
2. **Promoting sustainable and inclusive economic growth**
3. **Building a child-friendly city**
4. **Delivering the better lives programme**
5. **Dealing effectively with the city's waste**
6. **Becoming a more efficient and enterprising council**

OUR FOCUS FOR 2015/16

Delivering a **Council Tax Support** scheme that helps people into work

Further joining up **health** and **social care** services and meeting new Care Act 2014 duties

Delivering **housing growth** and meeting housing needs

Promoting community committees and the role of **community champions**

Continuing focus on helping **all children** to be **healthy, safe** from harm and to progress and **achieve** at school

Contributing to a successful **Tour de Yorkshire**

Continuing major refurbishment of **Kirkgate Market**

Establishing new integrated **sexual health** service and new **drug** and **alcohol** treatment services for the city

With a General Election in 2015, we know there will be changes. These objectives give us a clear focus for the year ahead against this uncertain backdrop.

To accelerate pace, we have established a new way of working that will break through traditional boundaries and engage partners and communities differently, with a clear focus on outcomes. The council's role in making the Tour de France Grand Départ in 2014 such a success for the city shows how well we can work in this way – and what happens when communities and partners take up a civic role too.

The seven breakthrough projects are:

- **Cutting carbon in Leeds**
- **Domestic violence and abuse**
- **Hosting world class events on a global stage as a smart city**
- **Housing growth, and jobs for young people**
- **Making Leeds the best place to grow old**
- **Reducing health inequalities through healthier lifestyles**
- **Rethinking the city centre**

Extending the roll-out of **alternate weekly bin collections** and garden waste

Reducing the council's workforce by the equivalent of 400 full-time **staff**

Improving **customer access** to Council services

Securing investment, delivering **economic growth**, **new jobs** and development in the Aire Valley Enterprise Zone

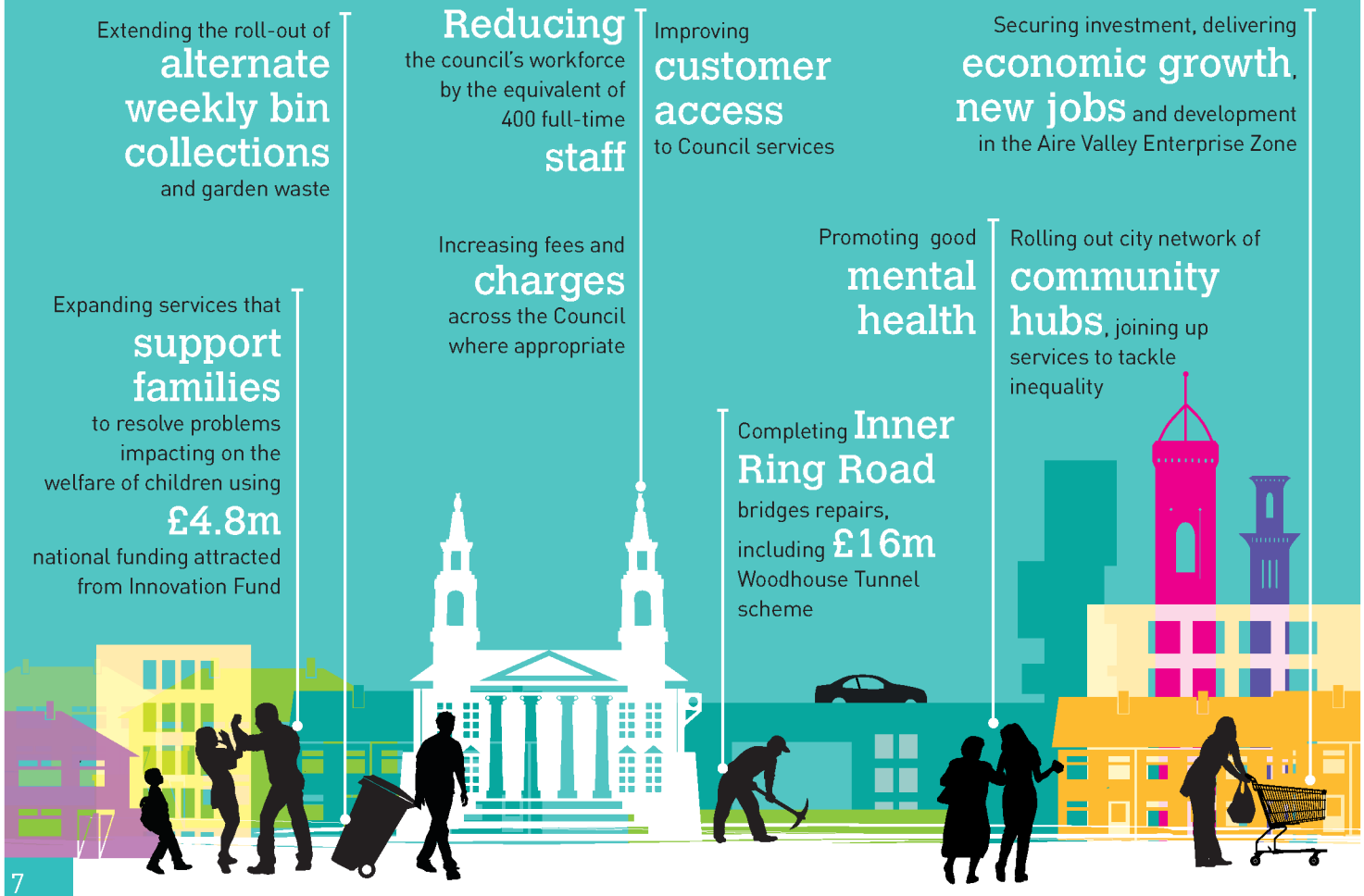
Increasing fees and **charges** across the Council where appropriate

Promoting good **mental health**

Rolling out city network of **community hubs**, joining up services to tackle inequality

Expanding services that **support families** to resolve problems impacting on the welfare of children using **£4.8m** national funding attracted from Innovation Fund

Completing **Inner Ring Road** bridges repairs, including **£16m** Woodhouse Tunnel scheme



LOOKING AHEAD TO 2020

We want Leeds to be the best city in the UK – one that is earning, learning, safe, healthy and engaged. A city that is great for people of all ages. To make this happen, we will continue to use our thinking from the Leeds-led Commission on the Future of Local Government. This report, published in 2012, set out a new direction for councils, which we have embraced. We have good examples of this new style of leadership making a positive difference in the city – but we want to do more.

Civic enterprise

We want to invest in the people that make Leeds a success – our communities, our schools and the many incredible community leaders in the city. These leaders are valuable resources – civic entrepreneurs with passion to make things happen. The council will work with our partners to create the right environment to harness this power and potential.

We are already seeing great results from social and civic enterprise initiatives. The council continues to fund the 37 Neighbourhood Networks, supporting more than 20,000 elderly people across the city. The Leeds Empties Project unites public, private and third sector organisations to bring empty properties up to standard and back into use. Leaders for Leeds is a cross-sector leadership network that connects civic entrepreneurs around the city.

Strong local democracy is essential for successful civic enterprise. The council has changed in recent years to become more enterprising and engaging. Our ten community committees represent a smarter and more inclusive approach to decision making, and our elected members are forging closer relationships with other key community leaders to build capacity, share expertise and develop mutual trust. We will build on these strong foundations to make the council as a whole more enabling and facilitating, and a catalyst for positive change.

Social contract

Our relationship with the people of Leeds has changed and will continue to change. We have moved to a more collaborative way of working, empowering people to influence decisions where they live. We are becoming better connected with the citizens of Leeds, and tackling the challenges of poverty, deprivation and inequality through our community hubs – integrating essential services for those who need them most.

We will build on this approach, and create the conditions that encourage people to make positive decisions about their own lives. We will extend our use of restorative practice to improve the way we communicate and engage with each other and with children, young people and families. A key element of this is Family Group Conferencing that uses families' own skills, strengths and personal knowledge to resolve difficulties.

The council will continue to offer services that support citizens with a particular focus on our most vulnerable residents. Where the budget pressures mean changes have to be made, we will listen and respond with collaborative solutions. Again, partnerships with all key sectors have a vital role to play to remove inequalities and increase opportunities.

21st century infrastructure

With the dual challenge of increased demand for services and severe financial constraints, we must still make the big decisions that will benefit the city now and for many years to come. Almost two centuries ago, our predecessors transformed Leeds and improved the quality of life and public health for residents by providing clean water, lighting and sewers. The infrastructure needed for the 21st century is very different but no less important in changing lives. We have a vital role to play in improving the city's physical and digital connection networks.

Leeds is determined to be a new kind of city, drawing on its unique assets to help shape the way global cities will be in the future. Leeds South Bank is fundamental to realising this goal by becoming an attractive, dynamic and sustainable place to invest, work, start a business, study and live.

We will work with partners in both the public and private sectors to enable affordable ultra-fast broadband; low carbon and low cost energy; affordable housing for families, first time buyers and the elderly; and transport that connects communities, cities and regions. We will continue to work with communities to ensure that neighbourhoods are clean, safe and meet local needs, with green spaces, cultural opportunities and places that everyone can enjoy. Through active engagement with our citizens and investment in infrastructure, energy and technology, Leeds will become a truly 'smart' city.

Good growth

Creating the right environment for economic growth is a vital part of this picture. For Leeds, good growth means more jobs and homes; improved skills and educational attainment for all; helping people out of financial hardship and into work; and increased inward investment. We will continue working with and learning from our business community to allow enterprise to thrive and to create sustainable jobs and careers.

We will continue to offer financial support schemes and advice to the most vulnerable people in the city, and to take a stand against high cost lenders. We are working with partners using innovative research techniques to understand how employment opportunities from major infrastructure and development projects can be better connected to households in poverty. We need to maximise the benefits of high speed rail and other transport investment, improving connectivity across the city and beyond. Building more homes, including affordable and social housing is also key, and our Core Strategy sets ambitious targets for this. We will continue to progress strategic development programmes for new infrastructure and homes and deliver more major projects including Victoria Gate and Kirkstall Forge.

Devolution and local freedoms

Bringing local business leaders and other partners together to work on jobs and skills has identified solutions that work for Leeds. The value of local knowledge and intelligence is an incredible resource for the city. We need the freedom from central government to allow more decisions to be taken at the right level, using this knowledge and insight.

We are already working collaboratively across the city region to make the most of any devolved powers, and have demonstrated that we are deserving of more powers to make a difference locally. The City Deal brought in a £1billion investment in transport through a combined transport authority, and a further £400million for infrastructure modernisation. The Local Enterprise Partnership was the first in the country to establish a coherent economic plan, and has helped SMEs to access £70million funding through the Regional Growth Fund.

Leeds will continue to be an enthusiastic and committed partner in the region, a loud voice for increased devolved power to cities, and a strong advocate for sharing power at a local level.

Organisational changes

To bring about these changes for the city, we must also change the council. This is already happening – by March 2016 we will have lost 2,500 employees in five years – and we will continue to get smaller as an organisation. We need to change the way we work to continue to make savings while, at the same time, delivering services that meet the needs of the people of Leeds.

We will continue to engage with our staff, communities and partners to make decisions and spend money wisely based on effective use of data and tailored information for an accurate picture of needs, demands and impact. Where possible, we will apply the principles of 'open data' for anyone to access, use and share our information. We plan to make significant savings by working differently: £5.5m through new ways of delivering internal support services, for example, by simplifying, standardising and sharing what we do; £5.5m through managing our suppliers and contracts differently; and £2.1m through reducing the number of office buildings we have.

To support a more adaptable way of working, we are redefining roles and by 2020 will expect to see council employees working in strong, more flexible teams. This flexibility will extend to our other assets. Council buildings will be multi-use, giving customers quicker and easier access to the things that are important to them. To support our staff through these changes, we will maintain our focus on meaningful engagement and ensuring everyone has a high quality appraisal. We want and need all our employees pulling together to deliver change. Our 'Manager Challenge' is already making a difference, with good 'manager habits' helping all staff to 'be their best'. This innovative work will continue, supporting and challenging in equal measure.

Our values are central to everything the Council does

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

APPENDIX

Scorecard KPIs - Best Council Plan set of indicators

City KPIs - how well is the city doing

Number of people supported into jobs

Number of people supported to improve skills

Change in numbers using foodbanks

Repeat incidence rate of domestic violence and abuse

Number of successful alcohol treatments

Number of successful drug treatments

Number of referrals to stop smoking services

Uptake of NHS health checks

Percentage of adult population (16+) active for 30 mins once per week

Number of delayed hospital discharges per 100,000 population

Number of bed weeks commissioned for older people in residential and nursing placements

Proportion of older people (65 years and over) who are still at home 91 days after leaving hospital into rehabilitation services

Proportion of people who use services who have control over their daily lives

Number of additional social enterprises supported through the Better Lives fund

Number of new extra care placement opportunities created

Achieve the housing growth target

Growth in business rates (NNDR)

Overall satisfaction with cultural provision in Leeds (based on % satisfied or very satisfied)

Percentage of A roads where structural maintenance should be considered

Number of people killed or seriously injured (KSI) in road traffic accidents

Number of children looked-after

Percentage of 16-18 year olds not in education, employment or training

City-level percentage of not known records (NEET)

Percentage of primary school absence (measured through levels of attendance)

Percentage of secondary school absence (measured through levels of attendance)

Percentage of young people gaining 5 or more GCSEs at grades A*-C, including English and Maths

Percentage of waste recycled

Tonnage to landfill (by weight) - domestic waste only

Council KPIs - how well is the organisation doing

Projected over/(under)spend / £ for this financial year

Capital receipts / £ from disposals in year

Council's energy consumption (carbon emissions)

Number of reported missed bins per 100,000

Number of complaints received about council services

Number of compliments received about council services

Percentage of major decision reports evidencing community engagement and consultation

Percentage of total self-service customer contact received via digital channels

Percentage of important decisions giving due regard to equality

Level of employee engagement

Average sickness levels per full-time equivalent (FTE) member of staff

Variation in FTEs in year

Variation in overtime spend compared to budget

Variation in agency spend compared to budget

Number of accidents and 'near misses' in the workplace

"We will meet our responsibilities in a way that serves our communities even better; reducing inequalities and achieving our ambitions of being the UK's best council and best city."

Cllr Keith Wakefield Leader of Leeds City Council
Tom Riordan Chief Executive of Leeds City Council

Best Council Plan and supporting plans

For more information please refer to supporting plans which include:

Adult Social Care Market Position Statement
Children & Young People's Plan
Citizens @ Leeds Strategy
Core Strategy and Site Allocations Plan
Drug & Alcohol Strategy
Health & Wellbeing Strategy
Integrated Waste Management Strategy
Leeds Growth Strategy
Leeds Local Flood Risk Management Strategy
Leeds Low Emissions Strategy
Leeds Museums & Galleries Strategic Plan
Leeds Strategy for Sport & Active Lives
Safer Leeds Hate Crime Strategy
West Yorkshire Transport Plan

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

Public Health England

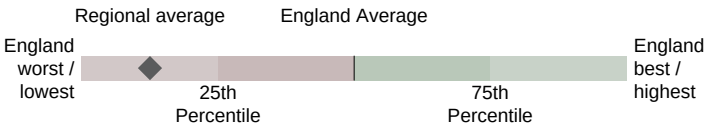
Protecting and improving the nation's health

Leeds

Adult Social Care

Key
Significance compared to goal / England average:

- Significantly worse
- Not significantly different
- Significantly better
- Significantly lower
- Significantly higher
- Significance not tested



People with care and support needs

		Period	Local count	Local value	Eng. value	Eng.worst / lowest	Range	Eng.best / highest
1	% of total population aged 65-74	2013	60,944	8.0	9.3	3.2		14.0
2	% of total population aged 75-84	2013	39,557	5.2	5.7	2.1		8.9
3	% of total population aged 85+	2013	14,980	1.97	2.30	0.72		4.01
4	IDAOPI	2010	30,268	20.1	18.1	51.8		7.2
5	% in long-term unemployment	Oct 2014	5,035	1.00	0.61	2.05		0.00
6	Prevalence of dementia	2012/13	4,578	0.55	0.57	1.13		0.22
7	Prevalence of mental health diagnoses	2012/13	7,646	0.92	0.84	1.46		0.30
8	Prevalence of learning disabilities aged 18+	2012/13	2,800	0.429	0.466	0.050		0.751
9	People aged 18-64 registered deaf or hard of hearing per 100,000	2009/10	450	85.8	172.8	0.0		492.4
10	People aged 65-74 registered deaf or hard of hearing per 100,000	2009/10	305	534	620	0		3518
11	People aged 75+ registered deaf or hard of hearing per 100,000	2009/10	1,135	2089	3089	140		12183
12	People aged 18-64 registered blind or partially sighted per 100,000	2010/11	1,215	227.6	206.9	0.0		454.1
13	People aged 65-74 registered blind or partially sighted	2010/11	415	720	654	0		2610
14	People aged 75+ registered blind or partially sighted	2010/11	3,260	5910	4774	0		10367
15	Adults with physical disabilities supported throughout the year per 100,000	2013/14	1,240	254	462	178		1601
16	Adults with learning disabilities supported throughout the year per 100,000	2013/14	1,910	391.9	414.0	0.0		800.6
17	Adults with mental health problems supported throughout the year per 100,000	2013/14	570	117	391	0		2333
18	Older people (65+) supported throughout the year per 100,000	2013/14	8,740	7568	9781	4187		22713
19	People aged 65+ in receipt of Attendance Allowance per 1,000	May 2014	15,070	133.0	149.9	99.5		221.3
20	Receiving DLA Pensionable Age per 1,000	May 2014	12,260	92.3	80.9	16.3		241.9

	People with care and support needs continued	Period	Local count	Local value	Eng. value	Eng.worst / lowest	Range	Eng.best / highest
21	Receiving DLA Working Age per 1,000	May 2014	21,280	43.8	45.5	15.3		90.1

Enhancing quality of life for people

		Period	Local count	Local value	Eng. value	Eng.worst / lowest	Range	Eng.best / highest
22	Social care-related quality of life	2013/14	99,720	18.8	19.0	17.8		20.6
23	Proportion of people who use services who have control over their daily life	2013/14	4,510	80.5	76.8	61.3		87.0
24	Proportion of people who receive self-directed support	2013/14	8,465	68.3	61.9	25.3		100
25	Proportion of people who receive direct payments	2013/14	2,090	16.9	19.1	6.1		78.4
26	Carer-reported quality of life	2012/13	2,890	8.0	8.1	6.5		9.3
27	Adults with learning disabilities in employment	2013/14	140	7.4	6.7	0.8		22.5
28	Adults in contact with mental health services in employment	2012/13	490	12.1	8.8	1.3		22.0
29	Adults with learning disabilities in settled accommodation	2013/14	1,550	82.4	74.9	47.6		94.4
30	Adults in contact with mental health services in settled accommodation	2012/13	2,135	52.5	58.5	5.5		94.1
31	Proportion of people who use services and their carers, who reported that they had as much social contact as they would like.	2013/14	3,015	70.2	74.5	62.0		85.3
32	% clients aged 18-64 receiving Self Directed Support	2013/14	2,500	35.3	33.7	0.0		55.0
33	% clients aged 65+ receiving Self Directed Support	2013/14	4,585	64.7	66.3	49.8		100
34	% of people who die at home	2012/13 Q3			-	37.0		49.4
35	Clients receiving intensive home care per 100,000	2010/11	1,610	271.2	282.4	0.0		650.2
36	Adults who attended day care on 31st March per 100,000	2013/14	1,920	318.5	226.6	0.0		532.1
37	Adults receiving direct payments/personal budgets on 31st March per 100,000	2013/14	1,300	216	289	0		1247
38	Adults receiving equipment and adaptations on 31st March per 100,000	2013/14	665	110	433	0		3362
39	Adults receiving home care on 31st March per 100,000	2013/14	3,815	633	658	200		1268
40	Adults receiving meals on 31st March per 100,000	2013/14	375	62.2	44.0	0.0		533.0
41	Adults receiving other services on 31st March per 100,000	2013/14	1,525	253	125	0		2147
42	Adults receiving professional support on 31st March per 100,000	2013/14	3,270	542	291	0		1189
43	Adults receiving short term residential care on 31st March per 100,000	2013/14	125	20.7	30.9	0.0		160.4
44	Adults receiving community support on 31st March per 100,000	2013/14	6,985	1159	1615	704		5116
45	Adults receiving day care services during the year per 100,000	2013/14	2,510	416.3	301.1	0.0		643.4
46	Adults who received direct payments during the year per 100,000	2013/14	1,610	267	367	0		1466
47	Adults who received equipment and adaptations during the year per 100,000	2013/14	1,025	170	844	0		4073
48	Adults who received home care during the year per 100,000	2013/14	5,395	895	1110	386		2207
49	Adults who received meals during the year per 100,000	2013/14	575	95.4	75.4	0.0		533.0
50	Adults who received other services during the year per 100,000	2013/14	2,225	369	177	0		2581
51	Adults who received professional support during the year per 100,000	2013/14	3,400	564	460	0		2107
52	Adults who received short term residential care (not respite) during the year per 100,000	2013/14	795	131.9	155.1	0.0		638.9
53	Adults who received any community based support during the year per 100,000	2013/14	8,835	1465	2482	983		6165

Delaying and reducing the need for care and support

		Period	Local count	Local value	Eng. value	Eng.worst / lowest	Range	Eng.best / highest
54	Permanent admissions to residential and nursing care homes per 100,000 aged 18-64	2013/14	60	12.3	14.4	44.7		2.5
55	Permanent admissions to residential and nursing care homes per 100,000 aged 65+	2013/14	650	563	651	1247		190
56	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital	2013/14	80	88.9	82.5	50.0		100.0
57	The proportion of older people aged 65 and over offered reablement services following discharge from hospital.	2013/14	90	0.6	3.3	0.6		25.8
58	Total delayed transfers of care	2013/14	53	8.8	9.6	27.0		1.1
59	Delayed transfers of care attributable to adult social care	2013/14	14	2.3	3.1	13.7		0.4
60	Permanent admissions into residential care per 100,000	2013/14	490	81.3	105.0	214.6		0.0
61	Permanent admissions into nursing care per 100,000	2013/14	220	36.5	49.2	120.0		0.0
62	Adults in permanent residential care on 31st March per 100,000	2013/14	1,970	326.7	369.9	825.2		149.0
63	Adults in residential care during the year per 100,000	2013/14	2,530	420	482	976		218
64	Adults in permanent nursing care on 31st March per 100,000	2013/14	875	145.1	132.9	300.5		0.0
65	Adults in nursing care during the year per 100,000	2013/14	1,230	204	200	448		0
66	Emergency readmissions within 28 days	2010/11	11,859	13.3	11.4	13.4		7.3
67	Delayed transfers of care per month per 100,000	Oct 2014	54	9.0	11.6	31.2		0.0
68	Adult Social Services gross expenditure (excl Supporting People) £1m per 100,000	2013/14	244	40.5	39.9	30.1		85.6
69	Adult Social Services Supporting People gross expenditure £1m per 100,000	2013/14	0	0.0	0.9	0.0		7.2
70	Total Adult Social Services gross expenditure £1m per 100,000	2013/14	244	40.5	40.7	30.9		85.6
71	Emergency bed days per 1000 population	2008/09			563.8	609.5		448.6

Ensuring a positive experience of care and support

		Period	Local count	Local value	Eng. value	Eng.worst / lowest	Range	Eng.best / highest
72	Overall satisfaction of people who use services with their care and support	2013/14	3,955	69.1	64.8	53.1		76.6
73	Overall satisfaction of carers with social services	2012/13	130	38.8	42.7	25.5		100.0
74	Proportion of carers who report that they have been included or consulted in discussion about the person they care for	2012/13	175	71.4	72.9	55.4		100.0
75	Proportion of people who use services and carers who find it easy to find information about services	2012/13		131.2	142.8	103.8		165.9
76	Proportion of people who use services who find it easy to find information about services	2013/14	2,455	43.9	44.5	35.3		54.5
77	Referrals of new clients that resulted in further assessment of need per 100,000	2013/14	13,985	2320	2347	0		8748
78	Referrals of new clients dealt with at point of contact per 100,000	2013/14	9,130	1514	2759	104		14482
79	Total referrals of new clients per 100,000 population	2013/14	23,115	3834	5106	1027		16507
80	Adult carers receiving assessments per 100,000	2013/14	5,340	886	968	0		5565

Safeguarding vulnerable adults

		Period	Local count	Local value	Eng. value	Eng.worst / lowest	Range	Eng.best / highest
81	Proportion of people who use services who feel safe	2013/14	3,415	60.3	66.0	54.6		81.8
82	Proportion of people who use services who say that those services have made them feel safe and secure	2013/14	4,490	83.1	79.1	53.9		92.6
83	2.24i - Injuries due to falls in people aged 65 and over	2013/14	2,688	2247	2064	3420		1320
84	Fuel Poverty	2011	55,050	16.3	14.6	23.7		3.4
85	% of people aged 65+ receiving winter fuel payments	2011/12	105,980	93.9	96.7	67.1		100
86	Adults receiving a review as a percentage of those receiving a service	2013/14	8,400	69.9	66.2	30.2		100
87	4.14i - Hip fractures in people aged 65 and over	2013/14	678	561	580	838		382
88	4.15i - Excess Winter Deaths Index (Single year, all ages)	Aug 2012 - Jul 2013	404	19.6	20.1	38.2		-3.3
89	1.15i - Statutory homelessness - homelessness acceptances	2013/14	323	1.0	2.3	12.5		0.1

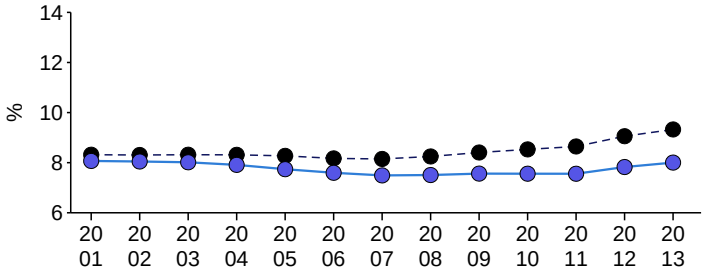
Better Care Fund

		Period	Local count	Local value	Eng. value	Eng.worst / lowest	Range	Eng.best / highest
90	Delayed transfers of care per month per 100,000	Oct 2014	54	9.0	11.6	31.2		0.0
91	Total delayed transfers of care	2013/14	53	8.8	9.6	27.0		1.1
92	Delayed transfers of care attributable to adult social care	2013/14	14	2.3	3.1	13.7		0.4
93	Permanent admissions to residential and nursing care homes per 100,000 aged 65+	2013/14	650	563	651	1247		190
94	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital	2013/14	80	88.9	82.5	50.0		100.0
95	The proportion of older people aged 65 and over offered reablement services following discharge from hospital.	2013/14	90	0.6	3.3	0.6		25.8
96	1.18i - Social Isolation: % of adult social care users who have as much social contact as they would like	2013/14		43.9	44.5	35.4		54.4
97	1.18ii - Social Isolation: % of adult carers who have as much social contact as they would like	2012/13		42.1	41.3	23.9		60.9
98	2.13i - Percentage of physically active and inactive adults - active adults	2013	259	57.7	56.0	43.5		69.2
99	2.24i - Injuries due to falls in people aged 65 and over	2013/14	2,688	2247	2064	3420		1320
100	2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79	2013/14	970	1162	989	1865		619
101	2.24iii - Injuries due to falls in people aged 65 and over - aged 80+	2013/14	1,718	5396	5182	8744		3344
102	Reducing avoidable emergency admissions	Mar 2013	1,257	165.9	178.9	322.9		30.5

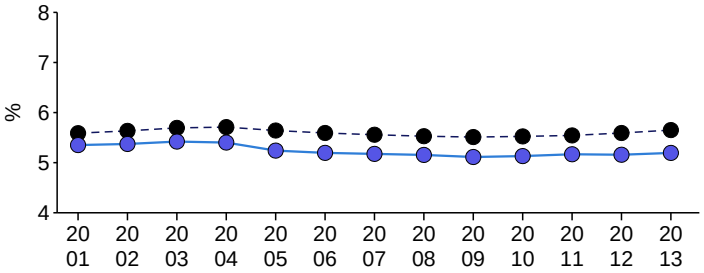
Trends

People with care and support needs

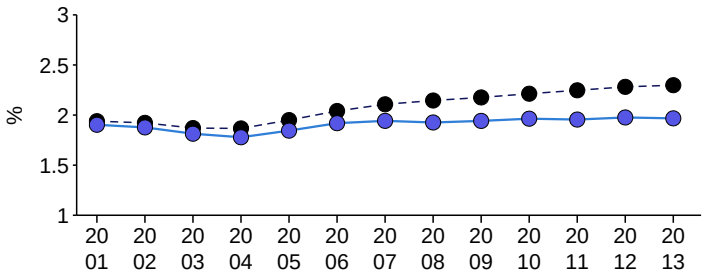
1. % of total population aged 65-74



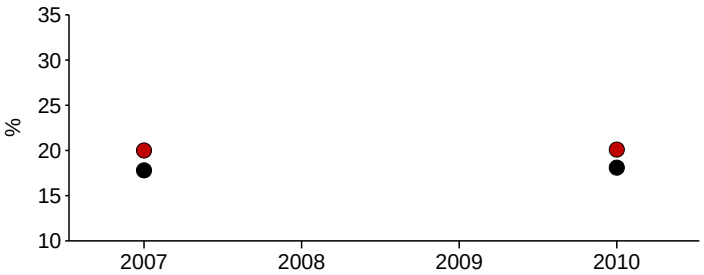
2. % of total population aged 75-84



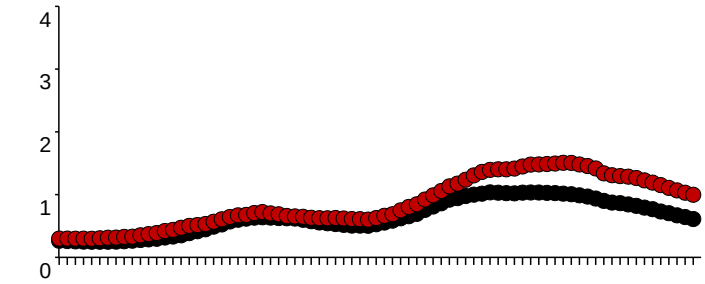
3. % of total population aged 85+



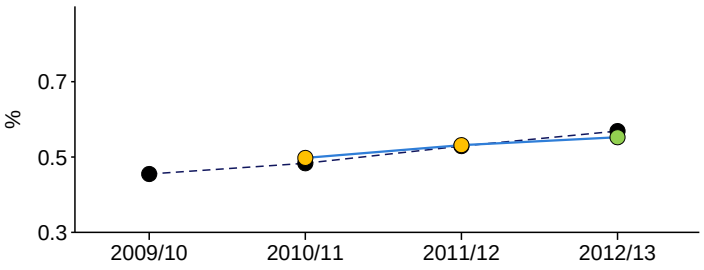
4. IDAOPI



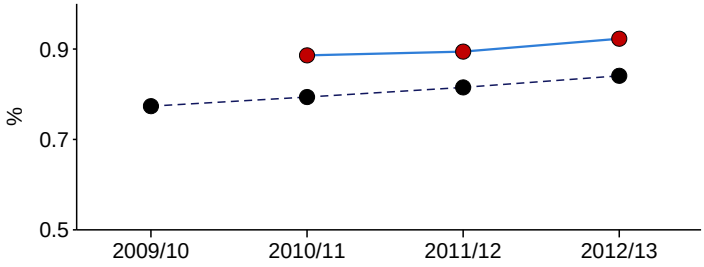
5. % in long-term unemployment



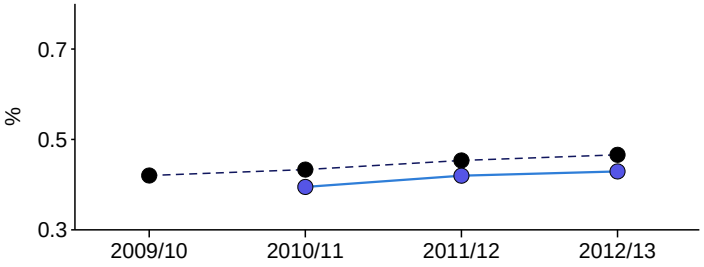
6. Prevalence of dementia



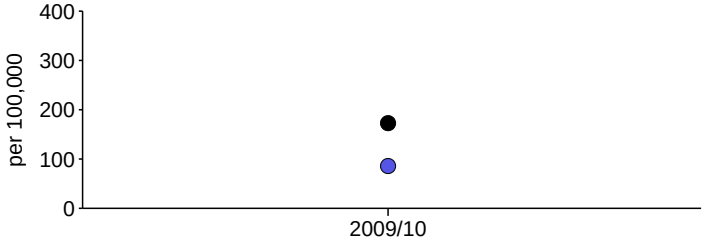
7. Prevalence of mental health diagnoses



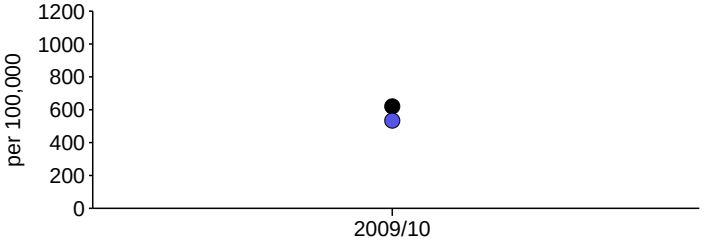
8. Prevalence of learning disabilities aged 18+



9. People aged 18-64 registered deaf or hard of hearing per 100,000

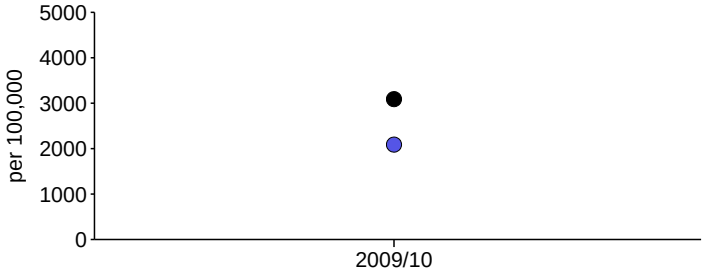


10. People aged 65-74 registered deaf or hard of hearing per 100,000



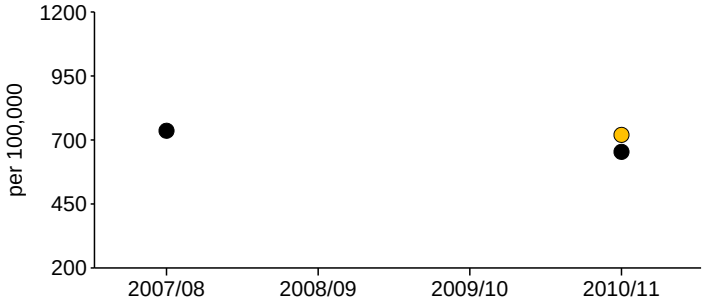
People with care and support needs continued

11. People aged 75+ registered deaf or hard of hearing per 100,000

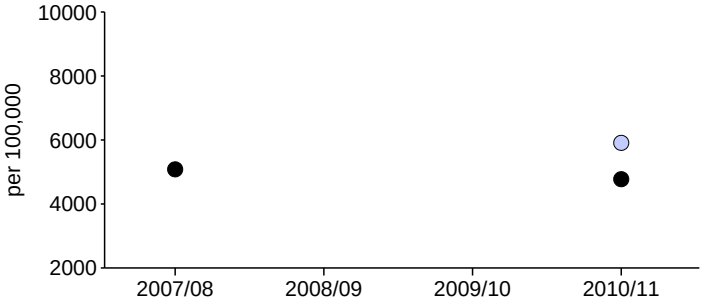


12. People aged 18-64 registered blind or partially sighted per 100,000

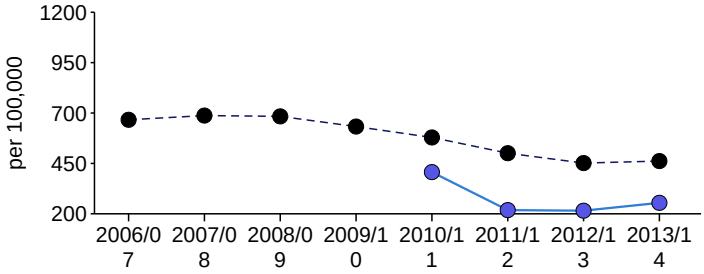
13. People aged 65-74 registered blind or partially sighted



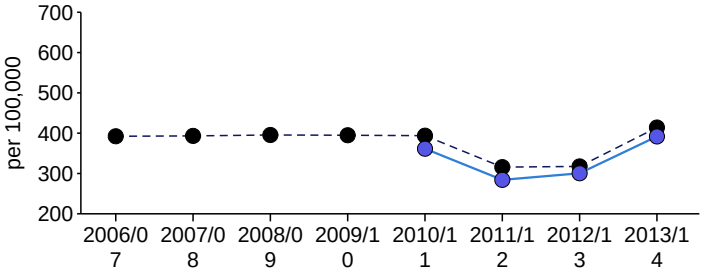
14. People aged 75+ registered blind or partially sighted



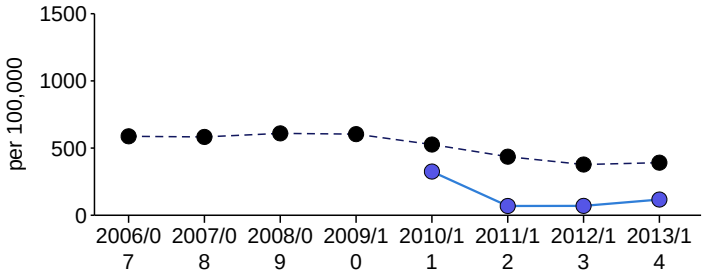
15. Adults with physical disabilities supported throughout the year per 100,000



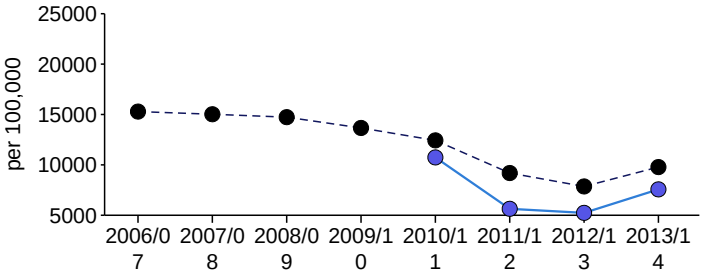
16. Adults with learning disabilities supported throughout the year per 100,000



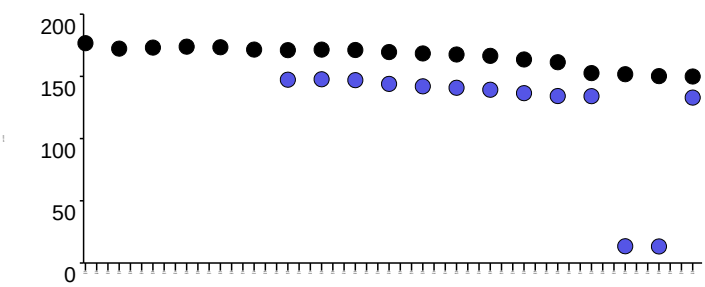
17. Adults with mental health problems supported throughout the year per 100,000



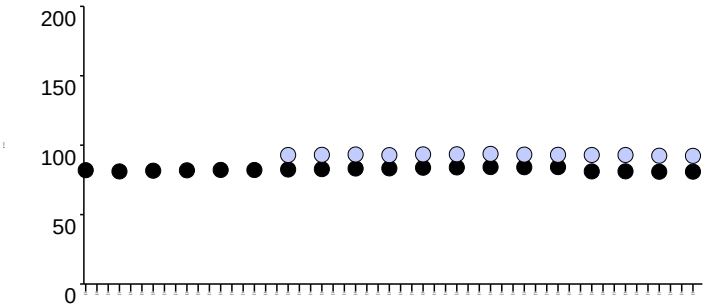
18. Older people (65+) supported throughout the year per 100,000



19. People aged 65+ in receipt of Attendance Allowance per 1,000

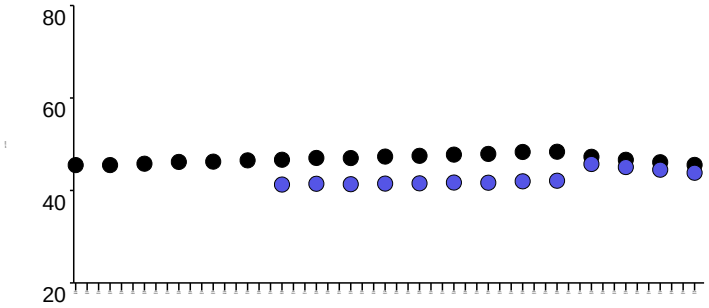


20. Receiving DLA Pensionable Age per 1,000



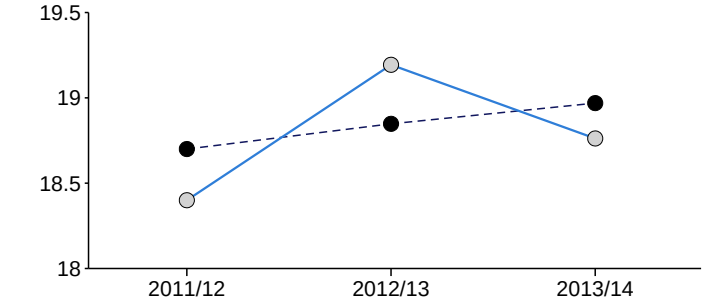
People with care and support needs continued

21. Receiving DLA Working Age per 1,000

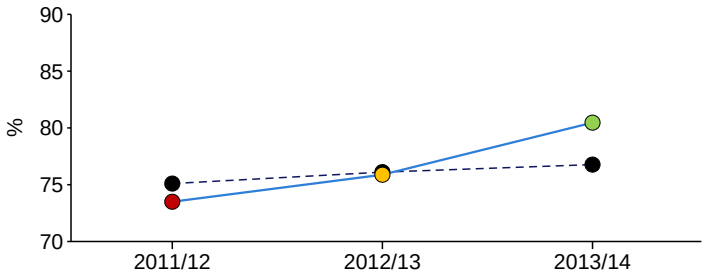


Enhancing quality of life for people

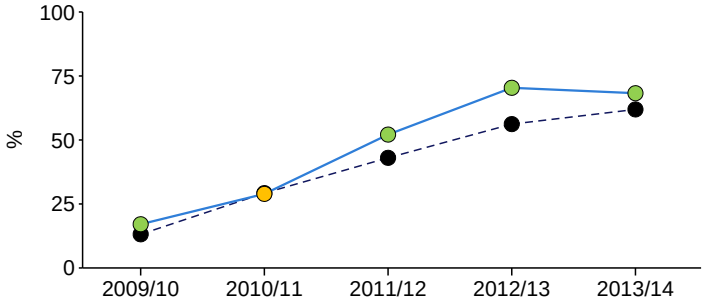
1. Social care-related quality of life



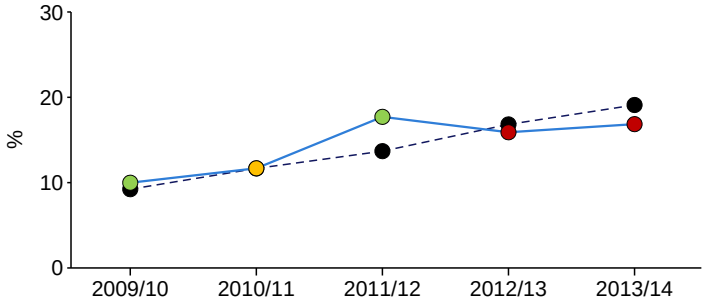
2. Proportion of people who use services who have control over their daily life



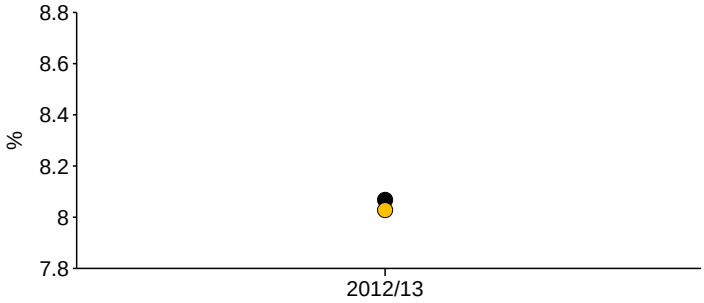
3. Proportion of people who receive self-directed support



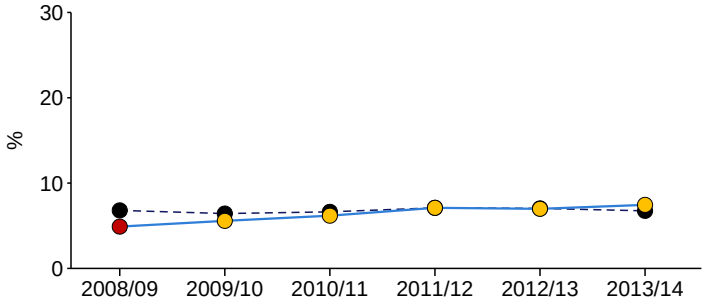
4. Proportion of people who receive direct payments



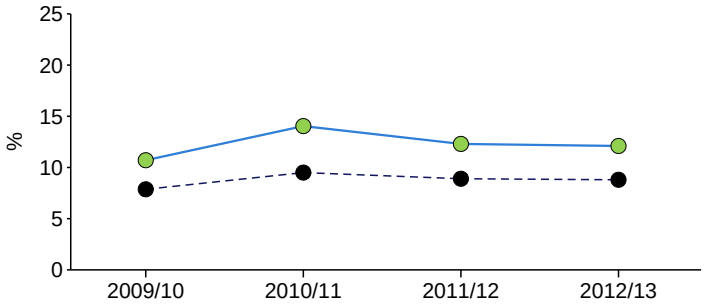
5. Carer-reported quality of life



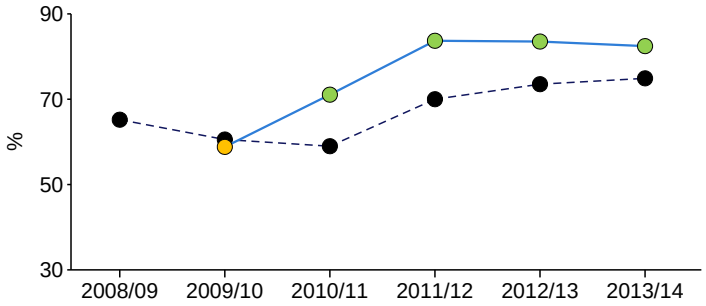
6. Adults with learning disabilities in employment



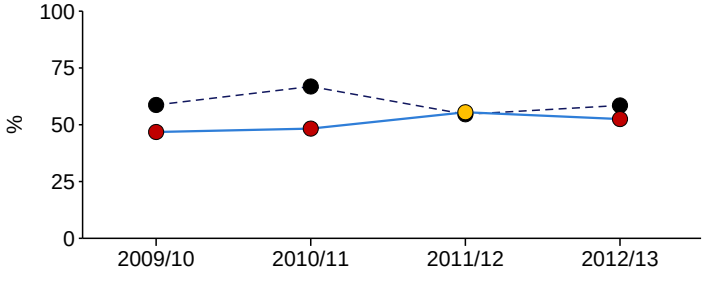
7. Adults in contact with mental health services in employment



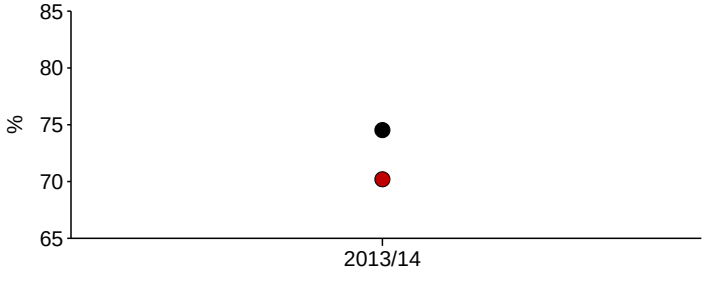
8. Adults with learning disabilities in settled accommodation



9. Adults in contact with mental health services in settled accommodation

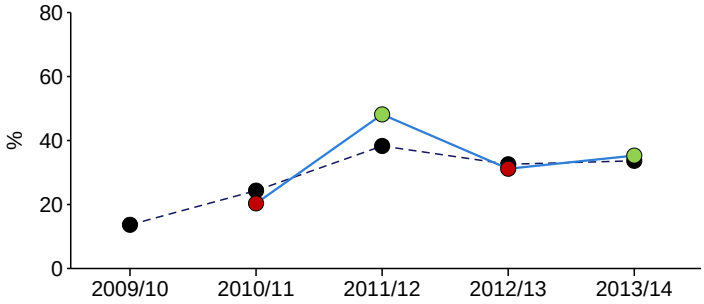


10. Proportion of people who use services and their carers, who reported that they had as much social contact as they would like.

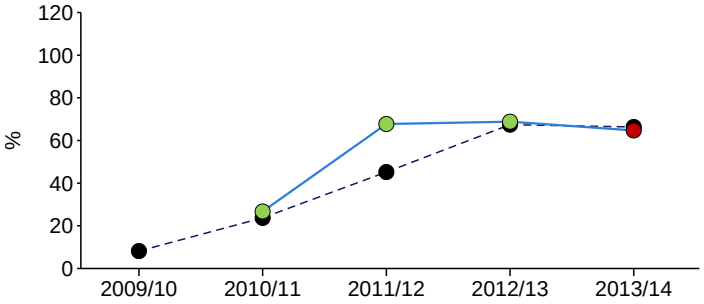


Enhancing quality of life for people continued

11. % clients aged 18-64 receiving Self Directed Support



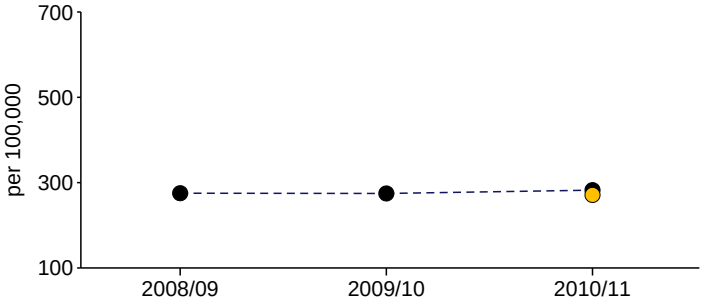
12. % clients aged 65+ receiving Self Directed Support



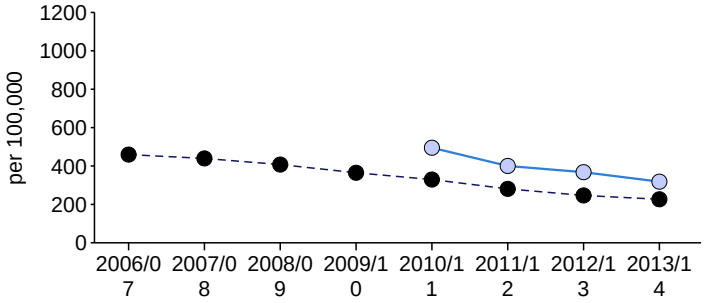
13. % of people who die at home

No data available

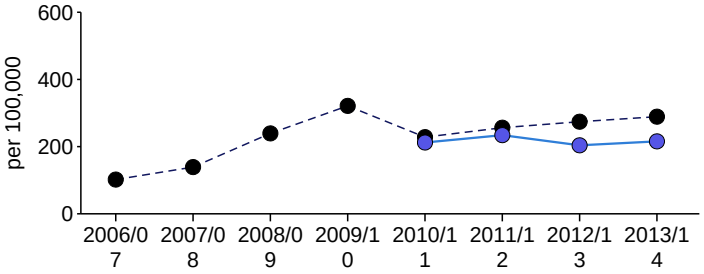
14. Clients receiving intensive home care per 100,000



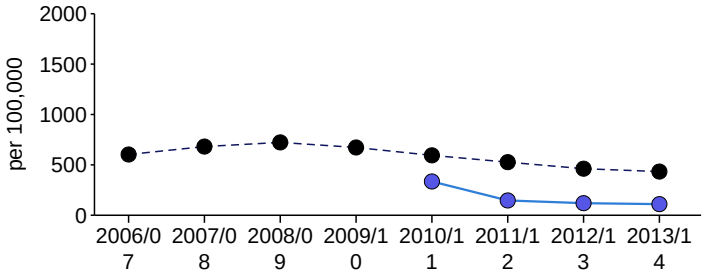
15. Adults who attended day care on 31st March per 100,000



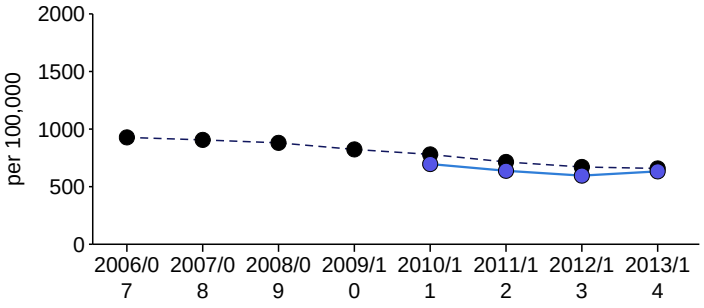
16. Adults receiving direct payments/personal budgets on 31st March per 100,000



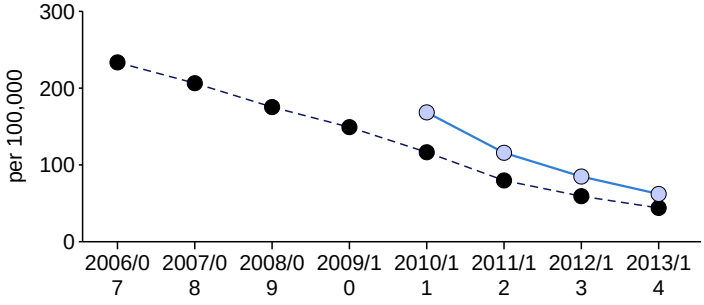
17. Adults receiving equipment and adaptations on 31st March per 100,000



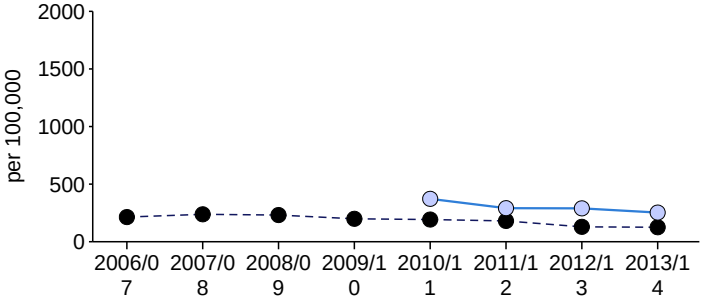
18. Adults receiving home care on 31st March per 100,000



19. Adults receiving meals on 31st March per 100,000

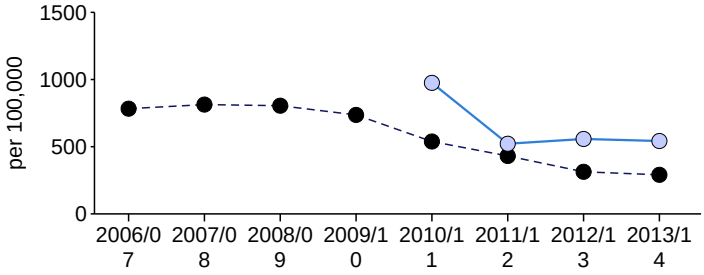


20. Adults receiving other services on 31st March per 100,000

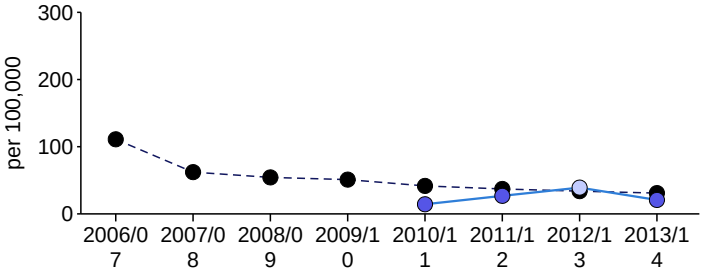


Enhancing quality of life for people continued

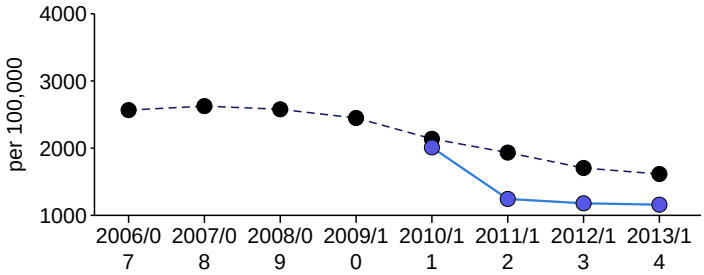
21. Adults receiving professional support on 31st March per 100,000



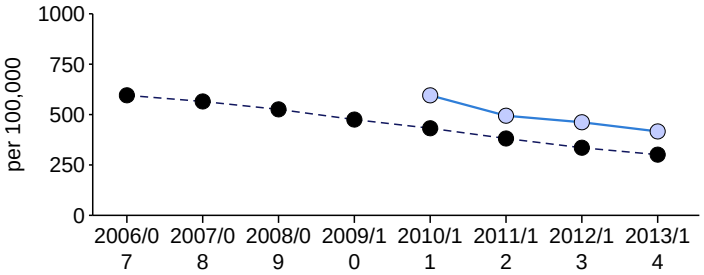
22. Adults receiving short term residential care on 31st March per 100,000



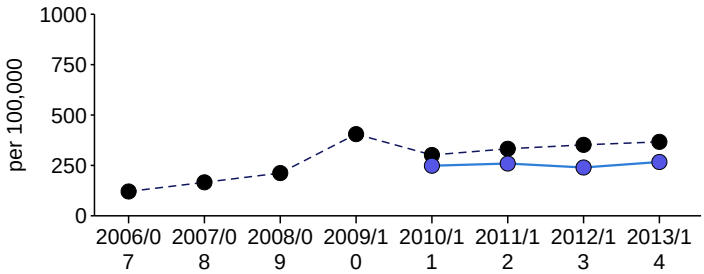
23. Adults receiving community support on 31st March per 100,000



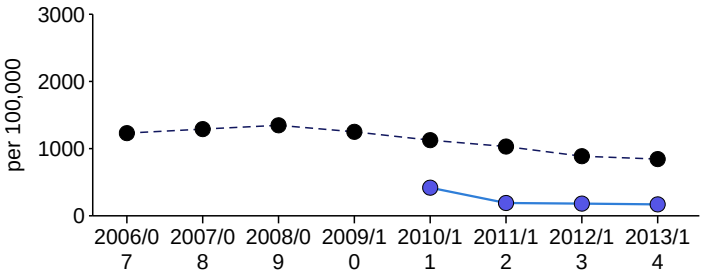
24. Adults receiving day care services during the year per 100,000



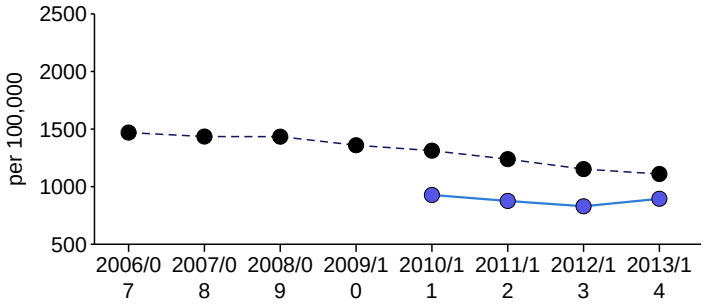
25. Adults who received direct payments during the year per 100,000



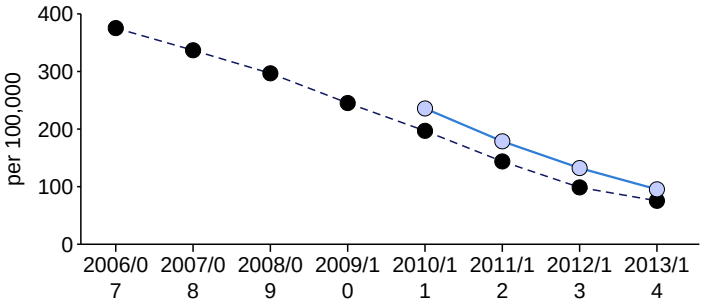
26. Adults who received equipment and adaptations during the year per 100,000



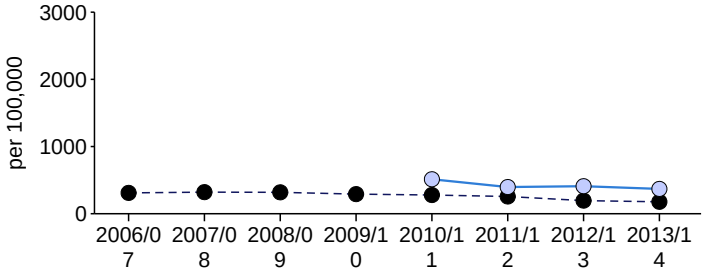
27. Adults who received home care during the year per 100,000



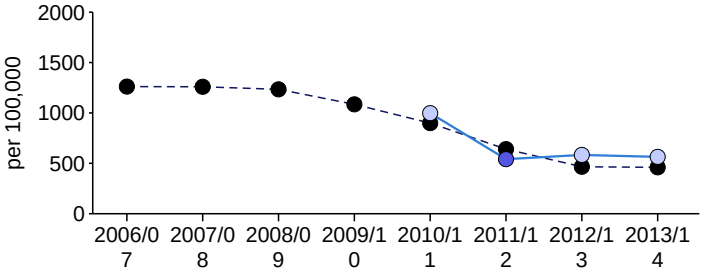
28. Adults who received meals during the year per 100,000



29. Adults who received other services during the year per 100,000

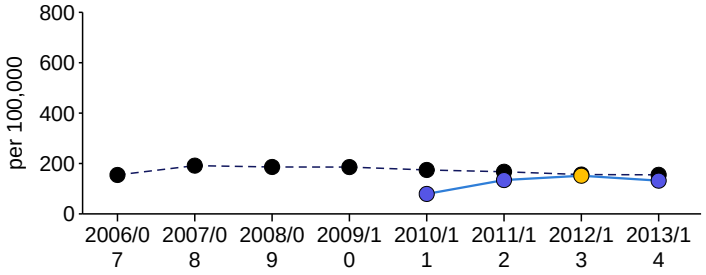


30. Adults who received professional support during the year per 100,000

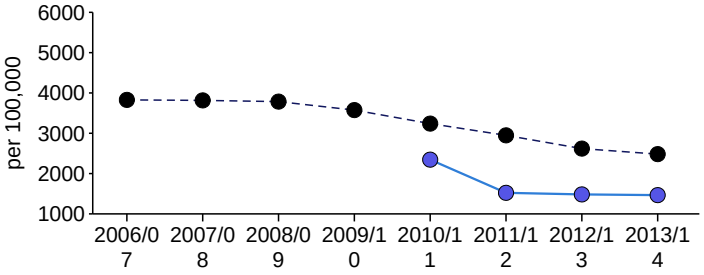


Enhancing quality of life for people continued

31. Adults who received short term residential care (not respite) during the year per 100,000

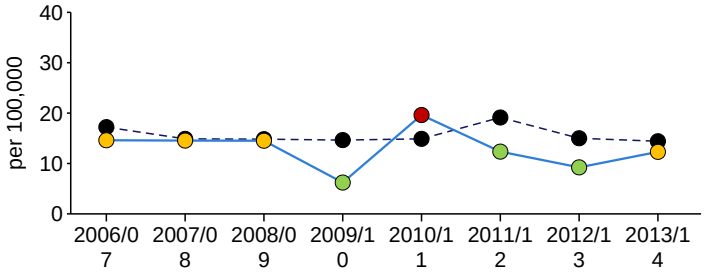


32. Adults who received any community based support during the year per 100,000

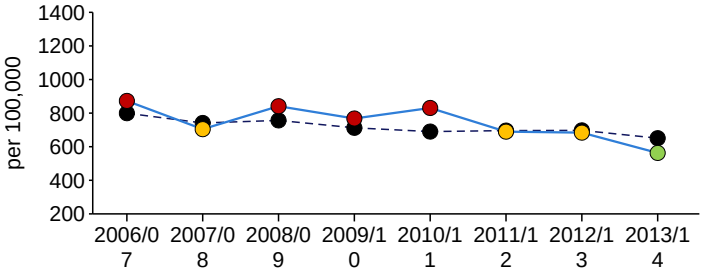


Delaying and reducing the need for care and support

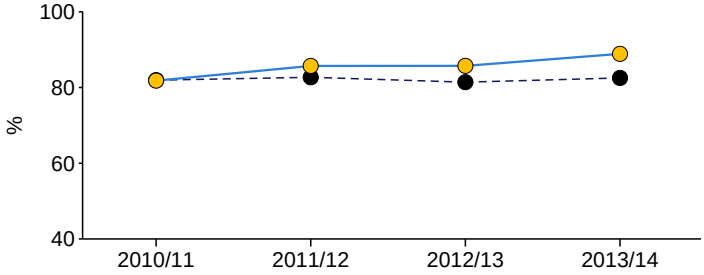
1. Permanent admissions to residential and nursing care homes per 100,000 aged 18-64



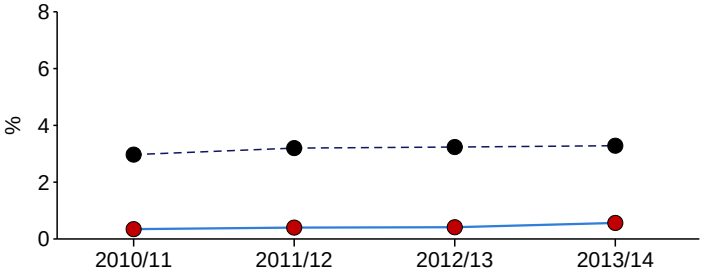
2. Permanent admissions to residential and nursing care homes per 100,000 aged 65+



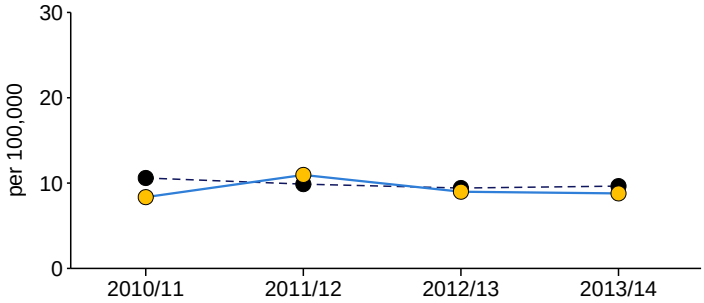
3. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital



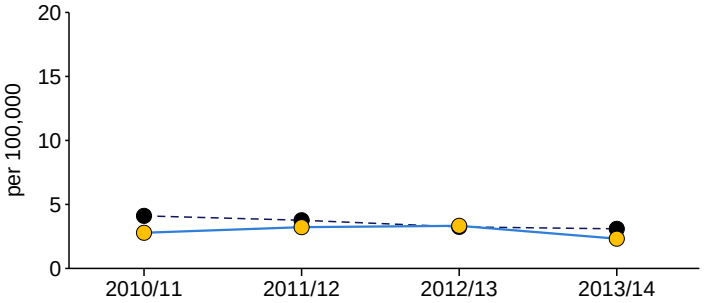
4. The proportion of older people aged 65 and over offered reablement services following discharge from hospital.



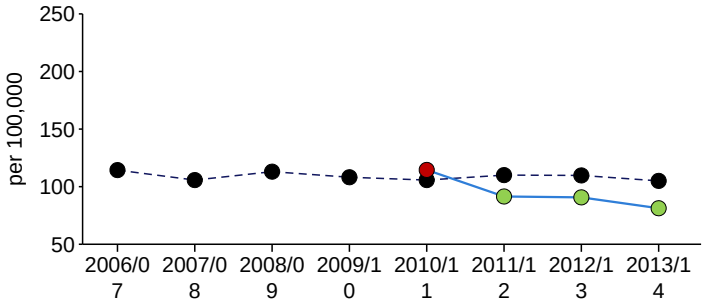
5. Total delayed transfers of care



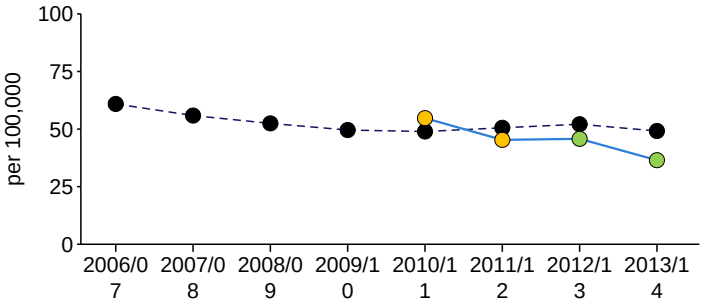
6. Delayed transfers of care attributable to adult social care



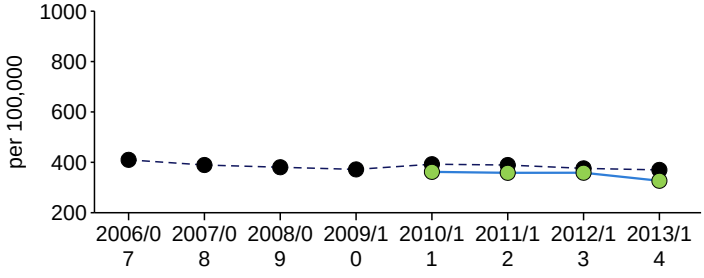
7. Permanent admissions into residential care per 100,000



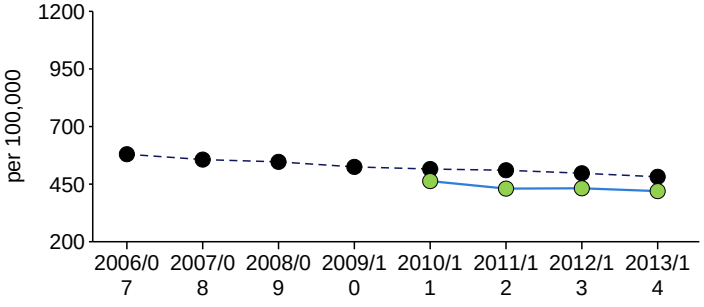
8. Permanent admissions into nursing care per 100,000



9. Adults in permanent residential care on 31st March per 100,000

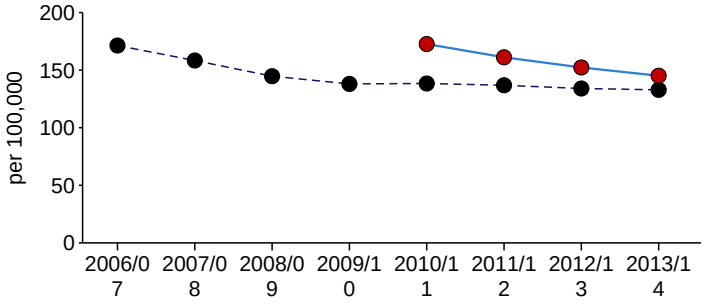


10. Adults in residential care during the year per 100,000

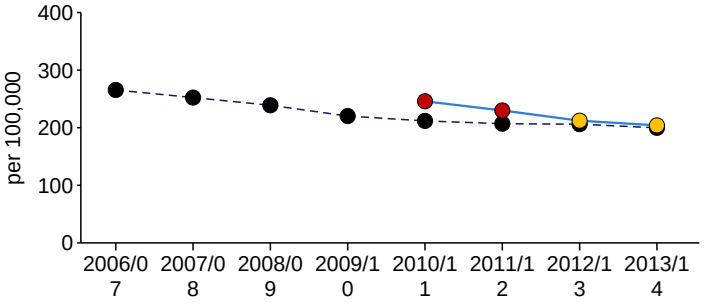


Delaying and reducing the need for care and support continued

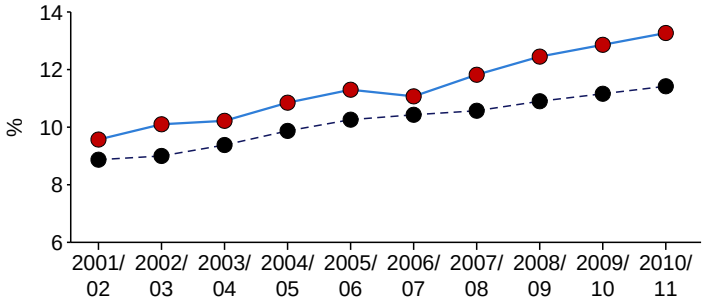
11. Adults in permanent nursing care on 31st March per 100,000



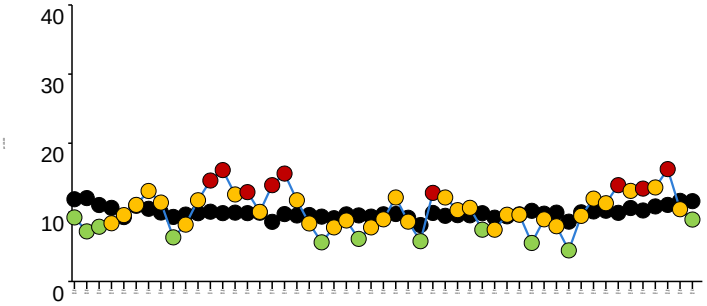
12. Adults in nursing care during the year per 100,000



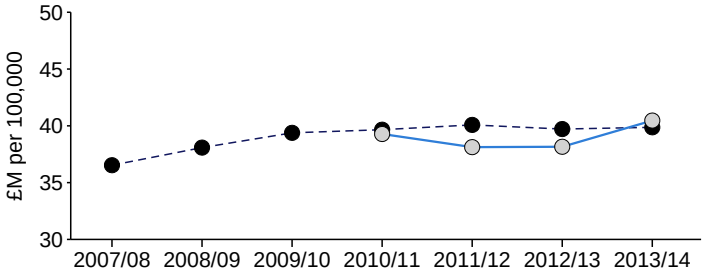
13. Emergency readmissions within 28 days



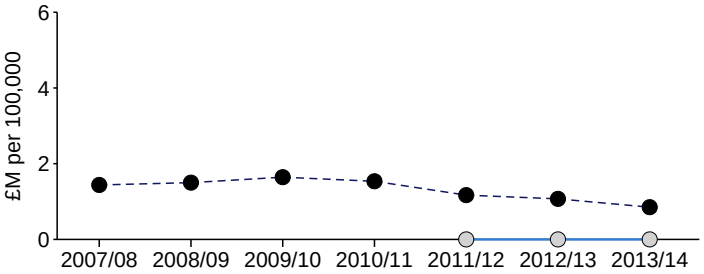
14. Delayed transfers of care per month per 100,000



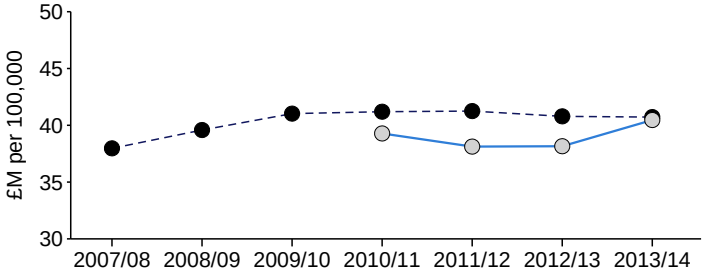
15. Adult Social Services gross expenditure (excl Supporting People) £1m per 100,000



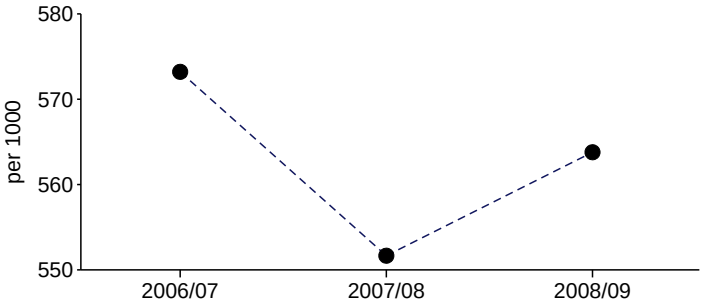
16. Adult Social Services Supporting People gross expenditure £1m per 100,000



17. Total Adult Social Services gross expenditure £1m per 100,000

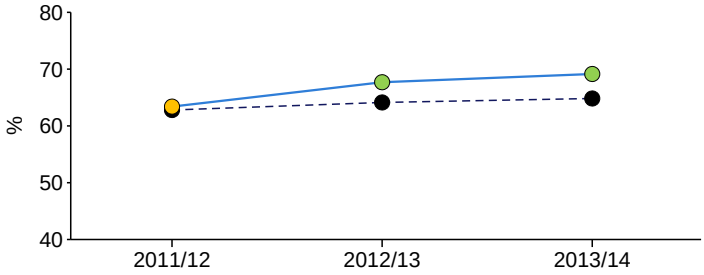


18. Emergency bed days per 1000 population

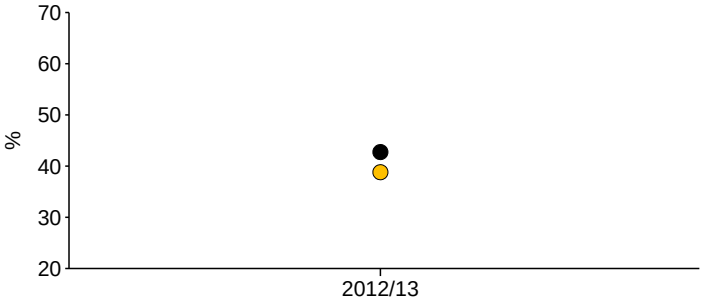


Ensuring a positive experience of care and support

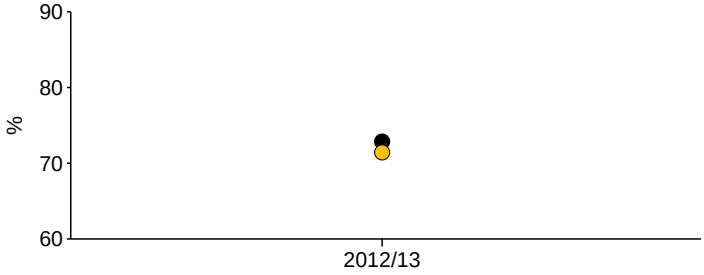
1. Overall satisfaction of people who use services with their care and support



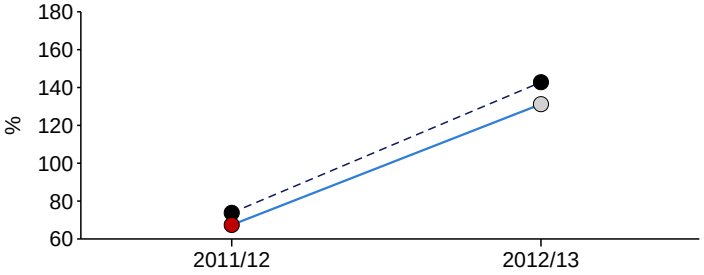
2. Overall satisfaction of carers with social services



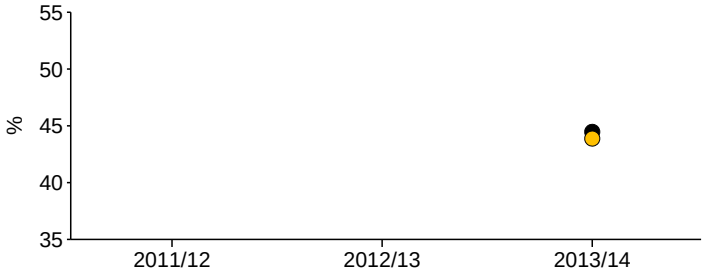
3. Proportion of carers who report that they have been included or consulted in discussion about the person they care for



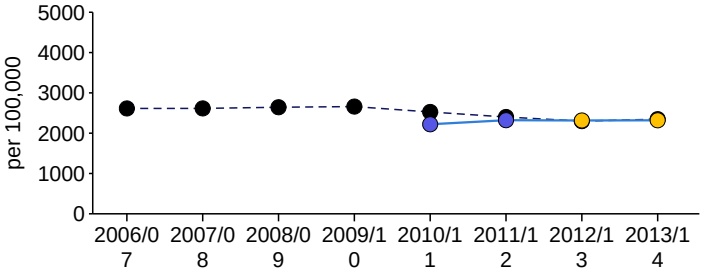
4. Proportion of people who use services and carers who find it easy to find information about services



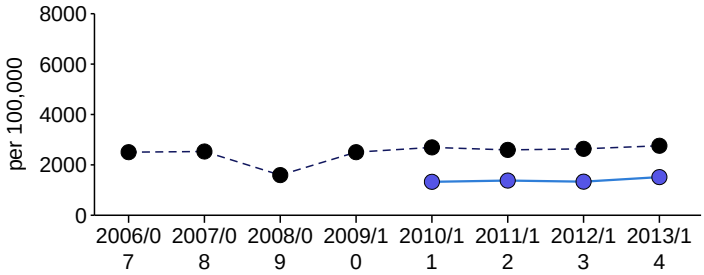
5. Proportion of people who use services who find it easy to find information about services



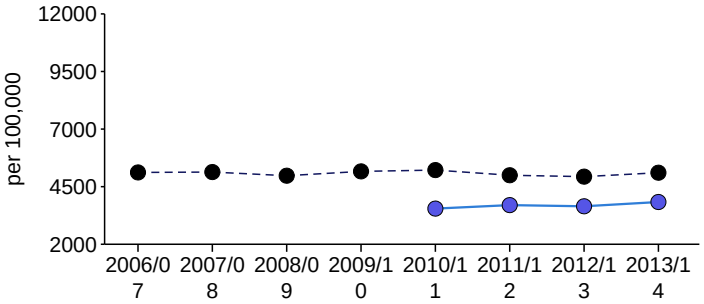
6. Referrals of new clients that resulted in further assessment of need per 100,000



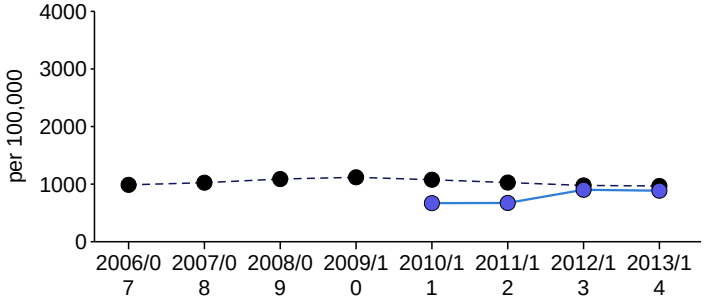
7. Referrals of new clients dealt with at point of contact per 100,000



8. Total referrals of new clients per 100,000 population

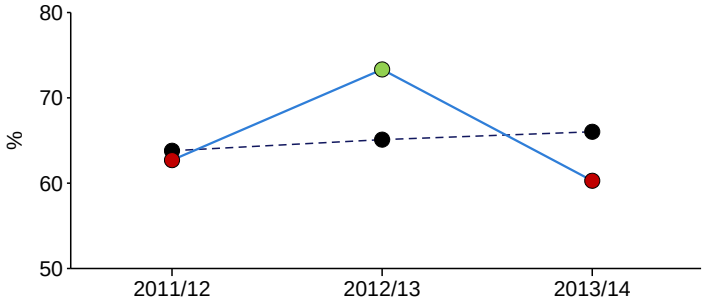


9. Adult carers receiving assessments per 100,000

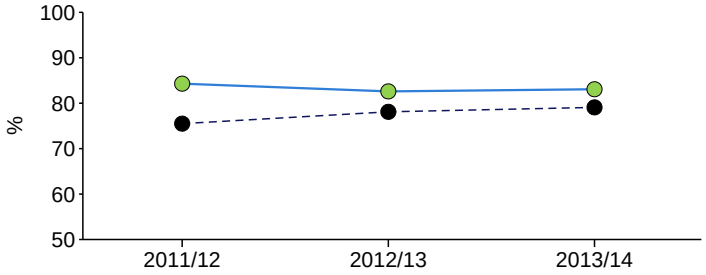


Safeguarding vulnerable adults

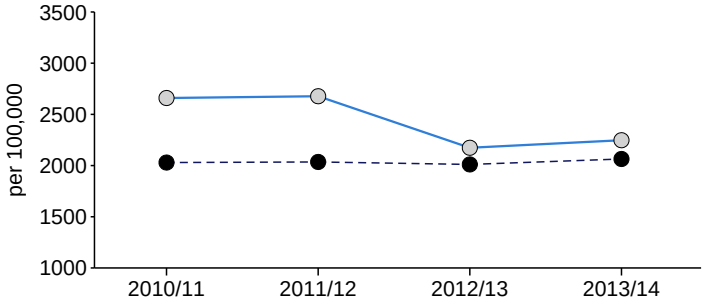
1. Proportion of people who use services who feel safe



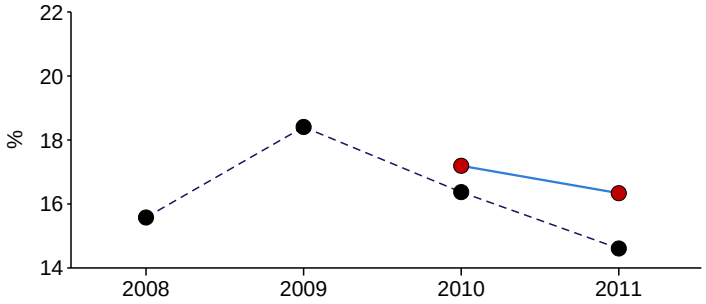
2. Proportion of people who use services who say that those services have made them feel safe and secure



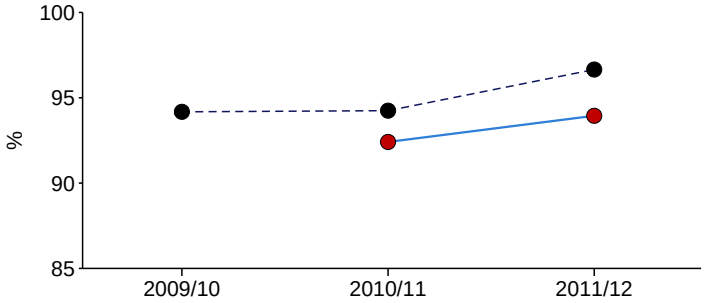
3. 2.24i - Injuries due to falls in people aged 65 and over



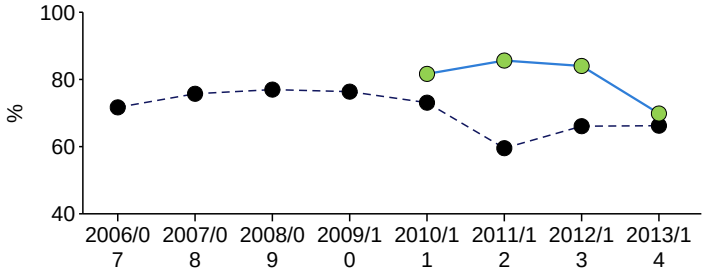
4. Fuel Poverty



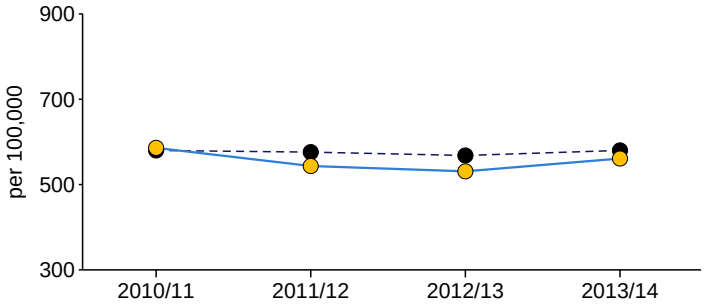
5. % of people aged 65+ receiving winter fuel payments



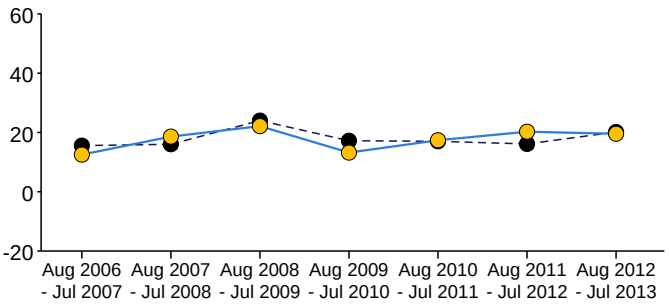
6. Adults receiving a review as a percentage of those receiving a service



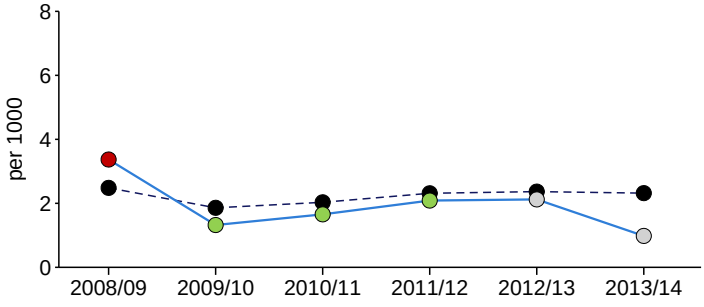
7. 4.14i - Hip fractures in people aged 65 and over



8. 4.15i - Excess Winter Deaths Index (Single year, all ages)

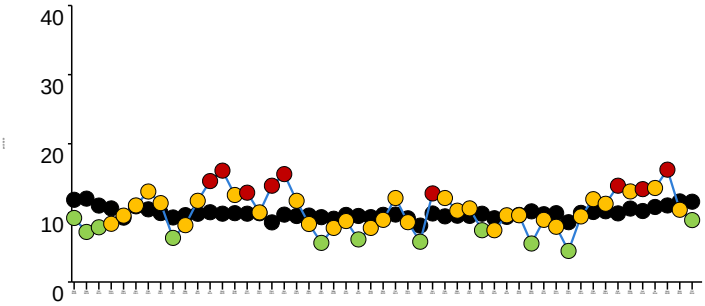


9. 1.15i - Statutory homelessness - homelessness acceptances

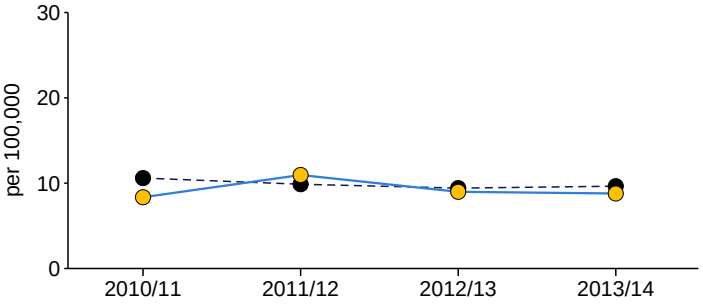


Better Care Fund

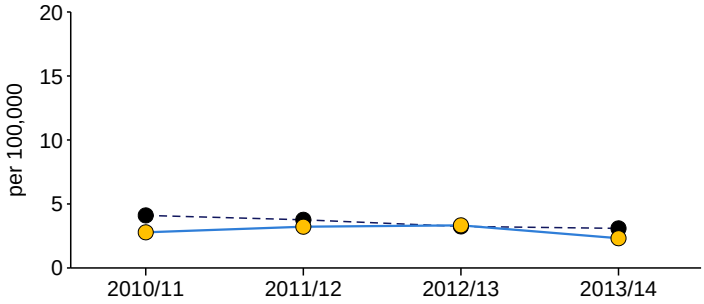
1. Delayed transfers of care per month per 100,000



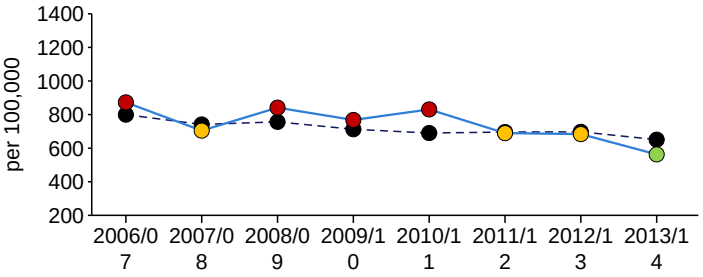
2. Total delayed transfers of care



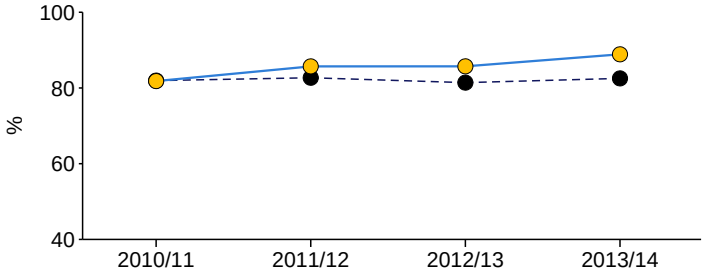
3. Delayed transfers of care attributable to adult social care



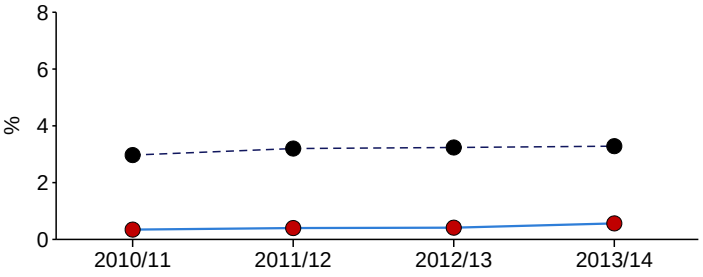
4. Permanent admissions to residential and nursing care homes per 100,000 aged 65+



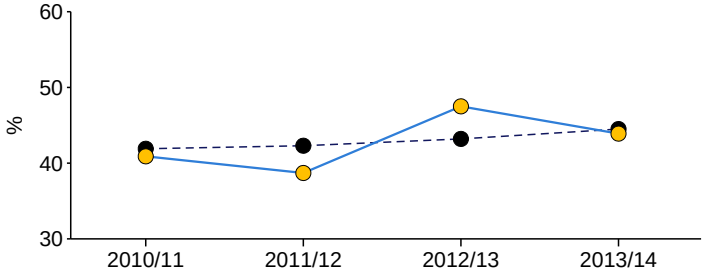
5. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital



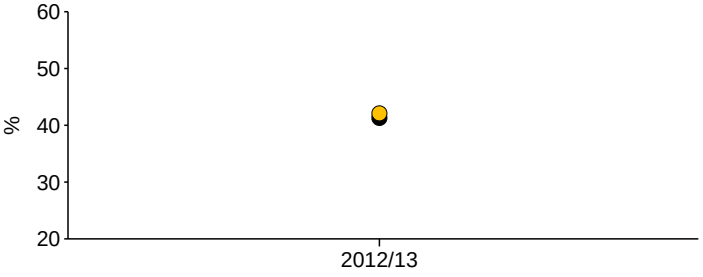
6. The proportion of older people aged 65 and over offered reablement services following discharge from hospital.



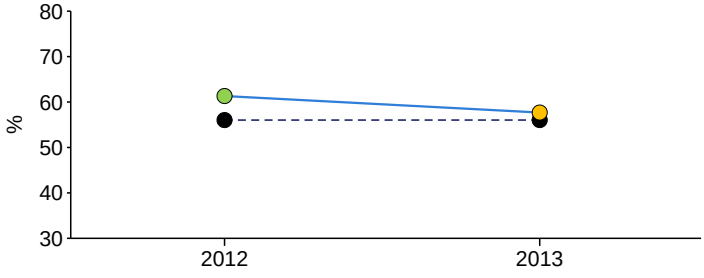
7. 1.18i - Social Isolation: % of adult social care users who have as much social contact as they would like



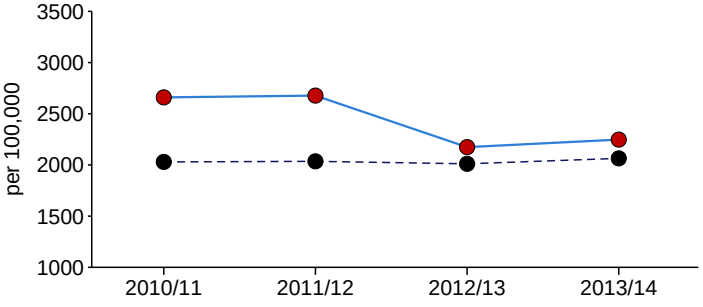
8. 1.18ii - Social Isolation: % of adult carers who have as much social contact as they would like



9. 2.13i - Percentage of physically active and inactive adults - active adults

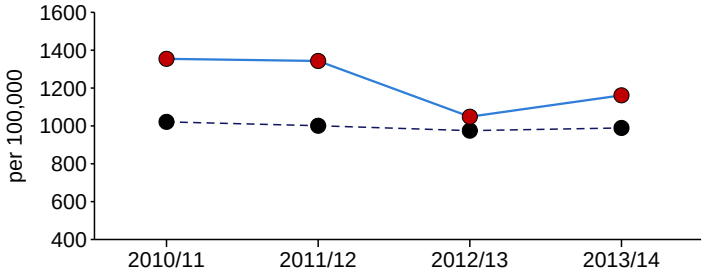


10. 2.24i - Injuries due to falls in people aged 65 and over

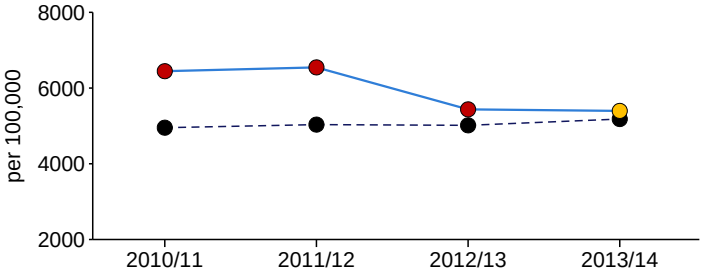


Better Care Fund continued

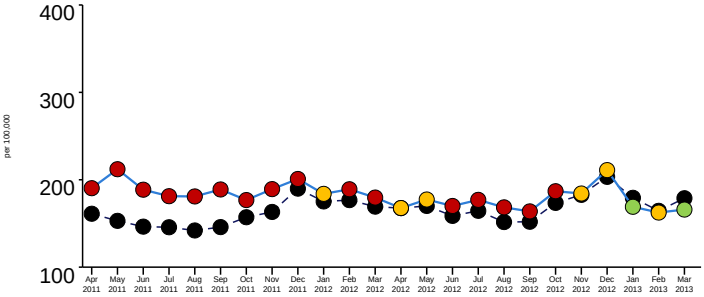
11. 2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79



12. 2.24iii - Injuries due to falls in people aged 65 and over - aged 80+



13. Reducing avoidable emergency admissions



Public Health England

Protecting and improving the nation's health

Leeds

Unitary Authority

This profile was produced on 2 June 2015

Health Profile 2015

Health in summary
The health of people in Leeds is varied compared with the England average. Deprivation is higher than average and about 21.6% (29,800) children live in poverty. Life expectancy for both men and women is lower than the England average.

Living longer
Life expectancy is 10.8 years lower for men and 8.5 years lower for women in the most deprived areas of Leeds than in the least deprived areas.

Child health
In Year 6, 19.3% (1,411) of children are classified as obese. The rate of alcohol-specific hospital stays among those under 18 was 34.7*. This represents 55 stays per year. Levels of teenage pregnancy, GCSE attainment and smoking at time of delivery are worse than the England average.

Adult health
In 2012, 19.5% of adults are classified as obese. The rate of alcohol related harm hospital stays was 639*. This represents 4,528 stays per year. The rate of self-harm hospital stays was 223.5*, worse than the average for England. This represents 1,817 stays per year. The rate of smoking related deaths was 368*, worse than the average for England. This represents 1,313 deaths per year. Estimated levels of adult smoking are worse than the England average. The rate of sexually transmitted infections is worse than average.

Local priorities
Priorities for Leeds include tackling the inequalities gap, reducing smoking, and giving every child the best start. For more information see www.leeds.gov.uk or http://observatory.leeds.gov.uk

* rate per 100,000 population

Population: 761,000
Mid-2013 population estimate. Source: Office for National Statistics.

This profile gives a picture of people's health in Leeds. It is designed to help local government and health services understand their community's needs, so that they can work together to improve people's health and reduce health inequalities.

Visit www.healthprofiles.info for more profiles, more information and interactive maps and tools.

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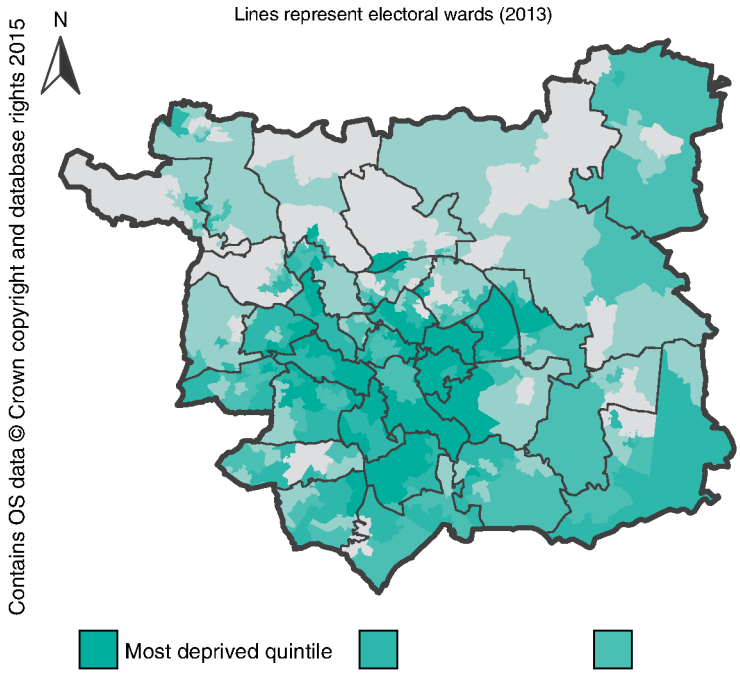
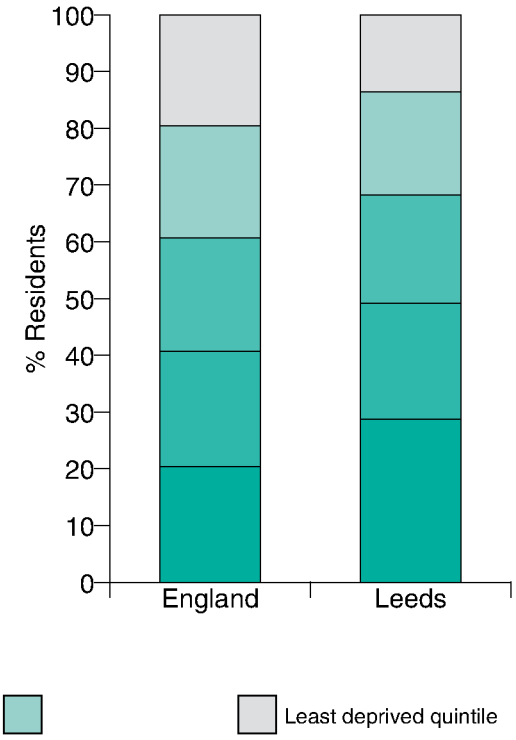
Deprivation: a national view

The map shows differences in deprivation in this area based on national comparisons, using quintiles (fifths) of the Index of Multiple Deprivation 2010, shown by lower super output area. The darkest coloured areas are some of the most deprived neighbourhoods in England.



This chart shows the percentage of the population who live in areas at each level of deprivation.

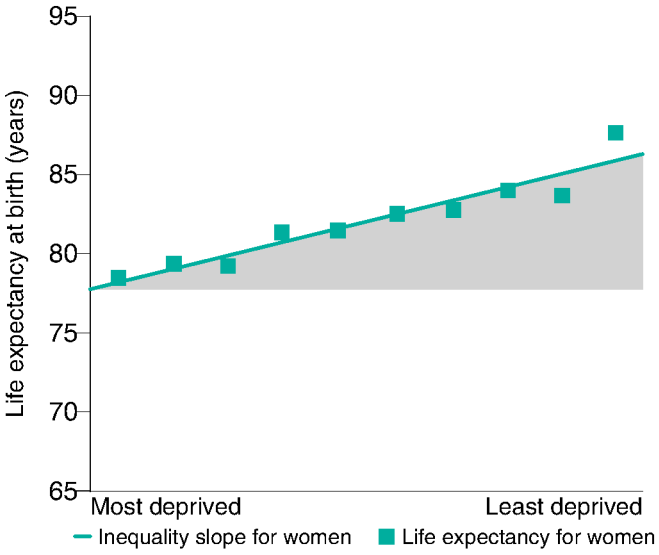


Life expectancy: inequalities in this local authority

The charts below show life expectancy for men and women in this local authority for 2011-2013. Each chart is divided into deciles (tenths) by deprivation, from the most deprived decile on the left of the chart to the least deprived decile on the right. The steepness of the slope represents the inequality in life expectancy that is related to deprivation in this local area. If there were no inequality in life expectancy as a result of deprivation, the line would be horizontal.

Life expectancy gap for men: 10.8 years

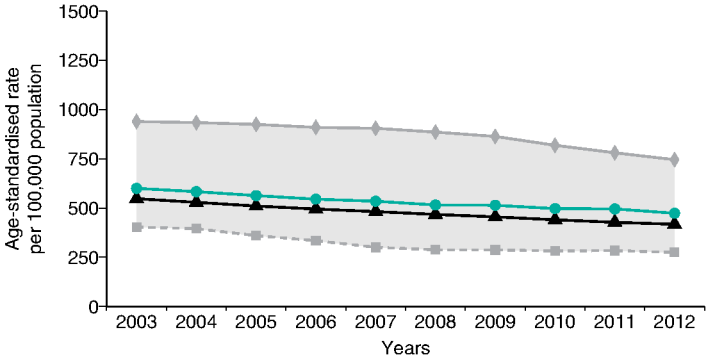
Life expectancy gap for women: 8.5 years



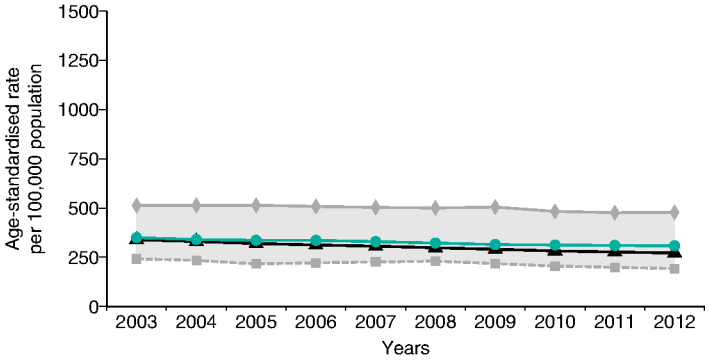
Health inequalities: changes over time

These charts provide a comparison of the changes in early death rates (in people under 75) between this area and all of England. Early deaths from all causes also show the differences between the most and least deprived quintile in this area. (Data points are the midpoints of 3 year averages of annual rates, for example 2005 represents the period 2004 to 2006).

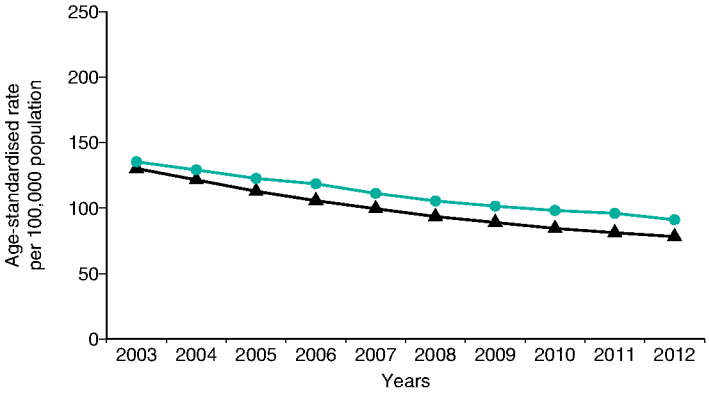
Early deaths from all causes: MEN



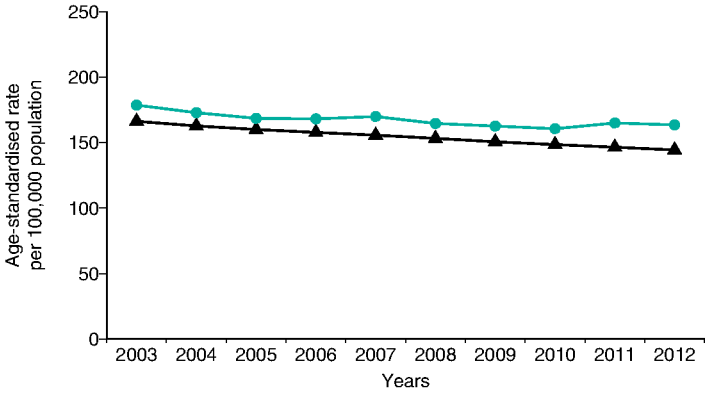
Early deaths from all causes: WOMEN

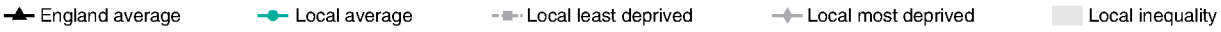


Early deaths from heart disease and stroke



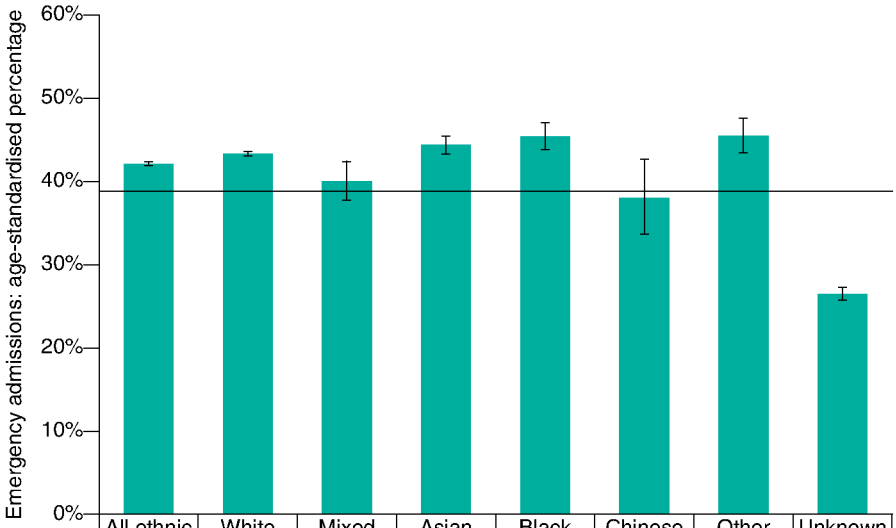
Early deaths from cancer





Health inequalities: ethnicity

Percentage of hospital admissions that were emergencies, by ethnic group, 2013



This chart shows the percentage of hospital admissions for each ethnic group that were emergencies, rather than planned. A higher percentage of emergency admissions may be caused by higher levels of urgent need for hospital services or lower use of services in the community. Comparing percentages for each ethnic group may help identify inequalities.

Leeds

England average (all ethnic groups)

95% confidence interval

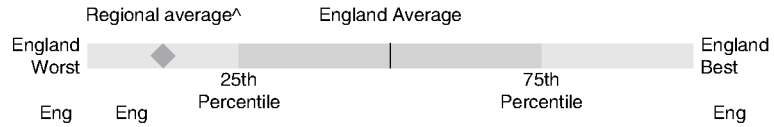
Figures based on small numbers of admissions have been suppressed to avoid any potential disclosure of information about individuals.

All ethnic groups	White	Mixed	Asian	Black	Chinese	Other	Unknown	
71,473	60,855	721	3,660	1,695	165	1,041	3,336	Local number of emergency admissions
42.1	43.3	40.0	44.4	45.4	38.0	45.5	26.5	Local value %
38.8	39.2	38.3	43.0	42.5	35.2	44.9	30.1	England value %

Health summary for Leeds

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average



Domain		Indicator	Local No Per Year	Local value	Eng value	Eng worst	Eng best
Our communities	1	Deprivation	218,402	28.7	20.4	83.8	0.0
	2	Children in poverty (under 16s)	29,805	21.6	19.2	37.9	5.8
	3	Statutory homelessness	323	1.0	2.3	12.5	0.0
	4	GCSE achieved (5A*-C inc. Eng & Maths)†	3,912	51.0	56.8	35.4	79.9
	5	Violent crime (violence offences)	7,830	10.3	11.1	27.8	2.8
	6	Long term unemployment	5,648	11.2	7.1	23.5	0.9
Children's and young people's health	7	Smoking status at time of delivery	1,296	13.2	12.0	27.5	1.9
	8	Breastfeeding initiation	7,117	74.8	73.9		
	9	Obese children (Year 6)	1,411	19.3	19.1	27.1	9.4
	10	Alcohol-specific hospital stays (under 18)†	55.0	34.7	40.1	105.8	11.2
	11	Under 18 conceptions	389	31.6	24.3	44.0	7.6
Adults' health and lifestyle	12	Smoking prevalence	n/a	21.6	18.4	30.0	9.0
	13	Percentage of physically active adults	259	57.7	56.0	43.5	69.7
	14	Obese adults	n/a	19.5	23.0	35.2	11.2
	15	Excess weight in adults	1,232	62.2	63.8	75.9	45.9
Disease and poor health	16	Incidence of malignant melanoma†	100.0	16.2	18.4	38.0	4.8
	17	Hospital stays for self-harm	1,817	223.5	203.2	682.7	60.9
	18	Hospital stays for alcohol related harm†	4,528	639	645	1231	366
	19	Prevalence of opiate and/or crack use	5,476	10.7	8.4	25.0	1.4
	20	Recorded diabetes	37,588	5.5	6.2	9.0	3.4
	21	Incidence of TB†	104.3	13.8	14.8	113.7	0.0
	22	New STI (exc Chlamydia aged under 25)	4,615	899	832	3269	172
	23	Hip fractures in people aged 65 and over	678	561	580	838	354
Life expectancy and causes of death	24	Excess winter deaths (three year)	380.5	18.6	17.4	34.3	3.9
	25	Life expectancy at birth (Male)	n/a	78.3	79.4	74.3	83.0
	26	Life expectancy at birth (Female)	n/a	82.1	83.1	80.0	86.4
	27	Infant mortality	35	3.4	4.0	7.6	1.1
	28	Smoking related deaths	1,313	368.4	288.7	471.6	167.4
	29	Suicide rate	72	9.8	8.8		
	30	Under 75 mortality rate: cardiovascular	492	91.1	78.2	137.0	37.1
	31	Under 75 mortality rate: cancer	882	163.5	144.4	202.9	104.0
	32	Killed and seriously injured on roads	298	39.3	39.7	119.6	7.8

Indicator notes

1 % people in this area living in 20% most deprived areas in England, 2013 2 % children (under 16) in families receiving means-tested benefits & low income, 2012 3 Crude rate per 1,000 households, 2013/14 4 % key stage 4, 2013/14 5 Recorded violence against the person crimes, crude rate per 1,000 population, 2013/14 6 Crude rate per 1,000 population aged 16-64, 2014 7 % of women who smoke at time of delivery, 2013/14 8 % of all mothers who breastfeed their babies in the first 48hrs after delivery, 2013/14 9 % school children in Year 6 (age 10-11), 2013/14 10 Persons under 18 admitted to hospital due to alcohol-specific conditions, crude rate per 100,000 population, 2011/12 to 2013/14 (pooled) 11 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2013 12 % adults aged 18 and over who smoke, 2013 13 % adults achieving at least 150 mins physical activity per week, 2013 14 % adults classified as obese, Active People Survey 2012 15 % adults classified as overweight or obese, Active People Survey 2012 16 Directly age standardised rate per 100,000 population, aged under 75, 2010-12 17 Directly age sex standardised rate per 100,000 population, 2013/14 18 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, directly age standardised rate per 100,000 population, 2013/14 19 Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2011/12 20 % people on GP registers with a recorded diagnosis of diabetes 2013/14 21 Crude rate per 100,000 population, 2011-13, local number per year figure is the average count 22 All new STI diagnoses (excluding Chlamydia under age 25), crude rate per 100,000 population, 2013 23 Directly age and sex standardised rate of emergency admissions, per 100,000 population aged 65 and over, 2013/14 24 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 01.08.10-31.07.13 25, 26 At birth, 2011-13 27 Rate per 1,000 live births, 2011-13 28 Directly age standardised rate per 100,000 population aged 35 and over, 2011-13 29 Directly age standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, 2011-13 30 Directly age standardised rate per 100,000 population aged under 75, 2011-13 31 Directly age standardised rate per 100,000 population aged under 75, 2011-13 32 Rate per 100,000 population, 2011-13

† Indicator has had methodological changes so is not directly comparable with previously released values. ^ "Regional" refers to the former government regions.

More information is available at www.healthprofiles.info and http://fingertips.phe.org.uk/profile/health-profiles Please send any enquiries to healthprofiles@phe.gov.uk

NHS

FIVE YEAR FORWARD VIEW

October 2014

CONTENTS

FOREWORD

The NHS may be the proudest achievement of our modern society.

It was founded in 1948 in place of fear - the fear that many people had of being unable to afford medical treatment for themselves and their families. And it was founded in a spirit of optimism - at a time of great uncertainty, coming shortly after the sacrifices of war.

Our nation remains unwavering in that commitment to universal healthcare, irrespective of age, health, race, social status or ability to pay. To high quality care for all.

Our values haven't changed, but our world has. So the NHS needs to adapt to take advantage of the opportunities that science and technology offer patients, carers and those who serve them. But it also needs to evolve to meet new challenges: we live longer, with complex health issues, sometimes of our own making. One in five adults still smoke. A third of us drink too much alcohol. Just under two thirds of us are overweight or obese.

These changes mean that we need to take a longer view - a Five-Year Forward View – to consider the possible futures on offer, and the choices that we face. So this Forward View sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health.

It represents the shared view of the NHS' national leadership, and reflects an emerging consensus amongst patient groups, clinicians, local communities and frontline NHS leaders. It sets out a vision of a better NHS, the steps we should now take to get us there, and the actions we need from others.

EXECUTIVE SUMMARY

1. **The NHS has dramatically improved over the past fifteen years**. Cancer and cardiac outcomes are better; waits are shorter; patient satisfaction much higher. Progress has continued even during global recession and austerity thanks to protected funding and the commitment of NHS staff. But quality of care can be variable, preventable illness is widespread, health inequalities deep-rooted. Our patients' needs are changing, new treatment options are emerging, and we face particular challenges in areas such as mental health, cancer and support for frail older patients. Service pressures are building.

2. Fortunately **there is now quite broad consensus on what a better future should be**. This 'Forward View' sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on various public health measures, and on local service changes – will need explicit support from the next government.

3. The first argument we make in this Forward View is that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a **radical upgrade in prevention and public health**. Twelve years ago Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.

4. The NHS will therefore now back hard-hitting national action on obesity, smoking, alcohol and other major health risks. We will help develop and support new workplace incentives to promote employee health and cut sickness-related unemployment. And we will advocate for stronger public health-related powers for local government and elected mayors.

5. Second, **when people do need health services, patients will gain far greater control of their own care** – including the option of shared budgets combining health and social care. The 1.4 million full time unpaid carers in England will get new support, and the NHS will become a better partner with voluntary organisations and local communities.

6. Third, **the NHS will take decisive steps to break down the barriers in how care is provided** between family doctors and hospitals, between physical and mental health, between health and social care. The future will see far more care delivered locally but with some services in specialist centres, organised to support people with multiple health conditions, not just single diseases.

7. **England is too diverse for a 'one size fits all'** care model to apply everywhere. But nor is the answer simply to let 'a thousand flowers bloom'. Different local health communities will instead be supported by the NHS' national leadership to choose from amongst a small number of radical new care delivery options, and then given the resources and support to implement them where that makes sense.

8. One new option will permit groups of GPs to combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care - the **Multispecialty Community Provider**. Early versions of these models are emerging in different parts of the country, but they generally do not yet employ hospital consultants, have admitting rights to hospital beds, run community hospitals or take delegated control of the NHS budget.

9. A further new option will be the integrated hospital and primary care provider - **Primary and Acute Care Systems** - combining for the first time general practice and hospital services, similar to the Accountable Care Organisations now developing in other countries too.

10. Across the NHS, **urgent and emergency care** services will be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services. **Smaller hospitals** will have new options to help them remain viable, including forming partnerships with other hospitals further afield, and partnering with specialist hospitals to provide more local services. Midwives will have new options to take charge of the **maternity** services they offer. The NHS will provide more support for frail older people living in **care homes**.

11. The foundation of NHS care will remain list-based **primary care**. Given the pressures they are under, we need a 'new deal' for GPs. Over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years. GP-led Clinical Commissioning Groups will have the option of more control over the wider NHS budget, enabling a shift in investment from acute to primary and community services. The number of GPs in training needs to be increased as fast as possible, with new options to encourage retention.

12. In order to support these changes, the **national leadership** of the NHS will need to act coherently together, and provide **meaningful local flexibility** in the way payment rules, regulatory requirements and other mechanisms are applied. We will back diverse solutions and local leadership, in place of the distraction of further national structural reorganisation. We will invest in new options for our workforce, and raise our game on health technology - radically improving patients' experience of interacting with the NHS. We will

improve the NHS' ability to undertake research and apply **innovation** – including by developing new 'test bed' sites for worldwide innovators, and new 'green field' sites where completely new NHS services will be designed from scratch.

13. In order to provide the comprehensive and high quality care the people of England clearly want, Monitor, NHS England and independent analysts have previously calculated that a combination of growing demand if met by no further annual efficiencies and flat real terms funding would produce a mismatch between resources and patient needs of nearly £30 billion a year by 2020/21. So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts – demand, efficiency and funding. Less impact on any one of them will require compensating action on the other two.

14. The NHS' long run performance has been efficiency of 0.8% annually, but nearer to 1.5%-2% in recent years. For the NHS repeatedly to achieve an extra 2% net efficiency/demand saving across its whole funding base each year for the rest of the decade would represent a strong performance - compared with the NHS' own past, compared with the wider UK economy, and with other countries' health systems. We believe it is possible – perhaps rising to as high as 3% by the end of the period - provided we take action on prevention, invest in new care models, sustain social care services, and over time see a bigger share of the efficiency coming from wider system improvements.

15. On funding scenarios, flat real terms NHS spending overall would represent a continuation of current budget protection. Flat real terms NHS spending *per person* would take account of population growth. Flat NHS spending *as a share of GDP* would differ from the long term trend in which health spending in industrialised countries tends to rise as a share of national income.

16. Depending on the combined efficiency and funding option pursued, the effect is to close the £30 billion gap by one third, one half, or all the way. Delivering on the transformational changes set out in this Forward View and the resulting annual efficiencies could - if matched by staged funding increases as the economy allows - close the £30 billion gap by 2020/21. Decisions on these options will be for the next Parliament and government, and will need to be updated and adjusted over the course of the five year period. However nothing in the analysis above suggests that continuing with a comprehensive tax-funded NHS is intrinsically un-doable. Instead it suggests that **there *are* viable options for sustaining and improving the NHS over the next five years**, provided that the NHS does its part, allied with the support of government, and of our other partners, both national and local.

CHAPTER ONE
Why does the NHS need to change?

Over the past fifteen years the NHS has dramatically improved. Cancer survival is its highest ever. Early deaths from heart disease are down by over 40%. Avoidable deaths overall are down by 20%. About 160,000 more nurses, doctors and other clinicians are treating millions more patients so that most long waits for operations have been slashed – down from 18 months to 18 weeks. Mixed sex wards and shabby hospital buildings have been tackled. Public satisfaction with the NHS has nearly doubled.

Over the past five years - despite global recession and austerity - the NHS has generally been successful in responding to a growing population, an ageing population, and a sicker population, as well as new drugs and treatments and cuts in local councils' social care. Protected NHS funding has helped, as has the shared commitment and dedication of health service staff – on one measure the health service has become £20 billion more efficient.

No health system anywhere in the world in recent times has managed five years of little or no real growth without either increasing charges, cutting services or cutting staff. The NHS has been a remarkable exception. What's more, transparency about quality has helped care improve, and new research programmes like the 100,000 genomes initiative are putting this country at the forefront of global health research. The Commonwealth Fund has just ranked us the highest performing health system of 11 industrialised countries.

Of course the NHS is far from perfect. Some of the fundamental challenges facing us are common to all industrialised countries' health systems:

- Changes in patients' health needs and personal preferences. Long term health conditions - rather than illnesses susceptible to a one-off cure - now take 70% of the health service budget. At the same time many (but not all) people wish to be more informed and involved with their own care, challenging the traditional divide between patients and professionals, and offering opportunities for better health through increased prevention and supported self-care.

- Changes in treatments, technologies and care delivery. Technology is transforming our ability to predict, diagnose and treat disease. New treatments are coming on stream. And we know, both from examples within the NHS and internationally, that there are better ways of organising care, breaking out of the artificial boundaries between hospitals and primary care, between health and social care, between generalists and specialists—all of which get in the way of care that is genuinely coordinated around what people need and want.

- Changes in health services funding growth. Given the after-effects of the global recession, most western countries will continue to experience budget pressures over the next few years, and it is implausible to think that over this period NHS spending growth could return to the 6%-7% real annual increases seen in the first decade of this century.

Some of the improvements we need over the next five years are more specific to England. In mental health and learning disability services. In faster diagnosis and more uniform treatment for cancer. In readily accessible GP services. In prevention and integrated health and social care. There are still unacceptable variations of care provided to patients, which can have devastating effects on individuals and their families, as the inexcusable events at Mid-Staffordshire and Winterbourne View laid bare.

One possible response to these challenges would be to attempt to muddle through the next few years, relying on short term expedients to preserve services and standards. Our view is that this is not a sustainable strategy because it would over time inevitably lead to three widening gaps:

The health and wellbeing gap: if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.

The care and quality gap: unless we reshape care delivery, harness technology, and drive down variations in quality and safety of care, then patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.

The funding and efficiency gap: if we fail to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of worse services, fewer staff, deficits, and restrictions on new treatments.

We believe none of these three gaps is inevitable. A better future is possible – and with the right changes, right partnerships, and right investments we know how to get there.

That's because there is broad consensus on what that future needs to be. It is a future that empowers patients to take much more control over their own care and treatment. It is a future that dissolves the classic divide, set almost in stone since 1948, between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment. One that no longer sees expertise locked into often out-dated buildings, with services fragmented, patients

having to visit multiple professionals for multiple appointments, endlessly repeating their details because they use separate paper records. One organised to support people with multiple health conditions, not just single diseases. A future that sees far more care delivered locally but with some services in specialist centres where that clearly produces better results. One that recognises that we cannot deliver the necessary change without investing in our current and future workforce.

The rest of this Forward View sets out what that future will look like, and how together we can bring it about. Chapter two – the next chapter – outlines some of the action needed to tackle the health and wellbeing gap. Chapter three sets out radical changes to tackle the care and quality gap. Chapter four focuses on options for meeting the funding and efficiency challenge.

BOX 1: FIVE YEAR AMBITIONS ON QUALITY

The definition of quality in health care, enshrined in law, includes three key aspects: patient safety, clinical effectiveness and patient experience. A high quality health service exhibits all three. However, achieving all three ultimately happens when a caring culture, professional commitment and strong leadership are combined to serve patients, which is why the Care Quality Commission is inspecting against these elements of quality too.

We do not always achieve these standards. For example, there is variation depending on when patients are treated: mortality rates are 11% higher for patients admitted on Saturdays and 16% higher on Sundays compared to a Wednesday. And there is variation in outcomes; for instance, up to 30% variation between CCGs in the health related quality of life for people with more than one long term condition.

We have a double opportunity: to narrow the gap between the best and the worst, whilst raising the bar higher for everyone. To reduce variations in where patients receive care, we will measure and publish meaningful and comparable measurements for all major pathways of care for every provider – including community, mental and primary care – by the end of the next Parliament. We will continue to redesign the payment system so that there are rewards for improvements in quality. We will invest in leadership by reviewing and refocusing the work of the NHS Leadership Academy and NHS Improving Quality. To reduce variations in when patients receive care, we will develop a framework for how seven day services can be implemented affordably and sustainably, recognising that different solutions will be needed in different localities. As national bodies we can do more by measuring what matters, requiring comprehensive transparency of performance data and ensuring this data increasingly informs payment mechanisms and commissioning decisions.

CHAPTER TWO
What will the future look like? A new relationship with patients and communities

One of the great strengths of this country is that we have an NHS that - at its best - is 'of the people, by the people and for the people'.

Yet sometimes the health service has been prone to operating a 'factory' model of care and repair, with limited engagement with the wider community, a short-sighted approach to partnerships, and under-developed advocacy and action on the broader influencers of health and wellbeing.

As a result we have not fully harnessed the renewable energy represented by patients and communities, or the potential positive health impacts of employers and national and local governments.

Getting serious about prevention

The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. Twelve years ago, Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.

Rather than the 'fully engaged scenario' that Wanless spoke of, one in five adults still smoke. A third of people drink too much alcohol. A third of men and half of women don't get enough exercise. Almost two thirds of adults are overweight or obese. These patterns are influenced by, and in turn reinforce, deep health inequalities which can cascade down the generations. For example, smoking rates during pregnancy range from 2% in west London to 28% in Blackpool.

Even more shockingly, the number of obese children doubles while children are at primary school. Fewer than one-in-ten children are obese when they enter reception class. By the time they're in Year Six, nearly one-in-five are then obese.

And as the 'stock' of population health risk gets worse, the 'flow' of costly NHS treatments increases as a consequence. To take just one example – Diabetes UK estimate that the NHS is already spending about £10 billion a year on diabetes. Almost three million people in England are already living with diabetes and another seven million people are at risk of becoming diabetic. Put bluntly, as the nation's waistline keeps piling on

the pounds, we're piling on billions of pounds in future taxes just to pay for preventable illnesses.

We do not have to accept this rising burden of ill health driven by our lifestyles, patterned by deprivation and other social and economic influences. Public Health England's new strategy sets out priorities for tackling obesity, smoking and harmful drinking; ensuring that children get the best start in life; and that we reduce the risk of dementia through tackling lifestyle risks, amongst other national health goals.

We support these priorities and will work to deliver them. While the health service certainly can't do everything that's needed by itself, it can and should now become a more activist agent of health-related social change. That's why we will lead where possible, or advocate when appropriate, a range of new approaches to improving health and wellbeing.

Incentivising and supporting healthier behaviour. England has made significant strides in reducing smoking, but it still remains our number one killer. More than half of the inequality in life expectancy between social classes is now linked to higher smoking rates amongst poorer people. There are now over 3,000 alcohol-related admissions to A&E every day. Our young people have the highest consumption of sugary soft drinks in Europe. So for all of these major health risks – including tobacco, alcohol, junk food and excess sugar - we will actively support comprehensive, hard-hitting and broad-based national action to include clear information and labelling, targeted personal support and wider changes to distribution, marketing, pricing, and product formulation. We will also use the substantial combined purchasing power of the NHS to reinforce these measures.

Local democratic leadership on public health. Local authorities now have a statutory responsibility for improving the health of their people, and councils and elected mayors can make an important impact. For example, Barking and Dagenham are seeking to limit new junk food outlets near schools. Ipswich Council, working with Suffolk Constabulary, is taking action on alcohol. Other councils are now following suit. The mayors of Liverpool and London have established wide-ranging health commissions to mobilise action for their residents. Local authorities in greater Manchester are increasingly acting together to drive health and wellbeing. Through local Health and Wellbeing Boards, the NHS will play its part in these initiatives. However, we agree with the Local Government Association that English mayors and local authorities should also be granted enhanced powers to allow local democratic decisions on public health policy that go further and faster than prevailing national law – on alcohol, fast food, tobacco and other issues that affect physical and mental health.

Targeted prevention. While local authorities now have responsibility for many broad based public health programmes, the NHS has a distinct role in secondary prevention. Proactive primary care is central to this, as is the more systematic use of evidence-based intervention strategies. We also need to make different investment decisions - for example, it makes little sense that the NHS is now spending more on bariatric surgery for obesity than on a national roll-out of intensive lifestyle intervention programmes that were first shown to cut obesity and prevent diabetes over a decade ago. Our ambition is to change this over the next five years so that we become the first country to implement at scale a national evidence-based diabetes prevention programme modelled on proven UK and international models, and linked where appropriate to the new Health Check. NHS England and Public Health England will establish a preventative services programme that will then expand evidence-based action to other conditions.

NHS support to help people get and stay in employment. Sickness absence-related costs to employers and taxpayers have been estimated at £22 billion a year, and over 300,000 people each year take up health-related benefits. In doing so, individuals collectively miss out on £4 billion a year of lost earnings. Yet there is emerging evidence that well targeted health support can help keep people in work thus improving their wellbeing and preserving their livelihoods. Mental health problems now account for more than twice the number of Employment and Support Allowance and Incapacity Benefit claims than do musculoskeletal complaints (for example, bad backs). Furthermore, the employment rate of people with severe and enduring mental health problems is the lowest of all disability groups at just 7%. A new government-backed Fit for Work scheme starts in 2015. Over and above that, during the next Parliament we will seek to test a win-win opportunity of improving access to NHS services for at-risk individuals while saving 'downstream' costs at the Department for Work and Pensions, if money can be reinvested across programmes.

Workplace health. One of the advantages of a tax-funded NHS is that - unlike in a number of continental European countries - employers here do not pay directly for their employees' health care. But British employers do pay national insurance contributions which help fund the NHS, and a healthier workforce will reduce demand and lower long term costs. The government has partially implemented the recommendations in the independent review by Dame Carol Black and David Frost, which allow employers to provide financial support for vocational rehabilitation services without employees facing a tax bill. There would be merit in extending incentives for employers in England who provide effective NICE recommended workplace health programmes for employees. We will also establish with NHS Employers new incentives to ensure the NHS as an employer sets a national example in the support it offers its own 1.3 million staff to stay healthy, and serve as "health ambassadors" in their local communities.

BOX 2.1: A HEALTHIER NHS WORKPLACE

While three quarters of NHS trusts say they offer staff help to quit smoking, only about a third offer them support in keeping to a healthy weight. Three quarters of hospitals do not offer healthy food to staff working night shifts. It has previously been estimated the NHS could reduce its overall sickness rate by a third – the equivalent of adding almost 15,000 staff and 3.3 million working days at a cost saving of £550m. So among other initiatives we will: ● Cut access to unhealthy products on NHS premises, implementing food standards, and providing healthy options for night staff. ● Measure staff health and wellbeing, and introduce voluntary work-based weight watching and health schemes which international studies have shown achieve sustainable weight loss in more than a third of those who take part. ● Support "active travel" schemes for staff and visitors. ● Promote the Workplace Wellbeing Charter, the Global Corporate Challenge and the TUC's Better Health and Work initiative, and ensure NICE guidance on promoting healthy workplaces is implemented, particularly for mental health. ● Review with the Faculty of Occupational Medicine the strengthening of occupational health.

Empowering patients

Even people with long term conditions, who tend to be heavy users of the health service, are likely to spend less than 1% of their time in contact with health professionals. The rest of the time they, their carers and their families manage on their own. As the patients' organisation National Voices puts it: personalised care will only happen when statutory services recognise that patients' own life goals are what count; that services need to support families, carers and communities; that promoting wellbeing and independence need to be the key outcomes of care; and that patients, their families and carers are often 'experts by experience'.

As a first step towards this ambition we will improve the information to which people have access—not only clinical advice, but also information about their condition and history. The digital and technology strategies we set out in chapter four will help, and within five years, all citizens will be able to access their medical and care records (including in social care contexts) and share them with carers or others they choose.

Second, we will do more to support people to manage their own health – staying healthy, making informed choices of treatment, managing conditions and avoiding complications. With the help of voluntary sector partners, we will invest significantly in evidence-based approaches such as group-based education for people with specific conditions and self-management educational courses, as well as encouraging independent peer-to-peer communities to emerge.

A third step is to increase the direct control patients have over the care that is provided to them. We will make good on the NHS' longstanding

promise to give patients choice over where and how they receive care. Only half of patients say they were offered a choice of hospitals for their care, and only half of patients say they are as involved as they wish to be in decisions about their care and treatment. We will also introduce integrated personal commissioning (IPC), a new voluntary approach to blending health and social care funding for individuals with complex needs. As well as care plans and voluntary sector advocacy and support, IPC will provide an integrated, "year of care" budget that will be managed by people themselves or on their behalf by councils, the NHS or a voluntary organisation.

Engaging communities

More broadly, we need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services. Programmes like NHS Citizen point the way, but we also commit to four further actions to build on the energy and compassion that exists in communities across England. These are better support for carers; creating new options for health-related volunteering; designing easier ways for voluntary organisations to work alongside the NHS; and using the role of the NHS as an employer to achieve wider health goals.

Supporting carers. Two thirds of patients admitted to hospital are over 65, and more than a quarter of hospital inpatients have dementia. The five and a half million carers in England make a critical and underappreciated contribution not only to loved ones, neighbours and friends, but to the very sustainability of the NHS itself. We will find new ways to support carers, building on the new rights created by the Care Act, and especially helping the most vulnerable amongst them – the approximately 225,000 young carers and the 110,000 carers who are themselves aged over 85. This will include working with voluntary organisations and GP practices to identify them and provide better support. For NHS staff, we will look to introduce flexible working arrangements for those with major unpaid caring responsibilities.

Encouraging community volunteering. Volunteers are crucial in both health and social care. Three million volunteers already make a critical contribution to the provision of health and social care in England; for example, the Health Champions programme of trained volunteers that work across the NHS to improve its reach and effectiveness. The Local Government Association has made proposals that volunteers, including those who help care for the elderly, should receive a 10% reduction in their council tax bill, worth up to £200 a year. We support testing approaches like that, which could be extended to those who volunteer in hospitals and other parts of the NHS. The NHS can go further, accrediting volunteers and devising ways to help them become part of the extended NHS family – not as substitutes for but as partners with our skilled employed staff. For example, more than 1,000 "community first responders" have been recruited by Yorkshire Ambulance in more rural

areas and trained in basic life support. New roles which have been proposed could include family and carer liaison, educating people in the management of long-term conditions and helping with vaccination programmes. We also intend to work with carers organisations to support new volunteer programmes that could provide emergency help when carers themselves face a crisis of some kind, as well as better matching volunteers to the roles where they can add most value.

Stronger partnerships with charitable and voluntary sector organisations. When funding is tight, NHS, local authority and central government support for charities and voluntary organisations is put under pressure. However these voluntary organisations often have an impact well beyond what statutory services alone can achieve. Too often the NHS conflates the voluntary sector with the idea of volunteering, whereas these organisations provide a rich range of activities, including information, advice, advocacy and they deliver vital services with paid expert staff. Often they are better able to reach underserved groups, and are a source of advice for commissioners on particular needs. So in addition to other steps the NHS will take, we will seek to reduce the time and complexity associated with securing local NHS funding by developing a short national alternative to the standard NHS contract where grant funding may be more appropriate than burdensome contracts, and by encouraging funders to commit to multiyear funding wherever possible.

The NHS as a local employer. The NHS is committed to making substantial progress in ensuring that the boards and leadership of NHS organisations better reflect the diversity of the local communities they serve, and that the NHS provides supportive and non-discriminatory ladders of opportunity for all its staff, including those from black and minority ethnic backgrounds. NHS employers will be expected to lead the way as progressive employers, including for example by signing up to efforts such as Time to Change which challenge mental health stigma and discrimination. NHS employers also have the opportunity to be more creative in offering supported job opportunities to 'experts by experience' such as people with learning disabilities who can help drive the kind of change in culture and services that the Winterbourne View scandal so graphically demonstrated is needed.

The NHS as a social movement

None of these initiatives and commitments by themselves will be the difference between success and failure over the next five years. But collectively and cumulatively they and others like them will help shift power to patients and citizens, strengthen communities, improve health and wellbeing, and—as a by-product—help moderate rising demands on the NHS.

So rather than being seen as the 'nice to haves' and the 'discretionary extras', our conviction is that these sort of partnerships and initiatives are

in fact precisely the sort of 'slow burn, high impact' actions that are now essential.

They in turn need to be matched by equally radical action to transform the way NHS care is provided. That is the subject of the next chapter.

BOX 2.2: SUPPORT FOR PEOPLE WITH DEMENTIA

About 700,000 people in England are estimated to have dementia, many undiagnosed. Perhaps one in three people aged over 65 will develop dementia before they die. Almost 500,000 unpaid carers look after people living with dementia. The NHS is making a national effort to increase the proportion of people with dementia who are able to get a formal diagnosis from under half, to two thirds of people affected or more. Early diagnosis can prevent crises, while treatments are available that may slow progression of the disease.

For those that are diagnosed with dementia, the NHS' ambition over the next five years is to offer a consistent standard of support for patients newly diagnosed with dementia, supported by named clinicians or advisors, with proper care plans developed in partnership with patients and families; and the option of personal budgets, so that resources can be used in a way that works best for individual patients. Looking further ahead, the government has committed new funding to promote dementia research and treatment.

But the dementia challenge calls for a broader coalition, drawing together statutory services, communities and businesses. For example, Dementia Friendly Communities – currently being developed by the Alzheimer's Society – illustrate how, with support, people with dementia can continue to participate in the life of their community. These initiatives will have our full support—as will local dementia champions, participating businesses and other organisations.

CHAPTER THREE
What will the future look like? New models of care

The traditional divide between primary care, community services, and hospitals - largely unaltered since the birth of the NHS - is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three.

Over the next five years and beyond the NHS will increasingly need to dissolve these traditional boundaries. Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. As a result there is now quite wide consensus on the direction we will be taking.

- Increasingly we need to manage systems – networks of care – not just organisations.
- Out-of-hospital care needs to become a much larger part of what the NHS does.
- Services need to be integrated around the patient. For example a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health addressed at the same time.
- We should learn much faster from the best examples, not just from within the UK but internationally.
- And as we introduce them, we need to evaluate new care models to establish which produce the best experience for patients and the best value for money.

Emerging models

In recent years parts of the NHS have begun doing elements of this. The strategic plans developed by local areas show that in some places the future is already emerging. For example:

In Kent, 20 GPs and almost 150 staff operate from three modern sites providing many of the tests, investigations, minor injuries and minor surgery usually provided in hospital. It shows what can be done when general practice operates at scale. Better results, better care, a better experience for patients and significant savings.

In Airedale, nursing and residential homes are linked by secure video to the hospital allowing consultations with nurses and consultants both in

and out of normal hours - for everything from cuts and bumps to diabetes management to the onset of confusion. Emergency admissions from these homes have been reduced by 35% and A&E attendances by 53%. Residents rate the service highly.

In Cornwall, trained volunteers and health and social care professionals work side-by-side to support patients with long term conditions to meet their own health and life goals.

In Rotherham, GPs and community matrons work with advisors who know what voluntary services are available for patients with long term conditions. This "social prescribing service" has cut the need for visits to accident and emergency, out-patient appointments and hospital admissions.

In London, integrated care pioneers that combine NHS, GP and social care services have improved services for patients, with fewer people moving permanently into nursing care homes. They have also shown early promise in reducing emergency admissions. Greenwich has saved nearly £1m for the local authority and over 5% of community health expenditure.

All of these approaches seem to improve the quality of care and patients' experience. They also deliver better value for money; some may even cut costs. They are pieces of the jigsaw that will make up a better NHS. But there are too few of them, and they are too isolated. Nowhere do they provide the full picture of a 21st century NHS that has yet to emerge. Together they describe the way the NHS of the future will look.

One size fits all?

So to meet the changing needs of patients, to capitalise on the opportunities presented by new technologies and treatments, and to unleash system efficiencies more widely, we intend to support and stimulate the creation of a number of major new care models that can be deployed in different combinations locally across England.

However England is too diverse – both in its population and its current health services – to pretend that a single new model of care should apply everywhere. Times have changed since the last such major blueprint, the 1962 Hospital Plan for England and Wales. What's right for Cumbria won't be right for Coventry; what makes sense in Manchester and in Winchester will be different.

But that doesn't mean there are an infinite number of new care models. While the answer is not one-size-fits-all, nor is it simply to let 'a thousand flowers bloom'. Cumbria and Devon and Northumberland have quite a lot in common in designing their NHS of the future. So do the hospitals on the

outer ring around Manchester and the outer ring around London. So do many other parts of the country.

That's why our approach will be to identify the characteristics of similar health communities across England, and then jointly work with them to consider which of the new options signalled by this Forward View constitute viable ways forward for their local health and care services over the next five years and beyond.

In all cases however one of the most important changes will be to expand and strengthen primary and 'out of hospital' care. Given the pressures that GPs are under, this is dependent on several immediate steps to stabilise general practice – see Box 3.1.

BOX 3.1: A new deal for primary care

General practice, with its registered list and everyone having access to a family doctor, is one of the great strengths of the NHS, but it is under severe strain. Even as demand is rising, the number of people choosing to become a GP is not keeping pace with the growth in funded training posts - in part because primary care services have been under-resourced compared to hospitals. So over the next five years we will invest more in primary care. Steps we will take include:

- *Stabilise core funding for general practice nationally over the next two years while an independent review is undertaken of how resources are fairly made available to primary care in different areas.*
- *Give GP-led Clinical Commissioning Groups (CCGs) more influence over the wider NHS budget, enabling a shift in investment from acute to primary and community services.*
- *Provide new funding through schemes such as the Challenge Fund to support new ways of working and improved access to services.*
- *Expand as fast as possible the number of GPs in training while training more community nurses and other primary care staff. Increase investment in new roles, and in returner and retention schemes and ensure that current rules are not inflexibly putting off potential returners.*
- *Expand funding to upgrade primary care infrastructure and scope of services.*
- *Work with CCGs and others to design new incentives to encourage new GPs and practices to provide care in under-doctored areas to tackle health inequalities.*
- *Build the public's understanding that pharmacies and on-line resources can help them deal with coughs, colds and other minor ailments without the need for a GP appointment or A&E visit.*

Here we set out details of the principal additional care models over and above the status quo which we will be promoting in England over the next five years.

New care model – Multispecialty Community Providers (MCPs)

Smaller independent GP practices will continue in their current form where patients and GPs want that. However, as the Royal College of General Practitioners has pointed out, in many areas primary care is entering the next stage of its evolution. As GP practices are increasingly employing salaried and sessional doctors, and as women now comprise half of GPs, the traditional model has been evolving.

Primary care of the future will build on the traditional strengths of 'expert generalists', proactively targeting services at registered patients with complex ongoing needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients. Future models will expand the leadership of primary care to include nurses, therapists and other community based professionals. It could also offer some care in fundamentally different ways, making fuller use of digital technologies, new skills and roles, and offering greater convenience for patients.

To offer this wider scope of services, and enable new ways of delivering care, we will make it possible for extended group practices to form – either as federations, networks or single organisations.

These Multispecialty Community Providers (MCPs) would become the focal point for a far wider range of care needed by their registered patients.

- As larger group practices they could in future begin employing consultants or take them on as partners, bringing in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers, and other staff.

- These practices would shift the majority of outpatient consultations and ambulatory care out of hospital settings.

- They could take over the running of local community hospitals which could substantially expand their diagnostic services as well as other services such as dialysis and chemotherapy.

- GPs and specialists in the group could be credentialed in some cases to directly admit their patients into acute hospitals, with out-of-hours

inpatient care being supervised by a new cadre of resident 'hospitalists' – something that already happens in other countries.

- They could in time take on delegated responsibility for managing the health service budget for their registered patients. Where funding is pooled with local authorities, a combined health and social care budget could be delegated to Multispecialty Community Providers.

- These new models would also draw on the 'renewable energy' of carers, volunteers and patients themselves, accessing hard-to-reach groups and taking new approaches to changing health behaviours.

There are already a number of practices embarking on this journey, including high profile examples in the West Midlands, London and elsewhere. For example, in Birmingham, one partnership has brought together 10 practices employing 250 staff to serve about 65,000 patients on 13 sites. It will shortly have three local hubs with specialised GPs that will link in community and social care services while providing central out-of-hours services using new technology.

To help others who want to evolve in this way, and to identify the most promising models that can be spread elsewhere, we will work with emerging practice groups to address barriers to change, service models, access to funding, optimal use of technology, workforce and infrastructure. As with the other models discussed in this section, we will also test these models with patient groups and our voluntary sector partners.

New care model – Primary and Acute Care Systems (PACS)

A range of contracting and organisational forms are now being used to better integrate care, including lead/prime providers and joint ventures.

We will now permit a new variant of integrated care in some parts of England by allowing single organisations to provide NHS list-based GP and hospital services, together with mental health and community care services.

The leadership to bring about these 'vertically' integrated Primary and Acute Care Systems (PACS) may be generated from different places in different local health economies.

- In some circumstances – such as in deprived urban communities where local general practice is under strain and GP recruitment is proving hard – hospitals will be permitted to open their own GP surgeries with registered lists. This would allow the accumulated surpluses and investment powers of NHS Foundation Trusts to kick-start the expansion of new style primary care in areas with high health inequalities. Safeguards will be needed to ensure that they do

this in ways that reinforce out-of-hospital care, rather than general practice simply becoming a feeder for hospitals still providing care in the traditional ways.

- In other circumstances, the next stage in the development of a mature Multispecialty Community Provider (see section above) could be that it takes over the running of its main district general hospital.

- At their most radical, PACS would take accountability for the whole health needs of a registered list of patients, under a delegated capitated budget - similar to the Accountable Care Organisations that are emerging in Spain, the United States, Singapore, and a number of other countries.

PACS models are complex. They take time and technical expertise to implement. As with any model there are also potential unintended side effects that need to be managed. We will work with a small number of areas to test these approaches with the aim of developing prototypes that work, before promoting the most promising models for adoption by the wider NHS.

New care model - urgent and emergency care networks

The care that people receive in England's Emergency Departments is, and will remain, one of the yardsticks by which the NHS as a whole will be judged. Although both quality and access have improved markedly over the years, the mounting pressures on these hospital departments illustrate the need to transition to a more sustainable model of care.

More and more people are using A&E – with 22 million visits a year. Compared to five years ago, the NHS in England handles around 3,500 extra attendances every single day, and in many places, A&E is running at full stretch. However, the 185 hospital emergency departments in England are only a part of the urgent and emergency care system. The NHS responds to more than 100 million urgent calls or visits every year.

Over the next five years, the NHS will do far better at organising and simplifying the system. This will mean:

- Helping patients get the right care, at the right time, in the right place, making more appropriate use of primary care, community mental health teams, ambulance services and community pharmacies, as well as the 379 urgent care centres throughout the country. This will partly be achieved by evening and weekend access to GPs or nurses working from community bases equipped to provide a much greater range of tests and treatments; ambulance services empowered to make more decisions, treating patients and making referrals in a more flexible way; and far greater use of pharmacists.

- Developing networks of linked hospitals that ensure patients with the most serious needs get to specialist emergency centres - drawing on the success of major trauma centres, which have saved 30% more of the lives of the worst injured.

- Ensuring that hospital patients have access to seven day services where this makes a clinical difference to outcomes.

- Proper funding and integration of mental health crisis services, including liaison psychiatry.

- A strengthened clinical triage and advice service that links the system together and helps patients navigate it successfully.

- New ways of measuring the quality of the urgent and emergency services; new funding arrangements; and new responses to the workforce requirements that will make these new networks possible.

New care model – viable smaller hospitals

Some commentators have argued that smaller district general hospitals should be merged and/or closed. In fact, England already has one of the more centralised hospital models amongst advanced health systems. It is right that these hospitals should not be providing complex acute services where there is evidence that high volumes are associated with high quality. And some services and buildings will inevitably and rightly need to be re-provided in other locations - just as they have done in the past and will continue to be in every other western country.

However to help sustain local hospital services where the best clinical solution is affordable, has the support of local commissioners and communities, we will now take three sets of actions.

First, NHS England and Monitor will work together to consider whether any adjustments are needed to the NHS payment regime to reflect the costs of delivering safe and efficient services for smaller providers relative to larger ones. The latest quarterly figures show that larger foundation trusts had EBITDA margins of 5% compared to -0.4% for smaller providers.

Second, building on the earlier work of Monitor looking at the costs of running smaller hospitals, and on the Royal College of Physicians Future Hospitals initiative, we will work with those hospitals to examine new models of medical staffing and other ways of achieving sustainable cost structures.

Third, we will create new organisational models for smaller acute hospitals that enable them to gain the benefits of scale without necessarily having to centralise services. Building on the recommendations of the

forthcoming Dalton Review, we intend to promote at least three new models:

- In one model, a local acute hospital might share management either of the whole institution or of their 'back office' with other similar hospitals not necessarily located in their immediate vicinity. These type of 'hospital chains' already operate in places such as Germany and Scandinavia.

- In another new model, a smaller local hospital might have some of its services on a site provided by another specialised provider – for example Moorfields eye hospital operates in 23 locations in London and the South East. Several cancer specialist providers are also considering providing services on satellite sites.

- And as indicated in the PACS model above, a further new option is that a local acute hospital and its local primary and community services could form an integrated provider.

New care model - specialised care

In some services there is a compelling case for greater concentration of care. In these services there is a strong relationship between the number of patients and the quality of care, derived from the greater experience these more practiced clinicians have, access to costly specialised facilities and equipment, and the greater standardisation of care that tends to occur. For example, consolidating 32 stroke units to 8 specialist ones in London achieved a 17% reduction in 30-day mortality and a 7% reduction in patient length of stay.

The evidence suggests that similar benefits could be had for most specialised surgery, and some cancer and other services. For example, in Denmark reducing by two thirds the number of hospitals that perform colorectal cancer surgery has improved post-operative mortality after 2 years by 62%. In Germany, the highest volume centres that treat prostate cancer have substantially fewer complications. The South West London Elective Orthopaedic Centre achieves lower post-operative complication rates than do many hospitals which operate on fewer patients.

In services where the relationship between quality and patient volumes is this strong, NHS England will now work with local partners to drive consolidation through a programme of three-year rolling reviews. We will also look to these specialised providers to develop networks of services over a geography, integrating different organisations and services around patients, using innovations such as prime contracting and/or delegated capitated budgets. To take one example: cancer. This would enable patients to have chemotherapy, support and follow up care in their local community hospital or primary care facility, whilst having access to world-leading facilities for their surgery and radiotherapy. In line with

the UK Strategy for Rare Diseases, we will also explore establishing specialist centres for rare diseases to improve the coordination of care for their patients.

New care model - modern maternity services

Having a baby is the most common reason for hospital admission in England. Births are up by almost a quarter in the last decade, and are at their highest in 40 years.

Recent research shows that for low risk pregnancies babies born at midwife-led units or at home did as well as babies born in obstetric units, with fewer interventions. Four out of five women live within a 30 minute drive of both an obstetric unit and a midwife-led unit, but research by the Women's Institute and the National Childbirth Trust suggests that while only a quarter of women want to give birth in a hospital obstetrics unit, over 85% actually do so.

To ensure maternity services develop in a safe, responsive and efficient manner, in addition to other actions underway – including increasing midwife numbers - we will:

- Commission a review of future models for maternity units, to report by next summer, which will make recommendations on how best to sustain and develop maternity units across the NHS.

- Ensure that tariff-based NHS funding supports the choices women make, rather than constraining them.

- As a result, make it easier for groups of midwives to set up their own NHS-funded midwifery services.

New care model – enhanced health in care homes

One in six people aged 85 or over are living permanently in a care home. Yet data suggest that had more active health and rehabilitation support been available, some people discharged from hospital to care homes could have avoided permanent admission. Similarly, the Care Quality Commission and the British Geriatrics Society have shown that many people with dementia living in care homes are not getting their health needs regularly assessed and met. One consequence is avoidable admissions to hospital.

In partnership with local authority social services departments, and using the opportunity created by the establishment of the Better Care Fund, we will work with the NHS locally and the care home sector to develop new shared models of in-reach support, including medical reviews, medication reviews, and rehab services. In doing so we will build on the success of

models which have been shown to improve quality of life, reduce hospital bed use by a third, and save significantly more than they cost.

How will we support the co-design and implementation of these new care models?

Some parts of the country will be able to continue commissioning and providing high quality and affordable health services using their current care models, and without any adaptation along the lines described above.

However, previous versions of local 'five year plans' by provider trusts and CCGs suggest that many areas will need to consider new options if they are to square the circle between the desire to improve quality, respond to rising patient volumes, and live within the expected local funding.

In some places, including major conurbations, we therefore expect several of these alternative models to evolve in parallel.

In other geographies it may make sense for local communities to discuss convergence of care models for the future. This will require a new perspective where leaders look beyond their individual organisations' interests and towards the future development of whole health care economies - and are rewarded for doing so.

It will also require a new type of partnership between national bodies and local leaders. That is because to succeed in designing and implementing these new care models, the NHS locally will need national bodies jointly to exercise discretion in the application of their payment rules, regulatory approaches, staffing models and other policies, as well as possibly providing technical and transitional support.

We will therefore now work with local communities and leaders to identify what changes are needed in how national and local organisations best work together, and will jointly develop:

- Detailed prototyping of each of the new care models described above, together with any others that may be proposed that offer the potential to deliver the necessary transformation - in each case identifying current exemplars, potential benefits, risks and transition costs.

- A shared method of assessing the characteristics of each health economy, to help inform local choice of preferred models, promote peer learning with similar areas, and allow joint intervention in health economies that are furthest from where they need to be.

- National and regional expertise and support to implement care model change rapidly and at scale. The NHS is currently spending several

hundred million pounds on bodies that directly or indirectly could support this work, but the way in which improvement and clinical engagement happens can be fragmented and unfocused. We will therefore create greater alignment in the work of strategic clinical networks, clinical senates, NHS IQ, the NHS Leadership Academy and the Academic Health Science Centres and Networks.

- National flexibilities in the current regulatory, funding and pricing regimes to assist local areas to transition to better care models.

- Design of a model to help pump-prime and 'fast track' a cross-section of the new care models. We will back the plans likely to have the greatest impact for patients, so that by the end of the next Parliament the benefits and costs of the new approaches are clearly demonstrable, allowing informed decisions about future investment as the economy improves. This pump-priming model could also unlock assets held by NHS Property Services, surplus NHS property and support Foundation Trusts that decide to use accrued savings on their balance sheets to help local service transformation.

BOX 3.2: FIVE YEAR AMBITIONS FOR MENTAL HEALTH

Mental illness is the single largest cause of disability in the UK and each year about one in four people suffer from a mental health problem. The cost to the economy is estimated to be around £100 billion annually – roughly the cost of the entire NHS. Physical and mental health are closely linked – people with severe and prolonged mental illness die on average 15 to 20 years earlier than other people – one of the greatest health inequalities in England. However only around a quarter of those with mental health conditions are in treatment, and only 13 per cent of the NHS budget goes on such treatments when mental illness accounts for almost a quarter of the total burden of disease.

Over the next five years the NHS must drive towards an equal response to mental and physical health, and towards the two being treated together. We have already made a start, through the Improving Access to Psychological Therapies Programme – double the number of people got such treatment last year compared with four years ago. Next year, for the first time, there will be waiting standards for mental health. Investment in new beds for young people with the most intensive needs to prevent them being admitted miles away from where they live, or into adult wards, is already under way, along with more money for better case management and early intervention.

This, however, is only a start. We have a much wider ambition to achieve genuine parity of esteem between physical and mental health by 2020. Provided new funding can be made available, by then we want the new waiting time standards to have improved so that 95 rather than 75 per cent of people referred for psychological therapies start treatment within six weeks and those experiencing a first episode of psychosis do so within a

fortnight. We also want to expand access standards to cover a comprehensive range of mental health services, including children's services, eating disorders, and those with bipolar conditions. We need new commissioning approaches to help ensure that happens, and extra staff to coordinate such care. Getting there will require further investment.

CHAPTER FOUR
How will we get there?

This 'Forward View' sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on local reconfigurations, or on various public health measures – need the explicit support of the elected government.

So in addition to the strategies we have set out earlier in this document we also believe these complementary approaches are needed, and we will play our full part in achieving them:

We will back diverse solutions and local leadership

As a nation we've just taken the unique step anywhere in the world of entrusting frontline clinicians with two thirds – £66 billion – of our health service funding. Many CCGs are now harnessing clinical insight and energy to drive change in their local health systems in a way that frankly has not been achievable before now. NHS England intends progressively to offer them more influence over the total NHS budget for their local populations, ranging from primary to specialised care.

We will also work with ambitious local areas to define and champion a limited number of models of joint commissioning between the NHS and local government. These will include Integrated Personal Commissioning (described in chapter two) as well as Better Care Fund-style pooling budgets for specific services where appropriate, and under specific circumstances possible full joint management of social and health care commissioning, perhaps under the leadership of Health and Wellbeing Boards. However, a proper evaluation of the results of the 2015/16 BCF is needed before any national decision is made to expand the Fund further.

Furthermore, across the NHS we detect no appetite for a wholesale structural reorganisation. In particular, the tendency over many decades for government repeatedly to tinker with the number and functions of the health authority / primary care trust / clinical commissioning group tier of the NHS needs to stop. There is no 'right' answer as to how these functions are arranged – but there is a wrong answer, and that is to keep changing your mind. Instead, the default assumption should be that changes in local organisational configurations should arise only from local work to develop the new care models described in chapter three, or in response to clear local failure and the resulting implementation of 'special measures'.

We will provide aligned national NHS leadership

NHS England, Monitor, the NHS Trust Development Authority, the Care Quality Commission, Health Education England, NICE and Public Health England have distinctive national duties laid on them by statute, and rightly so. However in their individual work with the local NHS there are various ways in which more action in concert would improve the impact and reduce the burden on frontline services. Here are some of the ways in which we intend to develop our shared work as it affects the local NHS:

- Through a combined work programme to *support the development of new local care models*, as set out at the end of chapter three. In addition to national statutory bodies, we will collaborate with patient and voluntary sector organisations in developing this programme.

- Furthermore, Monitor, TDA and NHS England will work together to create greater alignment between their respective *local assessment, reporting and intervention regimes* for Foundation Trusts, NHS trusts, and CCGs, complementing the work of CQC and HEE. This will include more joint working at regional and local level, alongside local government, to develop a whole-system, geographically-based intervention regime where appropriate. NHS England will also develop a new risk-based CCG assurance regime that will lighten the quarterly assurance reporting burden from high performing CCGs, while setting out a new 'special measures' support regime for those that are struggling.

- Using existing flexibilities and discretion, we will deploy national regulatory, pricing and funding regimes to support change in specific local areas that is in the interest of patients.

- Recognising the ultimate responsibilities of individual NHS boards for the quality and safety of the care being provided by their organisation, there is however also value in a forum where the key NHS oversight organisations can come together regionally and nationally to *share intelligence, agree action and monitor overall assurance on quality*. The National Quality Board provides such a forum, and we intend to re-energise it under the leadership of the senior clinicians (chief medical and nursing officers / medical and nursing directors / chief inspectors / heads of profession) of each of the national NHS leadership bodies alongside CCG leaders, providers, regulators and patient and lay representatives.

We will support a modern workforce

Health care depends on people — nurses, porters consultants and receptionists, scientists and therapists and many others. We can design innovative new care models, but they simply won't become a reality unless we have a workforce with the right numbers, skills, values and

behaviours to deliver it. That's why ensuring the NHS becomes a better employer is so important: by supporting the health and wellbeing of frontline staff; providing safe, inclusive and non-discriminatory opportunities; and supporting employees to raise concerns, and ensuring managers quickly act on them.

Since 2000, the workforce has grown by 160,000 more whole-time equivalent clinicians. In the past year alone staff numbers at Foundation Trusts are up by 24,000 – a 4% increase. However, these increases have not fully reflected changing patterns of demand. Hospital consultants have increased around three times faster than GPs and there has been an increasing trend towards a more specialised workforce, even though patients with multiple conditions would benefit from a more holistic clinical approach. And we have yet to see a significant shift from acute to community sector based working – just a 0.6% increase in the numbers of nurses working in the community over the past ten years.

Employers are responsible for ensuring they have sufficient staff with the right skills to care for their patients. Supported by Health Education England, we will address immediate gaps in key areas. We will put in place new measures to support employers to retain and develop their existing staff, increase productivity and reduce the waste of skills and money. We will consider the most appropriate employment arrangements to enable our current staff to work across organisational and sector boundaries. HEE will work with employers, employees and commissioners to identify the education and training needs of our current workforce, equipping them with the skills and flexibilities to deliver the new models of care, including the development of transitional roles. This will require a greater investment in training for existing staff, and the active engagement of clinicians and managers who are best placed to know what support they need to deliver new models of care.

Since it takes time to train skilled staff (for example, up to thirteen years to train a consultant), the risk is that the NHS will lock itself into outdated models of delivery unless we radically alter the way in which we plan and train our workforce. HEE will therefore work with its statutory partners to commission and expand new health and care roles, ensuring we have a more flexible workforce that can provide high quality care wherever and whenever the patient needs it. This work will be taken forward through the HEE's leadership of the implementation of the Shape of Training Review for the medical profession and the Shape of Care Review for the nursing profession, so that we can 'future proof' the NHS against the challenges to come.

More generally, over the next several years, NHS employers and staff and their representatives will need to consider how working patterns and pay and terms and conditions can best evolve to fully reward high performance, support job and service redesign, and encourage

recruitment and retention in parts of the country and in occupations where vacancies are high.

We will exploit the information revolution

There have been three major economic transitions in human history – the agricultural revolution, the industrial revolution, and now the information revolution. But most countries' health care systems have been slow to recognise and capitalise on the opportunities presented by the information revolution. For example, in Britain 86% of adults use the internet but only 2% report using it to contact their GP.

While the NHS is a world-leader in primary care computing and some aspects of our national health infrastructure (such as NHS Choices which gets 40 million visits a month, and the NHS Spine which handles 200 million interactions a month), progress on hospital systems has been slow following the failures of the previous 'connecting for health' initiative. More generally, the NHS is not yet exploiting its comparative advantage as a population-focused national service, despite the fact that our spending on health-related IT has grown rapidly over the past decade or so and is now broadly at the levels that might be expected looking at comparable industries and countries.

Part of why progress has not been as fast as it should have been is that the NHS has oscillated between two opposite approaches to information technology adoption – neither of which now makes sense. At times we have tried highly centralised national procurements and implementations. When they have failed due to lack of local engagement and lack of sensitivity to local circumstances, we have veered to the opposite extreme of 'letting a thousand flowers bloom'. The result has been systems that don't talk to each other, and a failure to harness the shared benefits that come from interoperable systems.

In future we intend to take a different approach. Nationally we will focus on the key systems that provide the 'electronic glue' which enables different parts of the health service to work together. Other systems will be for the local NHS to decide upon and procure, provided they meet nationally specified interoperability and data standards.

To lead this sector-wide approach a National Information Board has been established which brings together organisations from across the NHS, public health, clinical science, social care, local government and public representatives. To advance the implementation of this Five Year Forward View, later this financial year the NIB will publish a set of 'road maps' laying out who will do what to transform digital care. Key elements will include:

- Comprehensive transparency of performance data – including the results of treatment and what patients and carers say – to help health

professionals see how they are performing compared to others and improve; to help patients make informed choices; and to help CCGs and NHS England commission the best quality care.

- An expanding set of NHS accredited health apps that patients will be able to use to organise and manage their own health and care; and the development of partnerships with the voluntary sector and industry to support digital inclusion.

- Fully interoperable electronic health records so that patients' records are largely paperless. Patients will have full access to these records, and be able to write into them. They will retain the right to opt out of their record being shared electronically. The NHS number, for safety and efficiency reasons, will be used in all settings, including social care.

- Family doctor appointments and electronic and repeat prescribing available routinely on-line everywhere.

- Bringing together hospital, GP, administrative and audit data to support the quality improvement, research, and the identification of patients who most need health and social care support. Individuals will be able to opt out of their data being used in this way.

- Technology – including smartphones - can be a great leveller and, contrary to some perceptions, many older people use the internet. However, we will take steps to ensure that we build the capacity of all citizens to access information, and train our staff so that they are able to support those who are unable or unwilling to use new technologies.

We will accelerate useful health innovation

Britain has a track record of discovery and innovation to be proud of. We're the nation that has helped give humanity antibiotics, vaccines, modern nursing, hip replacements, IVF, CT scanners and breakthrough discoveries from the circulation of blood to the DNA double helix—to name just a few. These have benefited not only our patients, but also the British economy – helping to make us a leader in a growing part of the world economy.

Research is vital in providing the evidence we need to transform services and improve outcomes. We will continue to support the work of the National Institute for Health Research (NIHR) and the network of specialist clinical research facilities in the NHS. We will also develop the active collection and use of health outcomes data, offering patients the chance to participate in research; and, working with partners, ensuring use of NHS clinical assets to support research in medicine.

We should be both optimistic and ambitious for the further advances that lie within our reach. Medicine is becoming more tailored to the individual; we are moving from one-size-fits-all to personalised care offering higher cure rates and fewer side effects. That's why, for example, the NHS and our partners have begun a ground-breaking new initiative launched by the Prime Minister which will decode 100,000 whole genomes within the NHS. Our clinical teams will support this applied research to help improve diagnosis and treatment of rare diseases and cancers.

Steps we will take to speed innovation in new treatments and diagnostics include:

- The NHS has the opportunity radically to cut the costs of conducting Randomised Controlled Trials (RCTs), not only by streamlining approval processes but also by harnessing clinical technology. We will support the rollout of the Clinical Practice Research Datalink, and efforts to enable its use to support observational studies and quicker lower cost RCTs embedded within routine general practice and clinical care.

- In some cases it will be hard to test new treatment approaches using RCTs because the populations affected are too small. NHS England already has a £15m a year programme, administered by NICE, now called "commissioning through evaluation" which examines real world clinical evidence in the absence of full trial data. At a time when NHS funding is constrained it would be difficult to justify a further major diversion of resources from proven care to treatments of unknown cost effectiveness. However, we will explore how to expand this programme and the Early Access to Medicines programme in future years. It will be easier if the costs of doing so can be supported by those manufacturers who would like their products evaluated in this way.

- A smaller proportion of new devices and equipment go through NICE's assessment process than do pharmaceuticals. We will work with NICE to expand work on devices and equipment and to support the best approach to rolling out high value innovations—for example, operational pilots to generate evidence on the real world financial and operational impact on services—while decommissioning outmoded legacy technologies and treatments to help pay for them.

- The Department of Health-initiated Cancer Drugs Fund has expanded access to new cancer medicines. We expect over the next year to consult on a new approach to converging its assessment and prioritisation processes with a revised approach from NICE.

- The average time it takes to translate a discovery into clinical practice is however often too slow. So as well as a commitment to research, we are committed to accelerating the quicker adoption of cost-effective innovation - both medicines and medtech. We will explore with

partners—including patients and voluntary sector organisations—a number of new mechanisms for achieving this.

Accelerating innovation in new ways of delivering care

Many of the innovation gains we should be aiming for over the next five or so years probably won't come from new standalone diagnostic technologies or treatments - the number of these blockbuster 'silver bullets' is inevitably limited.

But we do have an arguably larger unexploited opportunity to *combine* different technologies and changed ways of working in order to transform care delivery. For example, equipping house-bound elderly patients who suffer from congestive heart failure with new biosensor technology that can be remotely monitored can enable community nursing teams to improve outcomes and reduce hospitalisations. But any one of these components by itself produces little or no gain, and may in fact just add cost. So instead we need what is now being termed 'combinatorial innovation'.

The NHS will become one of the best places in the world to test innovations that require staff, technology and funding all to align in a health system, with universal coverage serving a large and diverse population. In practice, our track record has been decidedly mixed. Too often single elements have been 'piloted' without other needed components. Even where 'whole system' innovations have been tested, the design has sometimes been weak, with an absence of control groups plus inadequate and rushed implementation. As a result they have produced limited empirical insight.

Over the next five years we intend to change that. Alongside the approaches we spell out in chapter three, three of the further mechanisms we will use are:

- Develop a small number of 'test bed' sites alongside our Academic Health Science Networks and Centres. They would serve as real world sites for 'combinatorial' innovations that integrate new technologies, bioinformatics, new staffing models and payment-for-outcomes. Innovators from the UK and internationally will be able to bid to have their proposed discovery or innovation deployed and tested in these sites.

- Working with NIHR and the Department of Health we will expand NHS operational research, RCT capability and other methods to promote more rigorous ways of answering high impact questions in health services redesign. An example of the sort of question that might be tested: how best to evolve GP out of hours and NHS 111 services so as to improve patient understanding of where and when to seek care, while improving clinical outcomes and ensuring the most appropriate

use of ambulance and A&E services. Further work will also be undertaken on behavioural 'nudge' type policies in health care.

- We will explore the development of health and care 'new towns'. England's population is projected to increase by about 3 to 4 million by 2020. New town developments and the refurbishment of some urban areas offers the opportunity to design modern services from scratch, with fewer legacy constraints - integrating not only health and social care, but also other public services such as welfare, education and affordable housing. The health campus already planned for Watford is one example of this.

We will drive efficiency and productive investment

It has previously been calculated by Monitor, separately by NHS England, and also by independent analysts, that a combination of a) growing demand, b) no further annual efficiencies, and c) flat real terms funding could, by 2020/21, produce a mismatch between resources and patient needs of nearly £30 billion a year.

So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts. Less impact on any one of them will require compensating action on the other two.

Demand

On demand, this Forward View makes the case for a more activist prevention and public health agenda: greater support for patients, carers and community organisations; and new models of primary and out-of-hospital care. While the positive effects of these will take some years to show themselves in moderating the rising demands on hospitals, over the medium term the results could be substantial. Their net impact will however also partly depend on the availability of social care services over the next five years.

Efficiency

Over the long run, NHS efficiency gains have been estimated by the Office for Budget Responsibility at around 0.8% net annually. Given the pressures on the public finances and the opportunities in front of us, 0.8% a year will not be adequate, and in recent years the NHS has done more than twice as well as this.

A 1.5% net efficiency increase each year over the next Parliament should be obtainable if the NHS is able to accelerate some of its current efficiency programmes, recognising that some others that have contributed over the past five years will not be indefinitely repeatable. For example as the economy returns to growth, NHS pay will need to stay broadly in line with private sector wages in order to recruit and retain frontline staff.

Our ambition, however, would be for the NHS to achieve 2% net efficiency gains each year for the rest of the decade – possibly increasing to 3% over time. This would represent a strong performance - compared with the NHS' own past, compared with the wider UK economy, and with other countries' health systems. It would require investment in new care models and would be achieved by a combination of "catch up" (as less efficient providers matched the performance of the best), "frontier shift" (as new and better ways of working of the sort laid out in chapters three and four are achieved by the whole sector), and moderating demand increases which would begin to be realised towards the end of the second half of the five year period (partly as described in chapter two). It would improve the quality and responsiveness of care, meaning patients getting the 'right care, at the right time, in the right setting, from the right caregiver'. The Nuffield Trust for example calculates that doing so could avoid the need for another 17,000 hospital beds - equivalent to opening 34 extra 500-bedded hospitals over the next five years.

Funding

NHS spending has been protected over the past five years, and this has helped sustain services. However, pressures are building. In terms of future funding scenarios, flat real terms NHS spending overall would represent a continuation of current budget protection. Flat real terms NHS spending *per person* would take account of population growth. Flat NHS spending *as a share of GDP* would differ from the long term trend in which health spending in industrialised countries tends to rise a share of national income.

Depending on the combined efficiency and funding option pursued, the effect is to close the £30 billion gap by one third, one half, or all the way.

- In scenario one, the NHS budget remains flat in real terms from 2015/16 to 2020/21, and the NHS delivers its long run productivity gain of 0.8% a year. The combined effect is that the £30 billion gap in 2020/21 is cut by about a third, to £21 billion.

- In scenario two, the NHS budget still remains flat in real terms over the period, but the NHS delivers stronger efficiencies of 1.5% a year. The combined effect is that the £30 billion gap in 2020/21 is halved, to £16 billion.

- In scenario three, the NHS gets the needed infrastructure and operating investment to rapidly move to the new care models and ways of working described in this Forward View, which in turn enables demand and efficiency gains worth 2%-3% net each year. Combined with staged funding increases close to 'flat real per person' the £30 billion gap is closed by 2020/21.

Decisions on these options will inevitably need to be taken in the context of how the UK economy overall is performing, during the next Parliament. However nothing in the analysis above suggests that continuing with a comprehensive tax-funded NHS is intrinsically undoable – instead it suggests that there are viable options for sustaining and improving the NHS over the next five years, provided that the NHS does its part, together with the support of government. The result would be a far better future for the NHS, its patients, its staff and those who support them.

BOX 5: WHAT MIGHT THIS MEAN FOR PATIENTS? FIVE YEAR AMBITIONS FOR CANCER

One in three of us will be diagnosed with cancer in our lifetime. Fortunately half of those with cancer will now live for at least ten years, whereas forty years ago the average survival was only one year. But cancer survival is below the European average, especially for people aged over 75, and especially when measured at one year after diagnosis compared with five years. This suggests that late diagnosis and variation in subsequent access to some treatments are key reasons for the gap.

So improvements in outcomes will require action on three fronts: better prevention, swifter access to diagnosis, and better treatment and care for all those diagnosed with cancer. If the steps we set out in this Forward View are implemented and the NHS continues to be properly resourced, patients will reap benefits in all three areas:

Better prevention. *An NHS that works proactively with other partners to maintain and improve health will help reduce the future incidence of cancer. The relationship between tobacco and cancer is well known, and we will ensure everyone who smokes has access to high quality smoking cessation services, working with local government partners to increase our focus on pregnant women and those with mental health conditions. There is also increasing evidence of a relationship between obesity and cancer. The World Health Organisation has estimated that between 7% and 41% of certain cancers are attributable to obesity and overweight, so the focus on reducing obesity outlined in Chapter two of this document could also contribute towards our wider efforts on cancer prevention.*

Faster diagnosis. *We need to take early action to reduce the proportion of patients currently diagnosed through A&E—currently about 25% of all diagnoses. These patients are far less likely to survive a year than those who present at their GP practice. Currently, the average GP will see fewer than eight new patients with cancer each year, and may see a rare cancer once in their career. They will therefore need support to spot suspicious combinations of symptoms. The new care models set out in this document will help ensure that there are sufficient numbers of GPs working in larger practices with greater access to diagnostic and specialist advice. We will*

also work to expand access to screening, for example, by extending breast cancer screening to additional age groups, and spreading the use of screening for colorectal cancer. As well as supporting clinicians to spot cancers earlier, we need to support people to visit their GP at the first sign of something suspicious. If we are able to deliver the vision set out in this Forward View at sufficient pace and scale, we believe that over the next five years, the NHS can deliver a 10% increase in those patients diagnosed early, equivalent to about 8,000 more patients living longer than five years after diagnosis.

Better treatment and care for all*. It is not enough to improve the rates of diagnosis unless we also tackle the current variation in treatment and outcomes. We will use our commissioning and regulatory powers to ensure that existing quality standards and NICE guidance are more uniformly implemented, across all areas and age groups, encouraging shared learning through transparency of performance data, not only by institution but also along routes from diagnosis. And for some specialised cancer services we will encourage further consolidation into specialist centres that will increasingly become responsible for developing networks of supporting services.*

But combined with this consolidation of the most specialised care, we will make supporting care available much closer to people's homes; for example, a greater role for smaller hospitals and expanded primary care will allow more chemotherapy to be provided in community. We will also work in partnership with patient organisations to promote the provision of the Cancer Recovery Package, to ensure care is coordinated between primary and acute care, so that patients are assessed and care planned appropriately. Support and aftercare and end of life care – which improves patient experience and patient reported outcomes – will all increasingly be provided in community settings.

ABBREVIATIONS

A&E	Accident & Emergency
AHSCs	Academic Health Science Centres
AHSNs	Academic Health Science Networks
BCF	Better Care Fund
CCGs	Clinical Commissioning Groups
CQC	Care Quality Commission
CT	Computerised Tomography
EBITDA	Earnings before interest, taxes, depreciation and amortisation
GP	General Practitioner
HEE	Health Education England
IPC	Integrated Personal Commissioning
IVF	In Vitro Fertilisation
LTCs	Long term conditions
NHS IQ	NHS Improving Quality
NHS TDA	NHS Trust Development Authority
NIB	National Information Board
NICE	National Institute for Health and Care Excellence
NIHR	National Institute of Health Research
PHE	Public Health England
RCTs	Randomised Controlled Trials
TUC	Trades Union Congress
WHO	World Health Organisation


CareQuality
Commission


NHS
Health Education England


Monitor
Making the health sector
work for patients


NHS
England


Public Health
England


tda
Trust
Development
Authority
Quality. Delivery. Sustainability.

Leeds CITY COUNCIL

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Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Adult Social Services, Public Health, NHS)

Date: 23 June 2015

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

Summary of main issues

1. This report presents the Department of Health '*Local Authority Health Scrutiny (June 2014)*' guidance and proposes the establishment of a working group to assist the Scrutiny Board (Adult Social Services, Public Health, NHS) fulfill part of its health scrutiny role and function.

Recommendation

2. Members are requested to:

   (a) Note the Department of Health '*Local Authority Health Scrutiny (June 2014)*' guidance.
   (b) Establish the Health Service Developments Working Group for the municipal year 2015/16, in line with the proposed Terms of Reference (presented at Appendix 2).
   (c) Determine the membership of the Health Service Developments Working Group for the municipal year 2015/16.

1.0 Purpose of this report

1.1 This report presents the Department of Health '*Local Authority Health Scrutiny (June 2014)*' guidance and proposes the establishment of a working group to assist the Scrutiny Board (Adult Social Services, Public Health, NHS) fulfill part of its health scrutiny role and function.

2.0 Main issues

2.1 As detailed elsewhere on the agenda, the Scrutiny Board (Adult Social Services, Public Health, NHS) has a specific remit / responsibility in relation to reviewing and scrutinising any matter relating to the planning, provision and operation of local health services. 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 (Adult Social Services, Public Health, NHS) and detailed in the terms of reference presented elsewhere on the agenda.

Local Authority Health Scrutiny

2.2 In June 2014, the Department of Health published its 'Local Authority Health Scrutiny' guidance to support local authorities and partners deliver effective health scrutiny. Some of the key messages from the guidance are presented 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.

2.2 The full Department of Health guidance is attached at Appendix 1 for information.

Local Authority Health Scrutiny

2.3 Historically, to help the relevant Scrutiny Board fulfill part of its health scrutiny role and function – particularly in relation to proposals around proposed changes or developments to local health services – an appropriate working group has been established.

2.4 It is recommended that similar arrangements are established for the current municipal year (i.e. 2015/16) and draft Terms of Reference are presented at Appendix 2.

2.5 Should the Scrutiny Board (Adult Social Services, Public Health, NHS) agree to establish the proposed working group for 2015/16, it may also wish to determine the membership of that working group.

3.0 Corporate Considerations

3.1 Consultation and Engagement

3.1.1 The Department of Health '*Local Authority Health Scrutiny (June 2014)*' guidance and working group terms of reference were considered by the former Scrutiny Board (Scrutiny Board (Health and Wellbeing and Adult Social Care)) in July 2014. This is the first opportunity to provide similar, updated information, during the new municipal year (2015/16).

3.1.2 Consultation with key stakeholders around the working group terms of reference was undertaken prior to July 2014.

3.2 Equality and Diversity / Cohesion and Integration.

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

3.3 Council Policies and the Best Council Plan

3.3.1 As this report relates to the Scrutiny Board's health scrutiny function relating to the NHS, there are no specific Council Policy or Best Council Plan implications. However, the Scrutiny Board may need to consider if there are any specific implications relating to any future NHS service development and/or change proposals.

3.4 Resources and Value for Money

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

3.5 Legal Implications, Access to Information and Call In

3.5.1 This report has no specific legal implications.

3.6 Risk Management

3.6.1 This report has no risk management implications.

4.0 Recommendation

4.1 Members are requested to:

(d) Note the Department of Health '*Local Authority Health Scrutiny (June 2014)*' guidance.
(e) Establish the Health Service Developments Working Group for the municipal year 2015/16, in line with the proposed Terms of Reference (presented at Appendix 2).
(f) Determine the membership of the Health Service Developments Working Group for the municipal year 2015/16.

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.

Department of Health

Local Authority Health Scrutiny

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

June 2014

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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

SCRUTINY BOARD (ADULT SOCIAL SERVICES, PUBLIC HEALTH, NHS)
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 delegates its health scrutiny function to the Scrutiny Board (Adult Social Services, Public Health, NHS) to discharge on its behalf.

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 following table.

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; service reconfiguration)	**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 (Adult Social Services, Public Health, NHS), regarding proposed developments and changes to local health services.

2.4 The working group also provides an opportunity for members to consider progress of previously discussed proposals.

2.5 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 (Adult Social Services, Public Health, NHS), for further consideration.

2.6 It should be recognised that the statutory duty to consider any substantial service changes or developments remains the responsibility of the Scrutiny Board (Adult Social Services, Public Health, NHS). As such, any substantial service changes and/or developments identified (i.e. category 4) will automatically be referred to the Scrutiny Board (Adult Social Services, Public Health, NHS) for consideration.

2.7 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 (Adult Social Services, Public Health, NHS) when considering such matters.

3.0 Frequency of meetings

3.1 The working group will aim to meet on a regular basis (e.g. bi-monthly). However, due to the nature of the work and the potential timing of proposed service changes and/or developments, the working group will adopt a flexible approach and additional meetings may be arranged as necessary.

3.2 The purpose of meeting on a regular basis is not only to ensure the early engagement of members of the Scrutiny Board (Adult Social Services, Public Health, NHS) with regard to emerging health service changes and/or developments, but to ensure continued involvement in relation to ongoing developments and any matters following implementation.

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[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 (Adult Social Services, Public Health, NHS).

4.2 The quorum of any working group meetings will be the Chair (or the Chair's nominee) plus a minimum of two other members from the Scrutiny Board (Adult Social Services, Public Health, NHS). 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 indicative contributors to the working group:

- NHS Leeds North Clinical Commissioning Group
- NHS Leeds South and East Clinical Commissioning Group
- NHS Leeds West Clinical Commissioning Group
- NHS England (West Yorkshire Area Team)
- 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 (Adult Social Services, Public Health, NHS) will be kept fully appraised of the activity of the working group.

June 2015

ANNEX A

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*