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

Meeting to be held in Civic Hall, Leeds, LS1 1UR on
Tuesday, 28th June, 2016 at 1.30 pm

(A pre-meeting will take place for ALL Members of the Board at 1.00 p.m.)

MEMBERSHIP

Councillors

C Anderson	-	Adel and Wharfedale;
J Chapman	-	Weetwood;
M Dobson	-	Garforth and Swillington;
B Flynn	-	Adel and Wharfedale;
P Gruen (Chair)	-	Cross Gates and Whinmoor;
A Hussain	-	Gipton and Harehills;
J Pryor	-	Headingley;
B Selby	-	Killingbeck and Seacroft;
A Smart	-	Armley;
P Truswell	-	Middleton Park;
S Varley	-	Morley South;

Co-opted Member (Non-voting)

–

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

Agenda compiled by:
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Produced on Recycled Paper

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 - 18 MAY 2016** To confirm as a correct record, the minutes of the meeting held on 18 May 2016.	1 - 4
7			**SCRUTINY BOARD TERMS OF REFERENCE** To receive a report from the Head of Scrutiny presenting the Scrutiny Board's terms of reference.	5 - 14
8			**CO-OPTED MEMBERS** To receive a report from the Head of Scrutiny on the appointment of co-opted members to Scrutiny Boards for 2016/17.	15 - 18
9			**CHAIR'S UPDATE** To receive an update from the Chair on scrutiny activity, not specifically included on this agenda, since the previous Board meeting.	19 - 20

Item No	Ward/Equal Opportunities	Item Not Open		Page No
10			**LEEDS COMMUNITY HEALTHCARE NHS TRUST - RESPONSE TO RECOMMENDATIONS** To receive a report from the Head of Scrutiny introducing Leeds Community Healthcare NHS Trust's formal response to the Scrutiny Board's report and recommendations relating to the Scrutiny Board Statement – '*Response to Leeds Community Healthcare NHS Trust Proposed Service Location Changes'.*	21 - 32
11			**THE BETTER LIVES STRATEGY IN LEEDS** To receive and consider two requests for scrutiny, alongside a report from the Director of Adult Social Services setting out the background and findings of recent consultation regarding proposals on the future provision of Council care home and day-centre services. ***(Report to follow)***.	
12			**DONISTHORPE HALL - UPDATE** To receive a report from the Head of Scrutiny presenting an Adult Social Services progress update in relation to services at Donisthorpe Hall.	33 - 60
13			**SCRUTINY INQUIRY REPORTS** To receive a report from the Head of Scrutiny presenting draft inquiry reports from the previous municipal year (2015/16) for consideration / agreement.	61 - 62
14			**SOURCES OF WORK FOR THE SCRUTINY BOARD** To receive a report from Head of Scrutiny on potential areas of work for the Scrutiny Board.	63 - 112

Item No	Ward/Equal Opportunities	Item Not Open		Page No
15			**LOCAL AUTHORITY HEALTH SCRUTINY** To receive a report from the Head of Scrutiny setting out the Board's role in relation to scrutiny of the NHS, alongside proposed details for the establishment of a working group to help discharge such functions and responsibilities.	113 - 150
16			**DATE AND TIME OF NEXT MEETING** Tuesday, 26 July 2016 at 1.30pm (pre meeting for all Board Members at 1.00pm) **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.	

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

WEDNESDAY, 18TH MAY, 2016

PRESENT: Councillor P Gruen in the Chair

Councillors C Anderson, B Flynn, R Grahame, A Hussain, G Hussain, S Lay, C Macniven, B Selby and S Varley

Co-opted Member: Dr J Beal (HealthWatch Leeds)

151 Late Items

The following late information was submitted to the Board:

- Agenda item 9 – Draft scrutiny inquiry report into bereavement
- Agenda item 10 – Draft scrutiny inquiry report into cancer wait times in Leeds.

The above information was not available at the time of agenda despatch, but was subsequently made available on the Council's website.

152 Declaration of Disclosable Pecuniary Interests

There were no disclosable pecuniary interests declared to the meeting, however the following matters were brought to the attention of the Scrutiny Board:

- Councillor B Selby advised that one family member was employed within the local NHS and another family member was employed within the General Register Office.
- Councillor R Grahame advised that a patient was known to him at Whinmoor Surgery and his wife was Ward Member representing Cross Gates and Whinmoor.

Councillor R Grahame and Councillor B Selby both remained present for the duration of the meeting.

153 Apologies for Absence and Notification of Substitutes

Apologies for absence were submitted by Councillors A Smart and E Taylor and Co-opted Member, Mr R Taylor. Notification had been received that Councillor R Grahame was substituting for Councillor E Taylor.

154 Minutes - 19 April and 29 April 2016

RESOLVED –

(a) That the minutes of the meeting held on 19 April 2016 be approved as a correct record.
(b) That subject to inclusion of an additional bullet point under minute no.149, as follows

- The Localism Act 2011, particularly in relation to concerns about local consultation and decision making. A response regarding this was sought from the Director of Adult Social Services.

That the minutes of the meeting held on 29 April 2016 be approved as a correct record.

155 Matters arising from the minutes - 19 April 2016

Minute no. 39 – Chair's Update

The Board briefly discussed the importance of NHS bodies fulfilling their duties by ensuring that local communities were appropriately involved and consulted on proposed services changes, particularly in relation to proposed closures to GP practices.

156 Minutes of Health and Wellbeing Board - 21 April 2016

RESOLVED – That the minutes of the Health and Wellbeing Board meeting held on 21 April 2016 be noted.

157 Minutes of Executive Board - 20 April 2016

RESOLVED – That the minutes of the Executive Board meeting held on 20 April 2016 be noted.

158 Matters arising from Executive Board - 20 April 2016

Minute no. 166 – A Business Case for a Leeds Academic Health Partnership

The Board identified the need for more detailed information and clarification regarding the role and desired outcomes from the Leeds Academic Health Partnership at a future meeting in the new municipal year.

159 Scrutiny Inquiry into Bereavement

The Head of Scrutiny and Member Development submitted a report which presented the Board's draft report following its recent inquiry into bereavement.

In accordance with the Council's Scrutiny Board Procedure Rules, the draft report was published and presented alongside the advice received from the Director or Public Health.

The following were in attendance:

- Fiona Day (Consultant in Public Health Medicine) – Office of the Director of Public Health, Leeds City Council.

The Board considered and discussed the advice received from the Director of Public Health and proposed amendments to the draft recommendations.

The key areas of discussion were:

- Cost implications associated with burial arrangements and whether there was scope for Leeds Credit Union to develop payment plans.
- The need to ensure that all faith groups were included as part of future discussions.

RESOLVED – That, subject to the amendments discussed and agreed at the meeting, the Board's draft scrutiny inquiry report and recommendations into bereavement, be approved.

160 Scrutiny Inquiry into Cancer Wait Times in Leeds

The Head of Scrutiny and Member Development submitted a report which presented the Board's draft report following its recent inquiry into cancer wait times in Leeds.

The following were in attendance:

- Fiona Day (Consultant in Public Health Medicine) – Office of the Director of Public Health, Leeds City Council.

The Board was advised that its focus on the prevention and early diagnosis of cancer was welcomed and its draft report was a helpful contribution for members of the Leeds Cancer Strategy Group.

As a representative of HealthWatch Leeds, Dr Beal particularly welcomed the patient focus and wider public involvement aspects of the draft report and recommendations.

The Board considered and discussed the advice received from the Director of Public Health and proposed amendments to the draft recommendations.

RESOLVED – That, subject to the amendments discussed and agreed at the meeting, the Board's draft scrutiny inquiry report and recommendations into cancer waiting times in Leeds, be approved.

161 Work Schedule - recommendations for 2016/17

The Head of Scrutiny and Member Development submitted a report which presented an opportunity to consider progress of the Board's work schedule for 2015/16 and make recommendations for the successor Board's work schedule for 2016/17.

The Board discussed a range of matters and potential matters for inclusion on the 2016/17 work schedule, including:

- Air quality;
- Delayed discharges;
- Clinical Commissioning Group (CCG) updates – particularly in relation to the new role as commissioners of primary care services;
- Care Quality Commissioning (CQC) inspection outcomes;
- Potential for more focussed work on budgets;
- A broader use of working groups;
- Submission of a request for scrutiny to be considered at the first Board meeting of new municipal year, 2016/17;
- Exploring opportunities for joint scrutiny work;
- Potential involvement of cluster chairs to discuss Child Adolescent Mental Health Services (CAMHS) and Targeted Mental Health Services (TaMHS), budget issues and the impact on service delivery;
- Capacity and the available resource for delivery of the Board's work schedule.

RESOLVED – That the following areas of work be considered by the successor Scrutiny Board in the new municipal year, 2016/17;

- Air quality;
- Delayed discharges;
- Clinical Commissioning Group (CCG) updates – particularly in relation to the new role as commissioners of primary care services;
- Care Quality Commissioning (CQC) inspection outcomes;
- More focussed work on budgets; and
- The financial landscape and budgetary issues likely to impact on the delivery of Child and Adolescent Mental Health Services (CAMHS) and Targeted Mental Health Services (TaMHS).

In closing the meeting, the Chair thanked Board Members for all their efforts and contributions throughout the year. Board Members reciprocated by thanking the Chair for all his efforts and leadership of the Board.

(The meeting concluded at 11.15am)

Agenda Item 7

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: 28 June 2016

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 This Board's terms of reference are related to functions delegated to the Director (Adult Social Services) and the Director of Public Health. The Scrutiny Board's terms of reference (as agreed by Council) are shown as Appendix 1 and the relevant officer delegations are summarised as:

Director of Adult Social Services

- Promotion of well-being;
- Information, advice and advocacy;
- Prevention and Recovery;
- Safeguarding;
- Assessment and eligibility;
- Diverse and High Quality Services; and
- Charging and financial assessments.

Director of Public Health

- 1) Commissioning of Public Health Services;
- 2) Promotion of Health and Wellbeing;
- 3) Health Protection;
- 4) Public Health advice;
- 5) Functions of Responsible Authority; and
- 6) Publication of the annual report on the health of the local population

2.2 The full officer delegations are detailed at Appendix 2.

2.3 In terms of Executive Members, the Scrutiny Board's role encompasses the areas of responsibility assigned to Cllr Rebecca Charlwood, 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.

2.4 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 19 May 2016.

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.

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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; and

    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.

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The Director of Adult Social Services is authorised[1] to discharge the following functions[2] through the commissioning and provision of services to support adults[3]

1) **Promotion of well-being including:-**
   a) Integration and personalisation of health and social care services across the city for the benefit and health and well-being of Leeds citizens;
   b) Promotion of the principle of well-being; and
   c) Consideration of supplier lead service innovation.

2) **Information, advice and advocacy including:-**
   a) Provision of information about available services;
   b) Provision of advice to potential service users; and
   c) Arrangement of independent advocacy to support participation in, or understanding of, the care and support system.

3) **Prevention and Recovery:-**
   To take steps to prevent, reduce or delay the need for care and support for all people including:-
   a) Preventative Services:-
      i) Provision or arrangement of community and home based services to adults with less intensive needs; and
   b) Re-Ablement Services:-
      i) Provision or arrangement of early intervention time-limited services to meet the immediate requirements of adults with short-term social care needs.

4) **Safeguarding including:-**
   a) Co-ordination of multiagency arrangements to ensure that resources are deployed in safeguarding vulnerable adults;
   b) Delivery of safeguarding training; and
   c) To promote and enable identification of and appropriate action for vulnerable adults at risk of abuse or neglect.

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[1] Save where the Leader or the relevant Portfolio Holder has directed or the Director considers that the matter should be referred to Executive Board for consideration.
[2] Together with similar and ancillary functions which have not been delegated to another Director.
[3] "Adults" includes any vulnerable person over the age of 18; whether vulnerable by reasons of mental health problems, learning disabilities, physical or sensory impairment, because they are older people or because they are carers.

5) **Assessment and eligibility**
   a) Assessment, support planning and review including:-
      i) Assessment of adults who appear to need care and support;
      ii) Identification of outcomes within the care and planning process that will establish the cornerstone of the subsequent support plan;
      iii) Provision of a Personal Budget for persons with eligible needs;
      iv) Co-ordination, management and review of care and support arrangements to meet eligible needs;
      v) Assessment of social care needs of carers; and
      vi) Arrangement and funding of services to meet the care and support needs of adults who are detained in prison or who are resident in approved premises; and
   b) Self-Directed Care
      i) Provision of assistance to adults to self-direct their support (including assistance with direct payments, individual service funds and trust funds).

6) **Diverse and High Quality Services**
   To commission or provide[4] directly care and support services that meet people's needs including:-
   a) Support to live at home:-
      i) Supported and other accommodation, including extra-care;
      ii) Assistance to enable access to other accommodation, including extra-care;
      iii) Equipment and adaptations;
      iv) Home care and community meals services;
      v) Day support and care services;
      vi) Short breaks;
      vii) Community alarm service and assistive technology;
      viii) Carers services; and
      ix) *Shared Lives* service;
   b) Residential and Nursing Care:-
      i) Residential placements, including specialist provision for people with mental health needs and dementia; and
      ii) Nursing placements, including specialist provision for people with dementia.

7) **Charging and financial assessments including:-**
   a) To undertake financial assessment; and
   b) Provision of deferred payments.

[4] Including arrangements to ensure continuity of care in the event of provider failure

The Director of Public Health is authorised[1] to discharge the following functions[2]

1) **Commissioning of Public Health Services including:-**
   a) Sexual Health Services (Mandatory);
   b) NHS Health Check Assessments (Mandatory);
   c) National Child Measurement Programme (Mandatory);
   d) Smoking Cessation Services;
   e) Weight Management Services;
   f) Mental Health Services;
   g) Alcohol and Drug Misuse Services;
   h) Healthy Child Programme (5-19);
   i) Health Visiting and Family Nurse Partnerships (0-5);
   j) Nutrition;
   k) Physical Activity;
   l) Oral Health; and
   m) Accident and Injury Prevention.

2) **Promotion of Health and Wellbeing including:-**
   a) Development and Implementation of Programmes and Campaigns including:-
      i) Cancer and Long Term Conditions Prevention;
      ii) Accidental Injury Prevention;
      iii) Workplace Health;
      iv) Seasonal Mortality;
      v) Seasonal Exclusion;
      vi) Best Start;
      vii) Behaviours and Lifestyles; and
      viii) Wider Determinants of Health.

3) **Health Protection including:-**
   a) Communicable and Infectious Disease Control;
   b) Vaccination and Immunisation Programmes;
   c) Oversight of National Screening Programmes including:-
      i) NHS screening programmes, both cancer and non-cancer; and
      ii) ante-natal and children's screening programmes;
   d) Emergency Planning Resilience;
   e) Response to Environmental hazards which include:-
      i) Air quality; and
      ii) Severe weather; and
   f) Assessment of risks posed by violent and sexual offenders.

4) **Public Health advice including:-**
   a) Provision of advice to the three Leeds Clinical Commissioning Groups (Mandatory).

[1] Save where the Leader or the relevant Portfolio Holder has directed or the Director considers that the matter should be referred to Executive Board for consideration.
[2] Together with similar and ancillary functions which have not been delegated to another Director.

5) **Functions of Responsible Authority including:-**
   a) Responses under the Licensing Act 2003, e.g. making representations about licensing applications.

6) **Publication of the annual report on the health of the local population[3].**

[3] In accordance with The National Health Service Act 2006 section 73B(5) the Director of Public Health must prepare this report (this responsibility is reflected in Article 12) and section 73B(6) the local authority must publish it.

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: 28 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'.

3.6 In considering the appointment of co-opted members, Scrutiny Boards should be satisfied that a co-opted member can use their specialist skill or knowledge to add value to the work of the Scrutiny Board. However, co-opted members should not be seen as a replacement to professional advice from officers.

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

3.8 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.

3.9 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

3.10 Historically, Scrutiny Boards that have considered issues across health and adult social care have tended to operate with standing co-opted members. Predominantly, such appointments have tended to include those groups / bodies representing the voice of patient and/or service user.

3.11 Following the formal establishment of Health Watch Leeds and after a period of consolidation, in 2014/15 the Scrutiny Board appointed a standing non-voting co-opted member representative from Healthwatch Leeds. Similar arrangements were in place for 2015/16 and the general consensus would suggest these arrangements have worked well; with the overarching aim being 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.

3.12 Initial discussions would further suggest that if invited to do so, HealthWatch Leeds would welcome similar arrangements for the municipal year 2016/17.

3.13 It should also be noted this approach would not preclude the appointment of any further co-opted members, within the overall provision provided by the Council's Constitution (described above).

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: 247 4707

Report of Head of Scrutiny and Member Development

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

Date: 28 June 2016

Subject: Chairs Update – June 2016

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

1 Purpose of this report

1.1 The purpose of this report is to provide an opportunity to formally outline some of the areas of work and activity of the Chair of the Scrutiny Board since the appointment by Council on 19 May 2016.

2 Main issues

2.1 Invariably, scrutiny activity can often takes place outside of the formal monthly Scrutiny Board meetings. Such activity may involve a variety of activities and can involve specific activity and actions of the Chair of the Scrutiny Board.

2.2 In 2015/16, the Chair of the Scrutiny Board established a system whereby all members of the Scrutiny Board were formally advised of the Chairs activities between the monthly meeting cycles.

2.3 As such, the purpose of this report is to provide an opportunity to formally update the Scrutiny Board on such activity and actions, including any specific outcomes, since the Chair's appointment by Council on 19 May 2016. It also provides an opportunity for members of the Scrutiny Board to identify and agree any further scrutiny activity that may be necessary.

2.4 The Chair and Principal Scrutiny Adviser will provide a verbal update at the meeting, as required.

3

3. Recommendations

3.1 Members are asked to:

a) Note the content of this report and the verbal update provided at the meeting.
b) Identify any specific matters that may require further scrutiny input/ activity.

4. Background papers[1]

4.1 None used

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

Report author: Steven Courtney
Tel: 247 4707

Report of Head of Scrutiny and Member Development

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

Date: 28 June 2016

Subject: Leeds Community Healthcare NHS Trust – response to Scrutiny Board Statement and recommendations

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

1 Purpose of this report

1.1 The purpose of this report is to present to Leeds Community Healthcare NHS Trust's formal response to the Scrutiny Board's report and recommendations relating to the Scrutiny Board Statement – '*Response to Leeds Community Healthcare NHS Trust Proposed Service Location Changes'.*

2 Main issues

2.1 In August 2015, Leeds Community Healthcare NHS Trust commenced a formal public consultation around a number of proposed changes to its service locations. The public consultation ran until 5 November 2015.

2.2 The proposed changes were presented to a meeting of the Health Service Developments Working Group (a working group of the Scrutiny Board (Adult Social Services, Public Health, NHS) on 16 October 2015. Representatives from Leeds Community Healthcare NHS Trust and NHS Leeds South and East Clinical Commissioning Group were in attendance.

2.3 A summary of the discussion from the Working Group was prepared, although a formal consultation response was not submitted before the end of the public consultation.

2.4 As part of its consultation work, LCH involved and advised local ward members where the proposed changes may have had an impact in their locality. It should be noted that while the proposed changes affected a number of different areas across

the City, members of the working group only received representation from Garforth and Swillington ward members, regarding the proposed closure and relocation of all existing services from Garforth Clinic.

2.5 At its meeting in February 2016, the Scrutiny Board considered a draft response that not only provided comments on the overall proposals, but also reflected the representations made by local ward members. Prior to concluding and agree the final report and recommendations, a draft was shared with Leeds Community Healthcare NHS Trust for both factually accuracy and for initial comments on the draft recommendations. The comments received from Leeds Community Healthcare NHS Trust were considered and discussed at the Scrutiny Board meeting held on 16 February 2016, where the final report and recommendations were agreed.

2.6 The final report is available on request; however for ease of reference, the following recommendations were agreed:

Recommendation 1

That by September 2016, Leeds Community Healthcare NHS Trust, in conjunction with service commissioners, sets out its long-term vision and 'master plan' for community health services in Leeds; detailing any proposed service changes and any associated arrangements for patient and public involvement.

Recommendation 2

That as part of any future decision-making processes around NHS service changes and/or developments, all NHS commissioners and providers include a 'You said, we did' section, in order to explicitly demonstrate the impact of the patient and public involvement, engagement and consultation.

Recommendation 3

That by June 2016, Leeds Community Healthcare NHS Trust provides a further report to the Scrutiny Board, setting out the detailed actions and outcomes arising from the additional recommendations identified by the Trust Board at its meeting in December 2015.

Recommendation 4

(a) That as part of any future decision-making processes, all NHS commissioners and providers in Leeds consider the potential implications for physical assets (i.e. buildings) and engage with the appropriate NHS agencies much earlier in the process to discuss and consider the implications and potential solutions.

(b) That all NHS commissioners and providers in Leeds detail the potential implications and solutions as part of the patient and public involvement, engagement and consultation processes.

2.7 The final report and recommendations were subsequently shared with Leeds Community Healthcare NHS Trust and a formal response requested

2.8 The formal response has been received and is appended to the report for consideration; and appropriate representatives from Leeds Community Heathcare

NHS Trust have been invited to the meeting to present the response and address any queries raised by the Scrutiny Board.

3. Recommendations

a) Members are asked to consider the attached response from Leeds Community Healthcare NHS Trust and identify any specific scrutiny activity that may now be required.

4. Background papers[1]

4.1 None used

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

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Leeds Community Healthcare NHS
NHS Trust

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Councillor Gruen
Chair, Scrutiny Board
(Adult Social Services, Public Health, NHS)
Leeds City Council
3rd Floor East
Civic Hall
LEEDS
LS1 1UR

5 May 2016

Dear Cllr Gruen

Re: Service relocation changes – response to final report

Thank you for giving us the opportunity to respond to Scrutiny's final report and recommendations on Leeds Community Healthcare Trust's service location changes. We have used this additional opportunity to liaise with CCG and provider partners to build on our previous response and to acknowledge the changes in the final report.

As you will be aware since this report was published there has been considerable public concern regarding the closure of Garforth clinic. We were recently asked by the local community to attend a public meeting to discuss the closure, however due to the pre-election period and the guidance for NHS organisations we were unfortunately unable to participate. We are committed to attending a public meeting outside of the pre-election period and were open to all public invitations during our 12 week engagement period. We have received the questions and issues raised and will be responding to these, along with our CCG colleagues.

We always want to engage meaningfully with patients, carers and the local population about the services we provide and we have continued to actively engage with the people affected by the changes in Garforth.

Recommendation 1

As previously indicated some key pieces of work are underway which will help determine how community services are delivered in the future;

- The seven main commissioners and providers in Leeds are already working together on the Sustainability and Transformation Plan (STP), with particular focus on the Leeds and localities footprint. There is a joint agreement that all long-term visions for services will be developed in line with the STP, which has local community services at its heart.

- The city-wide strategy for estates is also currently being developed to support the STP. Alongside this LCH is looking at its estate strategy ensuring we continue to make best use of our estate within financial constraints and our desire to provide the best possible and most accessible community services across the whole of Leeds.

By September we will be in a position to provide an update on the future model of community services. It is unlikely that fully developed plans will be complete by this time.

We are committed to working proactively with Scrutiny to ensure members have early sight of any proposed changes and are actively engaged on these as well as the approach to patient and public involvement. As previously discussed this may lend itself more to utilising the time of the Scrutiny Health Developments Working Group.

Recommendation 2

All providers and commissioners are committed to on-going meaningful patient, carer and public engagement. Commissioners require all providers to carry out robust engagement on any plans and proposals which impact on patients and the public, including a 'you said, we did'. The CCGs are satisfied that this was undertaken by LCH with regard to the engagement on recent service locations. The CCG's also ensure that the same approach is undertaken when carrying out their own engagement.

Feedback from people involved tells us that equally important as 'you said…we did' is 'you said…we didn't and why'. This demonstrates to them that we have not only listened and responded to what we 'wanted or expected to hear' but that we have given due consideration and responded to things that we have not been able to change. This includes what alternatives we have put in place to address the issues raised. This formed part of our final report to our Board detailing all the comments we received during the engagement period and our responses to them.

Recommendation 3

In June, we will provide an update on the progress to date including action to minimise impact, evaluation of the impact of changes and analysis of ongoing feedback and community engagement.

The full evaluation, as previously identified, will be available in August to ensure full consideration of the cycles of patient appointments. This will be shared with Scrutiny and reported back to Healthwatch Board as we agreed with them during our engagement.

We continue to actively engage with the people affected by the changes ensuring they know how to access services and to address any concerns or issues they may have.

Recommendation 4a

A thorough analysis is being carried out of the estate across all commissioners and providers as part of the STP. This analysis includes assessing the size, function and

costs of buildings and looks at how better use could be made of premises across the city. We recognise that this joint work to understand synergies and ensure potential solutions are considered at the earliest stage has not always taken place in the past.

In addition to this there are set NHS property regulations and guidance for disposing of the estate.

We look to explore this recommendation further when we report to Scrutiny as above.

Recommendation 4b

This is always our intended approach when carrying out major engagement with patients, carers and the public. We would expect to discuss our engagement plans with stakeholders including Scrutiny Board before we implement them.

We also attach a summary document detailing this response along with our previous response.

Yours sincerely

Thea Stein
Chief Executive
Leeds Community Healthcare NHS Trust

cc Steven Courtney, Principal Scrutiny Advisor

Enc.

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Leeds Community Healthcare Responses to Scrutiny Report

Rec	Draft recommendation	Response to draft	Commentary from Scrutiny response	Final recommendation	Proposed response
1	That by July 2016, Leeds Community Healthcare NHS Trust, in conjunction with service commissioners, sets out its long-term vision and 'master plan' for community services in Leeds; detailing any proposed service changes and any associated arrangements for patient and public involvement	Unfortunately we will not be able to meet the requirements of this recommendation within the timescales proposed. We are sorry for this. We are in the process of reviewing our estates strategy which will determine how our estate will support service provision going forward and this is linked to the estate strategy across the city. The vision for community services is also a wider system responsibility and will be part of the Sustainability and Transformation Plan that the city needs to be developed by June 2016. This is under the auspices of the Health and Wellbeing Board. We would be happy to update on issues involving our services and estates in the Autumn this year - and to do this alongside other providers in the city as it is connected. We have no service or building changes planned currently but continue to look to make best use of our estate.	In considering the response from Leeds Community Healthcare NHS Trust to the draft report, the Scrutiny Board acknowledges the comments made and the potential need for the input of other partners. However, the Scrutiny Board wishes to re-emphasise its role in representing patients, the public and the local communities of Leeds. As such, the Scrutiny Board believes it is vitally important to produce a long-term vision and 'master plan' for community health services in Leeds – irrespective of whether or not this requires co-production with other partners across Leeds' Health and Social Care economy. The role of the Scrutiny Board is often described as being 'a critical friend' – challenging NHS commissioners and providers regarding local health care services. Therefore, whilst recognising the national requirements to prepare a Sustainability and Transformational Plan (STP) by June 2016, the Scrutiny Board does not believe the STP and a master plan for	That by September 2016, Leeds Community Healthcare NHS Trust, in conjunction with service commissioners, sets out its long-term vision and 'master plan' for community health services in Leeds; detailing any proposed service changes and any associated arrangements for patient and public involvement.	As previously indicated some key pieces of work are underway which will help determine how community services are delivered in the future; • The seven main commissioners and providers in Leeds are already working together on the Sustainability and Transformation Plan (STP), with particular focus on the Leeds and localities footprint. There is a joint agreement that all long-term visions for services will be developed in line with the STP, which has local community services at its heart. • The city-wide strategy for estates is also currently being developed to support the STP. Alongside this LCH is refreshing its estate strategy ensuring we continue to make best use of our estate within the context of the long-term vision for community health estates. By September we will be in a position to provide a more detailed picture of how community services are delivered in the future. It is unlikely that fully developed plans will be complete by this time. We are committed to working proactively with Scrutiny to ensure members have early sight of any proposed changes and are actively engaged on these as well as the approach to patient and

Rec	Draft recommendation	Response to draft	Commentary from Scrutiny response	Final recommendation	Proposed response
			community health services are mutually exclusive and that by seeking to develop such a master plan will not only help close the three gaps across the health and care system highlighted in the 5-Year Forward View (i.e. health and wellbeing, care and quality, and finance and efficiency) but may also help facilitate access to additional resources to help deliver the local STP. As such, the Scrutiny Board wishes to retain its first recommendation, albeit with a slightly extended timeframe		public involvement. As previously discussed this may lend itself more to utilising the time of the Scrutiny Health Developments Working Group
2	That as part of any future decision-making processes around NHS service changes and/or developments, all NHS commissioners and providers include a 'You said, we did' section, in order to explicitly demonstrate the impact of the patient and public involvement, engagement and consultation	We agree with this recommendation and within the engagement report we did set out the key themes from the engagement and what we plan to do to mitigate these issues in order that people can see the direct action. Some modifications were also made to the proposals where concerns were not able to be mitigated successfully, e.g. in Rothwell, where we have created a new Adult Nutrition and Dietetics clinic in Rothwell Health Centre that means patients previously seen in GP clinics there will continue to be seen in the area, but without having a negative impact on improvements made through these proposals to		That as part of any future decision-making processes around NHS service changes and/or developments, all NHS commissioners and providers include a 'You said, we did' section, in order to explicitly demonstrate the impact of the patient and public involvement, engagement and consultation.	All providers and commissioners are committed to on-going meaningful patient, carer and public engagement. Commissioners require all providers to carry out robust engagement on any plans and proposals which impact on patients and the public, including a 'you said…we did'. The CCGs are satisfied that this was undertaken by LCH with regard to the engagement on recent service locations. The CCG's also ensure that the same approach if undertaken when carrying out their own engagement. Feedback from people involved tells us that equally important as 'you said…we did' is 'you said…we didn't and why'. This demonstrates to them that we have not only listened and

Rec	Draft recommendation	Response to draft	Commentary from Scrutiny response	Final recommendation	Proposed response
		access (number of appointments). We are committed to minimising the impact of these changes on people and are monitoring this closely. We are happy to provide an update to Scrutiny but suggest this is in August			responded to what we 'wanted or expected to hear' but that we have given due consideration and responded to things that we have not been able to change. This includes what alternatives we have put in place to address the issues raised.
3	That by June 2016, Leeds Community Healthcare NHS Trust provides a further report to the Scrutiny Board, setting out the detailed actions and outcomes arising from the additional recommendations identified by the Trust Board at its meeting in December 2014	which will be six months from implementation. For services, such as podiatry, where patients often have three-monthly appointments this will enable us to provide a clearer analysis of patients attending a new location the first time and continuing to attend at a future appointment		That by June 2016, Leeds Community Healthcare NHS Trust provides a further report to the Scrutiny Board, setting out the detailed actions and outcomes arising from the additional recommendations identified by the Trust Board at its meeting in December 2015.	In June, we will provide an update on the progress to date including action to minimise impact, evaluation of the impact of changes and analysis of ongoing feedback and community engagement. The full evaluation, as previously identified, will be available in August to ensure full consideration of the cycles of patient appointments. This will be shared with Scrutiny and reported back to Healthwatch Board as we agreed with them during our engagement. We continue to actively engage with the people affected by the changes ensuring they know how to access services and to address any concerns or issues they may have.
4a	That as part of any future decision-making processes, all NHS commissioners and providers in Leeds consider the potential implications for physical assets	We appreciate the point you raise here about future plans for the estate and hopefully the citywide estates plan will support this. As you are aware there are set NHS property regulations and guidance for disposing of estate that all organisations follow. We would be happy to explore this further with citywide partners going		That as part of any future decision-making processes, all NHS commissioners and providers in Leeds consider the potential implications for physical assets (i.e. buildings) and engage with the appropriate NHS	A thorough analysis is being carried out of the estate across all commissioners and providers as part of the STP. This analysis includes assessing the size, function and costs of buildings and looks at how better use could be made of premises across the city. We recognise that this joint work to understand synergies and ensure potential solutions are considered at

Rec	Draft recommendation	Response to draft	Commentary from Scrutiny response	Final recommendation	Proposed response
	(i.e. buildings) and engage with the appropriate NHS agencies much earlier in the process to discuss and consider the implications and potential solutions.	forward		agencies much earlier in the process to discuss and consider the implications and potential solutions	the earliest stage has not always taken place in the past. In addition to this there are set NHS property regulations and guidance for disposing of the estate. We look to explore this recommendation further when we report to Scrutiny as above.
4b	That all NHS commissioners and providers in Leeds detail the potential implications and solutions as part of the patient and public involvement, engagement and consultation processes.			That all NHS commissioners and providers in Leeds detail the potential implications and solutions as part of the patient and public involvement, engagement and consultation processes.	This is always our intended approach when carrying out major engagement with patients, carers and the public. We would expect to discuss our engagement plans with stakeholders including Scrutiny Board before we implement them

Report author: Steven Courtney

Tel: 247 4707

Report of Head of Scrutiny and Member Development

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

Date: 28 June 2016

Subject: Donisthorpe Hall – update

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

1 Purpose of this report

1.1 The purpose of this report is to provide a progress update in relation to the .

2 Main issues

2.1 In May 2016, following an inspection in March 2016, the Care Quality Commission published its report and found Donisthorpe Hall to be inadequate. A previous CQC inspection report had been published in November 2015 and had also found services to be inadequate.

2.2 To ensure the Scrutiny Board was aware of the issues and the processes in place to help address the identified issues, the Chair of the Scrutiny Board requested an update: This is provided at Appendix 1.

2.3 To further assist the Scrutiny Board, the May 2016 CQC inspection report is also appended to this report.

3. Recommendations

Members are asked to consider the information presented and identify any specific scrutiny activity that may now be required.

4. Background papers[1]

[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

4.1 None used

published works.

Leeds CITY COUNCIL

Adult Social Care Services

BRIEFING PAPER

ADULT COMMISSIONING BRIEFING NOTE	DATE: 14th June 2016
SUBJECT: **Donisthorpe Hall Nursing Home**	

PURPOSE: To provide an update to the Scrutiny Board on Donisthorpe Hall Nursing Home following their recent CQC rating of Inadequate.

BACKGROUND INFORMATION:

Donisthorpe Hall is a residential and nursing home run by the charity Donisthorpe Hall Management Committee through a Board of Trustees. The home is based in Moortown , has 189 beds and mainly caters for the Jewish community in the city.

Donisthorpe Hall has been part of the Council's residential and nursing framework contract since 2012 and for the first few years of the contract were an 'Enhanced Home' (as defined by the LCC Quality Framework), providing very good quality care. ASC Contracts team first started to notice problems in the quality of care being provided early in 2015, this was following the departure of most of the senior management team at the home. In March 2015, ASC withdrew the enhanced status of the home. Following further contract visits and a CQC inspection ASC suspended further admissions to the home in August 2015. CQC published their inspection report in November 2015 and awarded the home an inadequate rating. Since this time the home have attempted to address the issues however, this has proved unsuccessful and in May 2016, the CQC published their report following an inspection in March and again found Donisthorpe Hall to be inadequate.

Main issues:

During April 2016, the Trustees of the Management Board recognised the need for additional support to be able to address the issues and rectify the situation at the home. Following discussions with a number of providers the Trustees selected a national provider, BAM Healthcare, to provide support to the management of the home. BAM provide a range of consultancy and management services to Social Care and NHS organisations throughout the country and run a number of care homes in England and Scotland through their care home company; Silverline Care. BAM were also involved in the negotiations and restructuring when the Southern Cross failure occurred. Since being appointed, BAM have put in place a detailed 100 day plan of priorities which picks up the issues from the ASC/CCG monitoring visits and CQC inspections which include staffing, safeguarding, care planning, training and care delivery.

Officers from ASC contracts, together with colleagues from safeguarding and the CCG met with the consultant from BAM and the home manager on the 14th June 2016 to discuss progress against the 100 day plan which is now halfway through the plan period. BAM have reported (with evidence) the following progress against their plan:

- 3 new care managers have been appointed and a further appointment is currently being recruited for each of the units at the home. Each care manager is a qualified nurse.
- All the care managers are being supported by the senior leadership team and BAM have

brought in a management coach to provide additional support for the team.

- A dedicated night manager is also being recruited.
- The home has completed dependency audits for each resident and identified high dependency levels and staffing required.
- The home is now fully staffed and have commissioned a single staffing agency to ensure consistency of agency staff which may be required.
- Supervisions have now started for all staff. Training requirements are being identified and the training is now being embedded with the staff.
- BAM have identified issues with the care planning system and are making a request to the Trustees to change the system.
- The home are now up-to-date with all their DoLS assessment requests.
- A new electronic safeguarding process has now been introduced which is fit for purpose together with a new complaints and falls process.
- A weekly senior management team meeting now takes place and the care managers are required to report into this through a new audit tool developed by BAM.
- The manager and BAM hold regular meetings with the Trustees to update on progress and the Trustees have now withdrawn from the operational running of the home.
- The management team has now dealt with various HR issues which were affecting moral at the home.

The home management, with support of BAM, has made significant progress against their plan in a relatively short space of time and continues to show improvements across the home. The CCG have reported from a recent monitoring visit that both staff and residents were very positive about the care being provided at the home, which has not been the case over the last year. BAM have confirmed that they will not take any new residents until they are fully sure improvements at the home have been embedded and are being maintained.

ASC and the CCG will continue to closely monitor progress at the home.

CONCLUSIONS & RECOMMENDATIONS:

Scrutiny members are asked to note the content of this briefing.

Care Quality Commission

Donisthorpe Hall

Donisthorpe Hall

Inspection report

Donisthorpe Hall
Shadwell Lane
Leeds
West Yorkshire
LS17 6AW

Tel: 01132684248
Website: www.donisthorpehall.org

Date of inspection visit:
14 March 2016
17 March 2016
21 March 2016

Date of publication:
16 May 2016

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 14, 17 and 21 March 2016 and was unannounced. At the previous inspection in June 2015 we found seven breaches in regulations which related to safe care and treatment, staffing, person centred care, quality assurance, safeguarding people from abuse, consent to care and notification of significant events. We rated the service as inadequate. At this inspection we found the provider was still in breach of six of the same regulations. We found the provider had made improvements in one area and was safeguarding people from abuse.

Donisthorpe Hall provides residential, nursing and dementia care for a maximum of 189 residents. Care is provided in six specialist units. The management team told us there were 127 people using the service when we inspected. The home has a longstanding association with the Jewish community in Leeds but also offers care to people of other faiths or beliefs. At the time of the inspection, the service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

People told us they felt safe but we found they were not protected from risks associated with unsafe or inappropriate care. People told us there were not enough staff and we observed sometimes people did not receive care in a timely way. The service used a high number of agency staff which resulted in people regularly being cared for by staff they did not know. People using the service were not protected against the risks associated with the administration, use and management of medicines.

Staff did not always receive appropriate training and support although the provider had introduced more training opportunities and was supporting all care staff to complete the 'care certificate' which is an identified set of standards that health and social care workers adhere to in their daily working life. Some senior care workers and managers were undertaking management training. Staff did not understand what they must do to comply with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, and did not act within the law. The provider had effective recruitment and selection procedures in place.

People told us they received appropriate care. However, there was a lack of consistency in how people's care was assessed, planned and delivered. There was not always enough information to guide staff on people's care and support. Some people's health and well-being needed to be closely monitored but we found this was not being done properly. People's care records showed they had accessed a range of health professionals.

People lived in a pleasant and well maintained environment. They enjoyed the food and were offered a choice of meals. Drinks and snacks were offered to people throughout the day. People also enjoyed the range of social activities provided at the home and in the local and wider community.

The service was disorganised. The provider's systems to monitor and assess the quality of service provision were not effective. Actions that had been identified to improve the service were not always implemented. Information was displayed about how people could make formal complaints but some people were unsure who to talk to if they wanted to discuss concerns.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

There was a lack of consistency in how risk was managed. People were not protected against the risks associated with the unsafe management of medicines.

There was not sufficient skilled and competent staff being deployed to meet people's needs.

People were safeguarded from abuse. Safeguarding incidents were reported to the relevant agencies.

Is the service effective?

Inadequate

The service was not effective.

Staff were not always appropriately trained and supported so people may be cared for by staff who do not have the right skills and knowledge.

Key requirements of the Mental Capacity Act 2005 were not fully understood.

People enjoyed the food and were offered a choice of meals. Drinks and snacks were offered to people throughout the day.

Is the service caring?

Requires Improvement

The service was not always caring.

People were complimentary about the staff and told us they were satisfied with the care they received.

We saw people looked well dressed and cared for.

Some people's care records did not have information about their history so they might receive care from staff who do not know or understand them.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

There was a lack of consistency in how well people's needs were assessed and their care and support was planned.

People enjoyed a range of social activities.

Information was displayed about how people could make formal complaints but some people were unsure who to talk to if they wanted to discuss concerns.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of consistency in how the service was managed.

The systems in place to monitor the quality of service provision were not effective. Actions to improve the service were sometimes identified but then not followed up.

The provider did not take appropriate action following the last CQC inspection. The provider failed to notify CQC about important events that had occurred in the service.

Care Quality Commission

Donisthorpe Hall

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place over three days on 14, 17 and 21 March 2016. Day one and two were unannounced and day three was announced so we could meet members of the management team to provide feedback about our inspection findings. On day one, six adult social care inspectors, an inspection manager, a pharmacist inspector and a specialist advisor in governance attended. On day two, two adult social care inspectors, an inspection manager and a specialist advisor in governance attended. On day three, an adult social care inspector and a specialist advisor in governance attended.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed all the information we held about the service. This included statutory notifications that had been sent to us by the home, information that was shared by the local safeguarding authority, the local authority, other professionals and relatives. We contacted Healthwatch who is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

At the time of this inspection there were 127 people using the service. We spoke with 18 people who used the service, 11 relatives, 21 staff, including care workers, ancillary workers, nurses, care managers, activity workers, the registered manager, chief operating officer, operations manager, estates manager and head of human resources. We observed how care and support was provided to people. We looked at documents and records that related to people's care, and the management of the home such as rotas, staff recruitment and training records, policies and procedures, quality audits and medicines records. We looked at 14 people's care records.

Inadequate

Is the service safe?

Our findings

At the previous inspection in June 2015 we found breaches in regulation relating to safe care and treatment because the provider did not have systems for the proper and safe management of medicines and they were not doing all that was reasonable to mitigate risk. They did not have enough competent staff to meet people's needs. At this inspection we found similar concerns. At the previous inspection in June 2015 we found the provider was not safeguarding people from abuse. At this inspection we found they had made improvements in this area.

We looked at how the provider managed medicines and found they did not do this safely. Electronic medicines administration records (MARs) were in use. On the day of the inspection there was limited access to these. We could only view three people's MARs so we asked the home to provide further examples for us to review. The home printed 27 MARs and we reviewed 16 of them.

We looked at three (MARs) and spoke with the nurses responsible for medicines on the Maple unit. Medicines were stored securely in a locked treatment room and access was restricted to authorised staff. Controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were appropriate arrangements in place for the management of controlled drugs, however, stock balance checks had not been carried out regularly. The medicines management policy stated this should be done weekly and this was confirmed by the nurse on duty, but we saw one medicine had not been checked since 22 February 2016.

We checked medicines which required cold storage and found records were not always completed in accordance with the National Institute for Health and Care Excellence (NICE) guidance, 'Managing medicines in care homes guideline (March 2014)'. We saw only four temperature records had been completed out of a possible 14 in March 2016. During our visit the fridge thermometer showed the temperature exceeded the safe range and on two other occasions the temperature had been recorded as over the normal range and no action had been recorded. We asked the unit manager who was unaware there had been a problem with the fridge. This meant we could not be sure that medicines requiring refrigeration were safe to use.

Records indicated temperatures in the treatment room used to store medicines on the downstairs unit were consistently higher than the recommended maximum during January and February 2016.

Nurses recorded administrations on laptops during the medicines round using a barcode scanning system. We were concerned about how long the morning medicines round took on the Maple unit. Three people who were prescribed medicines at 9:00am did not receive them until at 11:41am, 12:06pm and 12:42pm, respectively.

Medicines were not always given as they had been prescribed. One person was prescribed a medicine used for thyroid problems which had been signed 'N' (offered, not required) on five days in February 2016. We checked medication notes and the electronic care notes but there was no entry to explain why the medicine

had not been given. Missing this medicine regularly could have caused the person to become unwell. The dose of this medicine was increased following a visit by the doctor, however, it took five days for the increased dose to be administered. On one day the person had been given both the lower and the increased dose because the old dose had not been deleted from the MAR. This meant they had been given almost double the dose prescribed. The same person had been prescribed a medicine to lower cholesterol which had been signed 'N' on six occasions in February 2016. Again, we checked medication notes and the electronic care notes but there was no entry to explain why the medicine had not been given. In addition, the person was prescribed a medicine for epilepsy which had been signed 'N' on three occasions in February 2016. There was no entry in the medication or care notes to explain why this had not been given. Missing medicines for epilepsy could increase the risk of the person having a seizure.

One person was self-administering their medicines; we checked their records and asked staff and found an assessment had not been completed to assess their capability to look after their own medicines. Staff did not check or keep records of whether medicines had been taken as prescribed. The person told us they never took one of their medicines which was unopened in their room, and staff had not attempted to inform the doctor the person was not taking it.

A third person was prescribed a strong pain relief patch which should have been applied once-weekly. We found this had been signed as 'N' on two occasions, however, the controlled drugs register confirmed the patch had been applied correctly. This meant the MAR did not accurately reflect the medicines which had been given. The patch was due to be applied on 12 March 2016, and again the MAR had been signed 'N'. On this occasion the controlled drugs register showed the patch had not been applied. We counted the number of remaining patches which confirmed it had not been changed. This meant the person may have experienced significant pain. We asked to see records relating to pain scores, but we were told this had not been recorded. This meant staff were not routinely checking whether the person was experiencing any pain which could have resulted in significant distress.

Similar concerns found on the day of the inspection were evident with the 16 MARs we reviewed. Seven people did not receive their medicine as prescribed by their doctor as the home had run out of stock; one of which was a heart medicine and another person's medicine for diabetes. Paracetamol was given too early for four people as the minimum time interval between doses was less than four hours. One person who was taking a blood pressure medicine that should have been given once a day in the morning was given a dose at midnight on one day and then another dose on the following morning medicines round which would have been over the recommended daily dose.

We concluded the registered person was not managing medicines safely. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We looked at how the provider was assessing and managing risk, and found there was a lack of consistency in how this was done. Some systems were in place to help keep people safe; however, other systems were not effective so people were not protected.

People had assessments and care plans that should identify areas of risk and action to help keep them safe; we found these were not always effective. For example, one person was assessed as 'severely underweight' but when we looked at their records we saw appropriate action was not taken. Another person was given salad at lunch; their care assessment showed they were at risk of choking and should have been offered a 'soft fork mashable' diet. One person had fallen several times, and had sustained injuries but changes were not made to their assessment and care plan, which would have helped identify how to prevent repeat falls. We saw some examples where risk was managed effectively. Assessments, in one unit, contained key areas

of risk, such as bathing/showering, falls and pressure care, and had been reviewed regularly and updated where appropriate.

We looked at two people's care records which showed they sometimes got angry with others and displayed behaviours that challenged. They did not have assessments relating to their behaviour so the level of risk was not assessed and care plans did not contain information to guide staff.

All staff we spoke with said they would record and report accidents and incidents but when we looked at records we found this was not always happening. For example, there were ten incidents in one person's daily notes which included attacking staff but no incident forms had been completed. Another person had several falls but accidents forms had not always been completed. We concluded the registered person was not assessing the risks to the health and safety of service users and did not do all that was reasonable to mitigate risk. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

The provider had reintroduced an emergency evacuation system which was known as a 'traffic light system' (red, amber and green) to indicate the level of support people needed in the event of an emergency evacuation. This involved using colour indicators on people's bedroom doors. Staff we spoke with understood the indicators and could tell us what they would do in the event of a fire. In some units there was a listing which showed the name of people living on the unit along with their moving and handling needs which had been rated as red, amber, or green; whereas in other units, lists were not up to date and staff did not know where these were kept. The management team who was responsible for estates agreed to make sure the emergency evacuation lists were updated and readily available to ensure people's safety.

We visited all units and looked around some bedrooms, bath and shower rooms and various communal living spaces. People lived in a pleasant and well maintained environment. At the time of the inspection we saw the home being decorated and one of the decorators confirmed this was an on-going programme, which ensured the home's standard of décor was maintained. Service records and certificates showed the building and equipment were checked to make sure they were safe. A schedule was in place to make sure checks were kept up to date; this was rigorously adhered to and it was evident this aspect of the service was very well managed.

Some staff we spoke with had a good understanding of how to manage risk. For example, they described the hazards people may face when bathing or showering. They described risks due to poor mobility and what they did to prevent this; for example, making sure people had the right equipment and aids in place.

We found the provider did not have enough competent staff to meet people's needs. People told us they did not always feel there were sufficient staff to meet their care and support needs. These were some of the things they said, "I don't think there is enough staff as they seem to be run off their feet", "I have raised issues about the lack of staff at residents' meetings over the past couple of years", "Sometimes we have to wait a long time for staff, we are told there is a shortage", "Care is ok, just waiting on call bells. Think they are short staffed", "It's not easy waiting for someone to support you to the toilet. You feel like saying something you should not", "They are always changing staff. You never know who is coming to attend to you. They tell me they are from the agency, but I don't know them"; "There is a high turnover of staff. I don't think they are paying them enough to keep them", "The staffing is ridiculous. Sometimes you have to wait ages to be served your meal. The place is badly run. The buzzer could ring for half an hour. The staff are dissatisfied .This is a good place if you have dementia you don't know what's going on", "No there isn't enough staff, sometimes you are calling for staff and they take a long time", "No one helps me I always ring down for people to come and make my bed". Some people told us there were enough staff.

We found visiting relatives also had concerns about staffing levels. One relative told us, "We are always worried about staffing levels. Staffing problems are always raised at relatives and resident meetings." Another relative said, "A few weeks ago, [name of person] was told, sorry you had to wait but I was dealing with other people. My [name of person] was waiting a good 20 minutes before anyone came and they were getting distressed." Another relative said, "On weekends there are less staff than through the week. [Name of person] came to visit my mum and there was no staff in the dining room. Other people were in there sat at the table with their food and no one to support them."

During the inspection we observed some people received prompt responses when they requested assistance but we also saw occasions where people did not receive appropriate support because there were not enough skilled and experienced staff. In one unit two people should have received one to one staffing support but there were not enough staff on duty. The member of staff in charge told us, "The staff are over stretched. We have to prioritise. People have a sensor so staff are checking but they have to leave the room where they are supposed to be. The baseline is there is not enough staff." On another occasion, one person was in pain, so staff had to ask another member of staff to leave their training session so they could administer medication. On another occasion staff told us they were short of staff. They said ten out of the 17 people on the unit required assistance from two staff. One member of staff said they should have four care workers and one nurse on duty but at the time they only had three care workers and one nurse. On another occasion, one person had requested assistance because they wanted to go to the toilet. They had to wait, did not getting to the toilet in time, which resulted in them being incontinent. We looked at staffing rotas but it was very difficult establishing staffing levels. The rota system was confusing and different pieces of information gave a different picture. A member of the management team who was overseeing staffing arrangements told us this had been an ongoing problem so they had very recently decided to plan staffing centrally rather than at unit level. This had only just been introduced so was in the early stages. The information available indicated some units were appropriately staffed whereas other units were not. For example, over an 18 day period, we found one unit was not fully staffed on eight occasions during the day and on two occasions during the night.

We observed call bells were ringing. We were told response times were not generally monitored. One person's response times were investigated in response to a complaint and this showed areas of concern such as failure to respond in less than 12 minutes on three occasions and failure to respond until after one hour and 13 minutes on another occasion during a six day audit.

We got a mixed response when we spoke to staff about staffing arrangements. Some staff we spoke with told us they sometimes felt under pressure. One staff member said, "I don't think we get to call bells quick enough because they are always going off and there are not enough of us to go round." Another member of staff said, "One day there was just two staff on, last Saturday. It is hit and miss, the staffing. There are 10 people who need two to one care and there are times when we don't have two staff to help." Another member of staff said, "At times we use a lot of agency so they don't always respond as quick." Another member of staff spoke about agency usage and told us, "Compared to what it was, it's heaven." Two members of staff told us when they were staffed to the planned numbers they had sufficient staff to meet people's needs as long as everyone worked as part of the team and 'pulled their weight'. One of the members of staff said the nursing staff did not do this; they often refused to be part of the team and would not help with getting people up, washed or bathed.

Members of the management team told us the staffing levels were not safe and raised concerns about the high usage of agency staff. The registered manager said they were concerned that the agency were not able to provide the home with sufficiently skilled/experienced qualified nurses with the awareness and knowledge around dementia care. She said, "At times, the registered nurses only seem to have a PIN and a

pulse." We looked at records which showed in the month of February 2016 the ratio of qualified nurses was over 50%. Eight nurses were required to work during the day; some shifts were covered by permanent staff but others were covered with mainly agency staff; on one occasion seven out of eight staff were agency workers. The registered manager and provider had already taken action to address some of the difficulties by closing one of the units and were looking at other options to improve the overall staffing arrangements. We concluded there were not sufficient numbers of suitable staff deployed throughout the home. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

We found the provider had introduced better systems to help make sure people were safeguarded from abuse. Staff we spoke with understood safeguarding procedures and were clear they had to report any concerns to a member of the management team. They told us they had received safeguarding training. The provider had recently updated their safeguarding policy and had issued staff with leaflets and advice cards. We asked several members of staff about people's finances. They told us the systems in place safeguarded people because money was not held on any of the units, and people could purchase personal care items and food and drink from the café but did not have to pay for these at the time.

People we spoke with said they felt safe living at Donisthorpe Hall. These were some of the comments people made, "Yes I do feel safe, I know no one will come in and attack us or take our things", "Yes, no reason not to be", "Safe that's the only reason I am here", "Yes I like it here I feel safe in my home", One relative told us, "Yes [name of person] feels safe here."

We looked at care records and saw where safeguarding incidents had occurred appropriate action had been taken in response. The registered manager explained they had met as a management team and clarified what needed referring and reporting to the local safeguarding authority and CQC. Our records showed the provider had notified us when safeguarding incidents had occurred.

The home followed safe recruitment practices. We looked at staff and volunteer recruitment records and found relevant checks had been completed before staff had worked unsupervised at the home. We saw completed application forms, proof of identity, references and Disclosure and Barring Service (DBS) checks. The DBS is a national agency that holds information about criminal records. A member of the management team who oversaw staff recruitment showed us they periodically carried out DBS checks to make sure existing staff were still suitable. Another member of the management team who oversaw recruitment of volunteers said they DBS checked all volunteers when they commenced and were introducing a system to renew these for volunteers that had worked at the home for a prolonged period.

Inadequate

Is the service effective?

Our findings

At the previous inspection in June 2015 we found breaches in regulation relating to supporting staff and consenting to care. At this inspection we found similar concerns.

When the provider submitted the PIR in December 2015, they told us 171 staff delivered regulated activities at Donisthorpe Hall; this included providing personal care. They told us 147 staff had been employed for more than 12 weeks but only 77 members of staff had completed many of the key training sessions such as health and safety, safeguarding adults, dignity, respect and person centred care, food hygiene, prevention and infection control and emergency awareness. They said 144 staff had completed moving and handling. At the inspection we saw training records which indicated less than a third of staff had received some key training, however, it was difficult to establish if all training completed had been captured on the data we reviewed. The information provided to us indicated that less than a third of staff had completed fire training in the last 12 months. We spoke with a member of the management team who was responsible for facilitating fire training. They were confident all staff had received fire training within the last year and showed us records that evidenced a much higher percentage of staff had attended fire training than the figures we had been given at the start of the inspection; this included signed attendance records. The human resources manager said they could only input data on the central training system that was provided by care leads from each unit. We received some information about staff training but then additional information suggested this was incorrect.

We looked at the induction pack which was given to newly appointed staff and saw this was comprehensive and included essential information such as clear advice on whistleblowing and safeguarding. We saw the provider was supporting all care staff to complete the 'care certificate' which is an identified set of standards that health and social care workers adhere to in their daily working life. Staff who were appointed and had already achieved the care certificate were assessed to ensure they met the required standard. Several staff told us they had benefitted from doing the care certificate training. The provider was supporting some senior care workers and managers to undertake management training.

Supervision and appraisal records indicated staff were not receiving regular supervision and most staff had not been appraised in the last 12 months. Supervision is where staff attend regular, structured meetings with a supervisor to discuss their performance and are supported to do their job well.

We received a mixed response when we asked staff about staff support and it was evident staff were unclear who was responsible for carrying out supervisions and how often. Some staff said they had received regular supervision sessions; others said they had not. One member of staff who was in charge of a unit told us supervisions were held every three months. Another member of staff in charge of another unit and had worked at the home for six months stated supervision records were kept with the care management team and human resources did everyone's supervision. They said they had received one supervision session since starting with the home. A member of staff who had worked at the home for four months said, "I sat with the unit manager to see how things were going but this was not recorded. The first formal supervision was at the end of three months. I am expecting another at six months." A member of staff who had worked at the home

for four months said, "I have had moving and handling training. I had a mentor when I started and completed a week of shadowing. My probation was for three months but was extended to six months. This is done for everyone." Another member of staff said, "I have a chat once a week but not sure if this is recorded. I don't have supervision throughout the year. I have had an annual appraisal with human resources."

We were told the provider did not have a supervision policy or any guidance around the frequency of supervision. The head of human resources said a policy was being drafted. We saw a recruitment policy that stated staff should receive supervision after one month, two month and three month. We saw from the supervision records this was not being provided to new members of staff.

Two members of the care management team told us they had identified staff were not receiving regular supervision and had introduced a matrix to help ensure all staff received supervision every two months. We saw a copy of this which was due to commence at the beginning of April 2016. We concluded that staff were not receiving appropriate support, training, supervision and appraisal as was necessary to enable them perform their job safely and appropriately. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. (The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).) It was evident from discussions with staff and management, and reviewing documentation there was a lack of understanding of the legislation.

In the PIR the provider told us 31 people were subject to authorisation under DoLS. We looked at a spreadsheet which indicated only four people were subject to authorisation under DoLS. We asked the registered manager to confirm the actual number but they were unable to tell us this. We got a mixed response when we asked staff about people who were subject to authorisation under DoLS and it was evident they did not know. One senior care worker told us applications had been submitted to the local authority but were not yet authorised; we saw copies of these in people's care files. The senior care worker told us they had contacted the local authority to check on the status. However, there was no written evidence of these discussions. In another unit, the nurse in charge told us they were unsure if anyone was subject to authorisation under DoLS but said they had applied for one for 'everyone' which showed a lack of understanding regarding people's capacity. We saw a spreadsheet in the same unit that indicated two DoLS applications had been submitted in December 2015 and January 2016.

We looked at people's care records and found that sometimes mental capacity assessments were not completed even though a DoLS authorisation had been submitted. In one unit a senior care worker told us, "I would say everybody here does not have full mental capacity." However, when we looked at three care files on the same unit we found two people did not have appropriate mental capacity assessments; one person did not have an assessment and the other had an assessment but it referred to 'he' rather than she.

Staff we spoke with did not generally understand what they must do to comply with the MCA. One member of staff said, "I don't know, I am still learning. Most cannot communicate their needs and most are bed bound." Another member of staff in charge of one unit told us mental capacity assessments were kept in finance. One member of staff gave an overview of the MCA and could talk about how they assisted and encouraged people to make choices and decisions to enhance their capacity. For example, making sure

people were supported and given time to make decisions such as what to wear, what to do and what to eat and how they did this. They spoke about always making sure everything they did with people was in their best interests. A member of the management team who oversaw care planning and assessments told us they were involved in the MCA or DoLS processes because the registered manager oversaw this aspect.The training records we reviewed showed 49% of staff had completed DoLS training, and in the PIR the provider said 77 staff had completed MCA and DoLS training. We concluded that staff were not acting in accordance with the MCA. This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need to consent.

We saw drinks and snacks were offered to people throughout the day. People we spoke with said they mostly enjoyed the meals and always had plenty to eat and drink. Daily menus were displayed showing up to six choices per course. Pictures of meals were added in some areas to assist people in making choices. People told us they had a choice. Comments included, "They try to please you, there are always choices and if they don't suit, they will offer you other things", "Breakfast is the best meal of the day, the rest is a lot to be desired", "Food is very good, Plenty of it. We get cups of tea and biscuits and fruit is always out", "There is plenty of food and you can choose what you want", "The food is good but I don't think it's prepared right, there's no seasoning so it tastes bland. The menu choices are written down each morning." Staff told us the food was good and there was plenty of choice.

We observed at least one meal time in all units and saw in the main, people had a good experience and received good support. Tables had cloths and were set with serviettes and condiments. In some units we saw people were given plastic cups for their drinks. Members of staff, referred to as 'hosts' helped organise meal times in the units. We observed breakfast experiences and saw people were offered a range of hot and cold food, which included finger foods. One person received support to eat their porridge but then enjoyed eating some sandwiches independently.

In one unit, people received good support at lunchtime, and ate in an unhurried and relaxed atmosphere. During the meal staff chatted with people and were considerate and patient when helping people choose what they wanted to eat. We saw staff offering alternatives to people who did not want the menu choices. Five people were assisted to eat their meal by members of staff who remained focused on the person they were supporting. They chatted with them and explained their action at every stage. In another unit, five people were in the dining room, two people were in a small lounge and everyone else ate in their room. A host was serving people in the dining room, and care staff were serving and supporting people in the small lounge and in their rooms. Cold drinks were offered and people were asked what they would like to eat.

We observed lunch in one unit which was chaotic. People did not always receive good support, and one person waited 40 minutes before they received assistance. In another unit, we saw staff assisted people to the dining room and were respectful and kind as they did this. However, at the beginning of the meal, only one member of staff was in the dining room with ten people; two staff were supporting a person with personal care. Some people were waiting for staff to cut up their food and people did not receive a drink until 15 minutes after they had started eating. One person asked for a drink which then triggered the member of staff to ask others.

We spoke with the chef who discussed the catering arrangements. They told us everything they made was fresh on the day. They said they used certain suppliers and were never restricted when purchasing provisions. They told us they were aware of people's nutritional needs and had up to date documentation about people's individual dietary requirements. We saw this was updated regularly, however, we found it did not include one person who required a 'soft diet'.

People told us they received effective support with their healthcare needs and saw health professionals such as opticians and GPs. One person told us, "The Doctor comes straight away if we are ill and they get you to hospital if you need to go." Another person said, "When I have to go to the hospital they always send a member of staff with me." A visiting relative said, "I am quite content with [name of person] being here as I know she is well looked after, with GPs and dentist."

Staff we spoke with told us people's health needs were met. One member of staff said, "It's important to report things so that things can be nipped in the bud, much better to get early treatment such as antibiotics." They also said there were systems in place to make sure people were accompanied to hospital appointments; both planned and emergencies. They said, "We never send someone off alone." They also said people who used the service could attend health care professionals such as dentists in the community and they frequently did. Another member of staff said, "Doctors come in when we need them. We also communicate by phone."

We saw from people's care records they had accessed a range of health professionals and included GPs, opticians, dieticians, speech and language therapy, dentists and district nurses. However, we saw there were also examples where people's health had deteriorated and other health professionals were not consulted promptly. For example, when someone lost weight. When we identified any concerns during the inspection we raised these with an appropriate member of staff who agreed to ensure these were followed up.

Requires Improvement

Is the service caring?

Our findings

We received mainly positive feedback from people who used the service and relatives about the care they received. People we spoke with were complimentary about the staff. Comments included, "I have had respect and kindness shown to me", "The staff are lovely, just very busy so don't have time to chat", "Staff are fabulous. There are lots of staff changes though I am unsure who people are". One person told us their experience was inconsistent. They said, "Staff generally speak to me with respect but it varies on the member of staff." A relative told us, "All staff are very obliging even the agency staff." When we asked people if staff understood how to meet their needs, one person said, "Staff understand my personal care needs and always ask how I feel." A relative told us, "Yes my mum is never upset or has mucky clothes on. Some days they may only have a couple of staff on though, think it may be down to staff holidays."

During the inspection we saw on occasions, in different units, staff were kind and caring in their approach with people. Staff were patient and gave people time. Staff talked to people who used the service in a friendly and respectful manner. We saw examples when people were distressed staff provided reassurance and comfort. People were comfortable and relaxed around staff. During meal times we saw people received individual support from staff. In one unit, we saw breakfast was very well organised and staff provided different levels of support to meet people's individual needs. For example, one person received dedicated staff time and were given assistance to eat. Another person was encouraged to eat but then given support when they started to struggle. Another person received prompts and lots of encouragement to eat independently. In the main, we observed good care practices, although in one unit we noted staff did not always interact well with people and focussed on the task rather than the person. In another unit, we saw a member of staff who had assisted a person to eat then use the handle of the same spoon to stir another person's drink. One person was having soup but the spoon being used was too big. A member of staff took a teaspoon from the sugar bowl and was wiping this with a serviette ready for them to use. A member of the inspection team intervened and asked the member of staff to use a clean spoon. During the morning, some people were being weighed in the small lounge; this was not done in private to ensure people's dignity.

The home has a longstanding association with the Jewish community in Leeds. There was a synagogue on site and all meals prepared met Jewish dietary requirements, known as Kosher. The service also offered care to people of other faiths and beliefs.

We looked at care records to find out how staff understood people's history, likes, preferences and needs. Some people had care plans that provided good information. We saw people had 'resident details' and a 'pen picture-life', which provided details about their background. They also had one page profiles which were available for staff to familiarise themselves with the needs of people. They covered 'what is important to me', 'what I don't like', 'how best to support me with my care needs', 'how best to support me at meal times' and 'people who are important to me'. However, we also saw that people's 'life history section' was sometimes blank and one person's 'one page profile' which provided an overview of their care needs, was out of date and had taken three months to change. We found there was a high usage of agency staff, therefore, having up to date information is very important when staff are not familiar with the person they are supporting.

People who used the service told us they made choices regarding the support they received. One person told us, "I get up and go to bed whenever I want to, you can sleep all day if you wish." Another person said, "It is my choice when I get up for instance, they are days when I fancy a good breakfast so I get up early or if I have to go somewhere." Another person told us, "I can do what I like, when I like and how I like it." Staff we spoke with said people were given choice. One member of staff said, "It's important to ask people how they like things, what they want to do and to ensure choices are respected."

People said staff supported and encouraged them to do things for themselves. They also described ways in which they felt the staff treated them as individuals and knew their preferences. For example, one person said, "They always knock on my door and ask if they can come in. " Another person said "Staff know me well and I feel listened to." Staff we spoke with said they provided good care and were respectful of people's privacy and dignity. They said it was important to ensure people had privacy, for example, when bathing or going to the toilet and to encourage as much independence as possible.

We saw people looked well dressed and cared for. For example, we saw people were wearing jewellery and some people had their nails painted and hair was nicely styled. People told us they chose their own clothes.

People and their relatives told us they were free to make visits at any time, and we saw visitors were made welcome when they came into Donisthorpe Hall.

We noted information was displayed in the home to help people understand their care. This included information about the home and what people should do if they were unhappy about their care. The previous inspection report was displayed in the entrance; an information sheet titled 'what we have done since CQC inspection' was available.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection in June 2015 we found breaches in regulation relating to person centred care. Some people's care plans did not identify how care should be delivered and had not been updated when their needs had changed. At this inspection we found similar concerns.

People provided generally positive feedback about the care they received but told us they did not feel involved in identifying how their needs should be met. One person said, "I have had no input into my care plan no one ever asks me about it." Another person said, "When I came a few years ago I was asked about things and they wrote it down since then I have not seen anything they have written." Another person said, "I don't know what that is." Another person said, "I am unsure of a care plan." One visiting relative told us, "I am not involved in [name of person] care plan." Another visiting relative told us, "I was initially asked for input but that's about it."

The service used mainly electronic care records although some checklists and charts were paper based. We looked at care plans and saw there was very little evidence to show how people had been involved in developing their care plan, In one unit we reviewed two care plans and neither had any evidence to show how people had been involved.

Some staff we spoke with said the care plans gave them enough information and guidance on how to provide the support people wanted and needed. Staff said they were encouraged to report changes in needs and these were acted upon promptly. One member of staff said, "We deliver person centred care and have the time to do so most of the time. I will not rush anyone; it's not about rushing people."

We saw evidence of pre-assessments which were completed before people moved into the home. Care plans covered communication, medical history, eating and drinking, interests and hobbies, mental health, night care, personal hygiene, personal relationships and religious and cultural needs. However, we saw there was a lack of consistency in how care plans were completed. Some were informative and described what staff must do to meet the person's needs; others did not contain enough information. Care plan audits were not being carried out effectively so omissions were not being picked up. Reviews were generally taking place, and sometimes on a monthly basis, although there was often little evidence of change, to show a meaningful review had taken place.

One person had a section in the care plan for 'bowel and continence' which contained good details of their needs. An advanced care plan stated they had a 'Do Not Attempt Cardiopulmonary Resuscitation' in place which should be reviewed every three months; we saw this was being reviewed correctly. Another person's care plan stated they must wear their call bell pendant to ensure they could request assistance. We observed the person wearing the pendant.

One person's eating and drinking section in the care plan stated to 'document dietary intake for three days. If no improvement follow local policy.' Daily notes and food intake were not recorded for three days. Another person's interest and hobbies section stated 'Likes to listen to music and engages with staff'. [Name person]

to have opportunity to engage in activity' However when we looked at records they showed the person was only engaging in activity once per month.

It was difficult to establish if people's personal care needs were being met although people looked clean. In one unit, we saw entries on the electronic care record system which showed people were having a bath or shower, although the entries were occasional. One person's care record showed they had only been bathed five times in over three months. Another person's care record showed they had been bathed only five times in two months. We spoke with a staff member who told us agency staff did not always record where they provided this care, although they did say agency staff were given their own login and password to add entries. In another unit, one person's care plan stated they had between one- two showers per week. We saw they had regular showers in February 2016 but no showers had been recorded in March 2016. In another unit, one person's record showed they had a bath or shower on only six occasions between 1 January and 14 March 2016. Another person's record showed they only had three between this period. We asked staff about arrangements for bathing and showering. One member of staff said, "You get a gist of what is going on. We always record if people have a bath or shower." The nurse in charge said the records were accurate and staff were giving people a daily wash. Another member of staff said, "The electronic system has good information. We record baths and showers under routine notes and not as a specific activity."

We were informed by staff that they completed checklists to make sure people's needs were being met. For example, a fluid chart for everybody, and a 15 minute checklist for people who were in their rooms which included checking if they were ok, wanted a drink and had not fallen on the floor. We looked at some of these checklists and found they were incomplete and did not provide assurance that people's needs were being met. For example, one person's recommended fluid intake was calculated at 2059mls but their fluid chart over a five day period indicated they had only received the recommended intake on one day. Another person's recommended fluid intake was calculated at 1923mls but their fluid chart indicated they had only received between 960mls and 1425mls. We looked at the 15 minute observation records and again found these were incomplete. One person's fluid chart indicated they had insufficient fluid over a 24 hour period. Staff had noted the person's urine was dark and strong smelling but there was no evidence they had taken any action. We shared these concerns with a member of the management team who assured us they would take prompt action. We concluded the care and treatment of people using the service was not appropriate, and at times, did not meet their needs. The provider was not carrying out collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of people using the service. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care.

We saw there was a scheduled and varied programme of social activities, which people told us they enjoyed. Some told us the range of activities had improved. One person said, "There are quite a lot of activities that I like to be involved in. I like quiz, bingo and music." Another person said, "I like to read a lot and make good use of the library." Another person said, "Whatever is taking place I join in, there's always something going on. Best of all is the exercise class." We saw information in the reception area and on the units about planned activities. People told us they were able to maintain links with the wider community. One person said, "I go out into the community, we go shopping in town sometimes. You can take part in as many or few activities as you want." Two people felt activities could improve. One person said," There is not enough activities, I enjoy going out, but it's mostly people who need support go out in the community." Another person said," I want to get out in the garden but there's no one to help me as I used to walk out myself before."

During the inspection, we saw social activities included an outing to Roundhay Park, keep moving, choir, film and in the evening bingo. Other activities on offer included 'book club', quiz, film afternoon, sing a long,

computers and listening to audio books and table tennis. One person who was going to Roundhay Park said "I like getting out when the weather is nice."

The service had activity workers who planned and co-ordinated activities. Volunteers helped facilitate activities. A member of the management team oversaw the activity and volunteer programme. Activity planner sheets were displayed in the units and evaluation sheets were
completed after each activity. We looked at some of the activity records and saw people participated in a wide range of activities.

Staff we spoke with said they thought people had enough to do. They described the types of activity on offer to people. They also said that if they could be spared from the unit they would sometimes accompany people who used the service on activities. One member of staff described how they had supported someone to attend bingo. They said the person had been too anxious to go alone so it had been arranged for the staff to go with them. They said this person was now going to the concerts in the home without staff support.

The provider had displayed information about how to complain in the home, giving people the contact details they needed. Complaint and suggestions leaflets were available in the entrance hall. Some people said they would raise concerns but others expressed hesitation. One person who used the service said, "If I have had to complain they have done something about it." Another person said, "I don't want to get into trouble, I made a complaint about things including shortage of staff and was made to feel I was mad." Another person said, "I don't like to start trouble but I would get them told." A relative told us "I don't have any complaints, I can't recommend it highly enough and am thrilled [name of person] got a bed here. The home got [name of person] a large adapted remote so she could turn the television over herself without having to ask people to do it for her." Some concerns were raised because people did not know who was in charge or who they could talk to if they wanted to discuss any concerns. One person said, "If I wanted to complain I would but I don't know who to go to." Others said they would speak to whoever was in charge.

One visiting relative talked about a recent experience where they had raised a concern. They had contacted a member of the management team about a potential risk relating to the premises and told us prompt action was taken in response to the concern. A member of staff discussed another recent incident where a relative had raised a concern about delayed medication, which had led to a change in care practice They said they believed it was reported to safeguarding. There was no record of the concern/complaint/safeguarding or what action had been taken or how the investigation had been completed.

When we asked about formal complaint records we were told by a member of the management team that most units did not deal with these; one unit had a formal complaint record file but this was empty and the member of staff in charge said they had not received any written complaints. We looked at complaints held centrally and found these were coordinated by a member of the administration team. Complaints received were logged and acknowledged, and then sent to the registered manager to review and commence investigation. On completion of the investigation, a response to the complainant was made. This process was usually completed within two weeks.

We saw people had provided positive feedback and complimented the home. One unit had received nine compliments; several complimented staff and thanked them for their 'kindness and caring attitude'.

Inadequate

Is the service well-led?

Our findings

The service had a registered manager. They were registered as a 'registered manager' by the Care Quality Commission in December 2015 so were not in post at the inspection in June 2015. At the previous inspection we found breaches in regulation relating to good governance because the quality assurance systems were not effective. At this inspection we found similar concerns.

The registered manager was supported by a management team, which included the chief operating officer, an operations manager, estates manager, head of human resources and two care managers. The registered manager said they were actively recruiting additional care managers. Each unit had a designated lead which dependant on the type of unit was either a registered nurse or senior care worker.

We got a mixed response when we asked staff about management and leadership. Some felt the service was well managed whereas others did not. Several members of staff said the registered manager visited the units daily. A member of the catering team said, "We work really hard; it's a good place to work. Management are great." Another member of staff said, "[Name of care manager] comes to make sure things are being done right." Another member of staff said, "It's definitely got better, they are trying to get everybody on board with the paperwork. I think it is working." Another member of staff said, "It's really poor. It's just hopeless. Changes are made without communicating them to staff until they are in place." Another member of staff said, "I think every unit should have a permanent manager; I find it awkward because there is no one for guidance or advice. We definitely need unit managers to manage the units." A member of staff who had worked at the home for four months did not know who the registered manager was. A visiting relative told us there was a lack of communication from the home, and gave an example where important information about their relative was not shared with them.

During the inspection we found it was difficult to locate information and establish what systems were in place for gathering, recording and evaluating information about the quality and safety of the service. We received different information from members of staff and managers. We were shown different records which provided conflicting information. There was a lack of organisation and systems were not operated effectively. For example, in one unit, we struggled to establish staffing levels. We began by looking at rotas held on the unit. These did not show what was actually worked. The nurse in charge told us there was a rota book kept by the care management team but when we reviewed this it showed similar to the unit rota. A member of the care management team suggested using handover records to look at numbers and skill mix of staff who had worked. We reviewed the handover records and were then told by another member of the care management team that these would not be accurate as "staff don't complete these properly, can't get them to do." They said the 'Daily requirements' sheets were an accurate record of what was worked on each unit. However, these records did not use staff surnames so it was confusing when permanent staff or agency staff had the same first name.

We looked at audits and found there was a lack of consistency in how and when these were carried out. The registered manager told us a medicine IT system (EMAR) had recently been introduced which could facilitate medicine audits. However, at the time of the inspection the registered manager said there was no audit

evidence available. A member of the care management team said they had previously done some medicine audits but these had not been written up. A clinical audit was due in January 2016 but had not been undertaken. There were no dignity audits.

The registered manager said monthly care plan audits should be completed and they had tried to make this a priority of the nursing staff. However, we found these were not being completed. In one unit, we saw on the office wall there was an overview of when care plan reviews and audits were due. However, there was no documentary evidence provided that actual audits were carried out. In two other units we were told there were no care plan audits. A member of the care management team told us the registered manager was responsible for carrying out the audits. We saw from minutes that, at a meeting in February 2016, nursing staff had been informed that failure to complete care plan audits was a disciplinary offence. However no disciplinary action was undertaken even though care plan audits were not being carried out.

The registered manager said mattress audits were undertaken monthly, together with a hand hygiene audit. We saw a number of mattress audits which were kept in the relevant units. However, they were not available in all units.

A 'care audit' was carried out by two members of the management team in October 2015. Several issues were highlighted such as, catering assistants were not serving meals (nursing staff were), there was a slow response to call bells, nurses were distracted during medicine rounds and there was a lack of protected meal times. We saw action was taken to address some of the issues; catering assistants were serving meals and nurses wore 'red 'do not disturb' tabards when they were administering medicines. However, we found meal times remained unprotected and there was no system for checking call bell response times.

The service did not carry out a formal 'end of Life' audit programme. However, we saw there were some reflections after people had died; this is good practice and helps a service learn and improve their end of life care delivery.

We asked staff about accident and incident reporting but were told different systems were in place. Some said they sent incident forms to the care management team and others said they sent forms to a member of the administration team. Once logged centrally, they were sent to a third party company for review and reporting. This was a recent development and information was only available for incidents over the past four months. The report indicated the type of incident but there was no evidence of how patterns or trends were identified within the service. There was no breakdown of incidents that had occurred within each unit. A member of the management team said this was an area that was being developed.

We saw that following some accidents/incidents, a 'root cause analysis' (RCA) was carried out and actions were identified to reduce the risk of repeat events. However, when we looked at three of these in more detail, we found these were not comprehensive. For example, a RCA was undertaken after one person left the home despite their care plan identifying them at risk and to monitor closely. The RCA focussed on the CCTV recordings which showed incorrect times and required the clocks to be synchronised. When we checked the CCTV system there was a discrepancy of 15 minutes. Another person sustained a serious injury and it was evident there was a delay in seeking medical assistance. Following the RCA, no staff member was disciplined, nor was there evidence of staff being informed formally of the need for prompt action. Another person had several falls but appropriate action was not taken to reduce the risk of repeat events. A number of accident records stated 'manager's investigation recorded' and 'increase staff awareness' and 'staff to continue to be vigilant'. However, when we looked at the person's care plan this did not make any reference to staff awareness or vigilance. The care plan stated 'mobility with assistance'- falls risk assessment to be reviewed monthly or post fall. We saw the falls risk assessment had not been reviewed after a fall. The

person last fell four days before the inspection. We brought these concerns to the attention of a member of the management team who assured us they would ensure appropriate action was taken.

The provider undertook quality assurance surveys and sent them to three separate stakeholders: people who used the service, relative/friends and staff. The response rates were low with only 16 from 145 sent to people who used the service returned (11%), 24 from relatives/friends (18%) and 30 from 220 staff (13%).The feedback from people who used the service and relatives was generally satisfactory. However, the one from staff was contradictory; the preference indicator (Likert scale) showed staff were satisfied but the free text comments did not reflect this. There was no specific action plan to address the survey results although the registered manager said there were plans to introduce a staff forum/council in the future.

Most people we spoke with were aware resident meetings were held. One person told us, "I am not interested in going to these meetings." Another person said, "Yes I go to the meetings regular we discuss if we have any issues or want anything changing." Another person told us, "I am unsure of any resident meetings." We saw there was a 'resident's welfare group' which was chaired by a trustee.

The registered manager said staff/team meetings were held but had not been minuted and attendance was not recorded. The last staff meeting minute the registered manager could locate was dated June 2015. We asked in individual units but most said they did not hold meeting minutes; one unit showed us minutes from a meeting held in January 2016. Another unit had a staff meeting file which showed the last meeting took place in June 2015, however, the minutes contained no evidence of 'feedback around concerns' or 'lessons learned' where staff could use the opportunity for learning. One member of staff told us a recent meeting was held and they had been able to put points across and had felt listened to. They said this had mainly been about workload issues and some team members not 'pulling their weight'. Minutes for this meeting were not available. At the inspection we identified there was a lack of gathering, recording and evaluating information about the quality and safety of the service and concluded the provider's systems and processes were not operated effectively. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

At previous inspections we have reported that the provider has not always notified us about important events. It is an offence not to notify CQC when a relevant incident, event or change has occurred. At the last inspection we found the provider had notified CQC about some significant events such as deaths and serious injuries, however, they had not sent any notification of abuse or allegations of abuse. We said we were dealing with this breach separately and would report on this when the work was complete. After the inspection in June 2015, we monitored notifications of abuse or allegations of abuse and found the provider was sending these through when incidents arose. At this inspection, we checked a number of safeguarding cases and found we were notified about these. We concluded the provider had sent notifications of abuse or allegations of abuse. However, we found they had not sent any notification to CQC about authorisations to deprive a person of their liberty, which is a notifiable event. It was evident at this inspection they were again failing to report notifiable events. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009. Notification of other incidents.

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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: 28 June 2016

Subject: Scrutiny Inquiry Reports

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. During the municipal year 2015/16, the Scrutiny Board undertook a variety of work and inquiry areas, including the Involvement of the Third Sector in the Provision of Health and Social Care Services across Leeds and Primary Care.

2. The purpose of the report is to introduce the draft reports and recommendations from those aspects of work, for consideration and agreement.

3. Scrutiny Board Procedure Rule 13.2 states:

   "Where a Scrutiny Board is considering making specific recommendations it shall invite advice from the appropriate Director(s) prior to finalising its recommendations. The Director shall consult with the appropriate Executive Member before providing any such advice. The detail of that advice shall be reported to the Scrutiny Board and considered before the report is finalised".

4. In line with Scrutiny Board Procedure Rule 13.2, advice on the draft reports and recommendations will be sought from the relevant Directors and, on receipt, the advice will be published alongside the draft Scrutiny Board reports, for consideration by the Scrutiny Board before finalising its report.

5. As such, the Scrutiny Board's report will be presented as supplementary information to this report (alongside the relevant advice) and will be published in advance of the meeting on the 28 June 2016.

6. Once the Board publishes its final report, the appropriate bodies will be asked to formally respond to the Scrutiny Board's recommendations, which will be reported to a future Scrutiny Board meeting.

Recommendations

7. Taking account of the appropriate advice, Members of the Scrutiny Board are asked to consider and agree the draft scrutiny inquiry reports presented.

Background documents

8. None used[1]

[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: 28 June 2016

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 February 2016 to reflect the significant changes to the context in which the council is working. The resulting 'Best Council Plan – Summary' is attached as Appendix 2.

Leeds' Joint Health and Wellbeing Strategy (2016 – 2021)

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) (2016-2021) – attached at Appendix 3.

3.3 In determining items of scrutiny work and activity, 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 (2016-2021) in addition to acting as a 'critical friend' to the Health and Wellbeing Board.

Scrutiny of the NHS

3.4 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.

3.5 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.

Areas of Scrutiny work brought forward from the previous year

3.6 Throughout the previous municipal year (2015/16), the Scrutiny Board (Health and Wellbeing and Adult Social Care) covered a range of issues and also identified a number of matters for potential scrutiny that were unable to be commenced or completed during the year. At its final meeting of the municipal year in May 2016, the

previous Scrutiny Board resolved that the following issues areas of work be considered by the successor Scrutiny Board in the new municipal year, 2016/17

- Air quality;
- Delayed discharges;
- Clinical Commissioning Group (CCG) updates – particularly in relation to the new role as commissioners of primary care services;
- Care Quality Commissioning (CQC) inspection outcomes;
- More focussed work on budgets; and
- The financial landscape and budgetary issues likely to impact on the delivery of Child and Adolescent Mental Health Services (CAMHS) and Targeted Mental Health Services (TaMHS).

Other sources of Scrutiny work

3.7 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 the recent publication, 'The State of Men's Health in Leeds: A summary' is attached at Appendix 4.

3.8 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.

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]

[1] The background documents listed in this section are available to download from the Council's website,

7.1 None

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

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Tackling poverty and reducing inequalities

Our vision is for Leeds to be the best city in the UK: one that is compassionate with a strong economy, that tackles poverty and reduces the inequalities that still exist. We want Leeds to be a city that is fair and sustainable, ambitious, fun and creative for all. We will continue to work with others to achieve better outcomes for the city through a combination of innovation and efficiencies.

Everyone who works for Leeds City Council plays a vital role in shaping our amazing city. Our day-to-day jobs may be very different but they all contribute to improving life in Leeds and creating a strong economy and compassionate city.

We are pleased to share our priorities for 2016/17 in this plan and also look at how we all need to work to achieve our ambitions.

We shared our vision for the future of Leeds City Council in the Best Council Plan 2015-2020: a more enterprising council, working with partners and businesses who are more civic; and a more engaged public. Our overall approach is still guided by this vision and closely aligned with the budget that has been agreed. Significant progress has been made towards these ambitions, using a civic enterprise approach, but more needs to be done – and against a challenging backdrop.

We know that 2016/17 will bring continued reductions in our funding and that this will continue to 2020.

Leeds has a growing and ageing population with increasingly complex needs; some communities are not benefiting from the economic growth the city has experienced and welfare changes could make the inequality gap bigger.

That is one reality but it is certainly not the full story. The full story is about our ambition, and our growing confidence and resilience as a council, a city and a region.

We are determined to keep building a strong economy and working compassionately to tackle poverty and disadvantage. This includes improving the health of the poorest fastest; working to become a child friendly city, investing in our young people; and building on the scale and diversity of the Leeds economy through business investment and expansion.

Maintaining provision of the good quality, efficient services that communities in the city need is essential, while finding new ways of delivering the best for Leeds. Innovative approaches developed with service users, citizens and partners are already changing relationships and shifting responsibilities, with positive results. We encourage everyone to find those big and small ideas which will improve outcomes faster and reduce costs.

We recognise that we are again asking for a lot from our colleagues. We would like to share our heartfelt thanks for all your efforts so far, and for the hard work that will be needed in the year ahead.

Cllr Judith Blake
Leader of Leeds City Council

Tom Riordan
Chief Executive of Leeds City Council

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Leeds CITY COUNCIL

BEST COUNCIL PLAN 2015-20
UPDATE FOR 2016/17

Tackling poverty and reducing inequalities

BEST COUNCIL PLAN 2015-20 – UPDATE FOR 2016/17

BEST CITY · BEST COUNCIL

Tackling poverty and reducing inequalities

AMBITIONS • Leeds… **A Strong Economy and a Compassionate City** • Leeds City Council… **An Efficient and Enterprising Organisation**

2016/17 PRIORITIES

What we and our partners are doing in 2016/17 to improve outcomes

1. Supporting economic growth and access to economic opportunities
2. Keeping people safe from harm
3. Supporting communities, raising aspirations
4. Improving educational achievement and closing achievement gaps
5. Providing skills programmes and employment support
6. Helping people adjust to welfare changes
7. Providing enough homes of a high standard in all sectors
8. Keeping the streets clean and improving road safety
9. Supporting children to have the best start in life
10. Preventing people dying early
11. Promoting physical activity
12. Building capacity for individuals to withstand or recover from illness
13. Supporting healthy ageing
14. Enabling carers to continue their caring role and careers
15. Improving air quality
16. Helping deliver a well-connected transport system
17. Providing an inclusive, accessible range of transport options
18. Hosting world class events in Leeds
19. Supporting a resilient, inclusive, cultural and creative sector
20. Enhancing the quality of our public realm and green spaces

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OUTCOMES

We want everyone in Leeds to…

- Be safe and feel safe
- Enjoy happy, healthy, active lives
- Live with dignity and stay independent for as long as possible
- Do well at all levels of learning and have the skills they need for life
- Earn enough to support themselves and their families
- Live in good quality, affordable homes within clean and well cared for places
- Move around a well-planned city easily
- Enjoy greater access to green spaces, leisure and the arts

BREAKTHROUGH PROJECTS

How we are delivering our 2016/17 priorities: a set of 8 cross-cutting projects

20 FOR 2020

How we are measuring progress in achieving better outcomes: 20 key indicators

1. Number of children looked after
2. Number of domestic violence and abuse incidents with repeat victims
3. Number of recorded nuisance and damage related incidents
4. Percentage of adult population active for 30 mins once per week
5. Obesity levels at age 11
6. Number of Air Quality Management Areas
7. Total number of bed weeks in residential and nursing care homes for older people / working age adults supported by the local authority
8. Proportion of people who use social care services who say that these services have made them feel safe and secure
9. Primary and secondary school attendance
10. Percentage of young people NEET (not in education /employment/training) / not known
11. Percentage of adults in Leeds who have all 5 basic digital skills
12. Percentage of Leeds households in receipt of a welfare benefit and in work
13. Business rate growth
14. Jobs growth
15. Housing growth target
16. Energy and thermal efficiency performance of houses
17. Percentage of waste recycled
18. Access to employment by public transport
19. Percentage of city centre travel by sustainable modes (bus, train, cycling, walking)
20. Overall satisfaction with cultural provision in Leeds

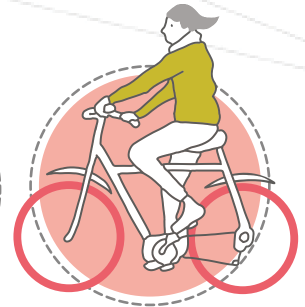
Leeds CITY COUNCIL

COUNCIL VALUES

Underpinning what we do and how we work

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

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



Leeds Health and Wellbeing Strategy

2016-2021

Dazl
Dance Action Zone Leeds

Foreword

Leeds – The Best City for Health and Wellbeing

by Councillor Lisa Mulherin
Chair of the Leeds Health & Wellbeing Board

In Leeds, as we grow up and as we grow old, the people around us, the places we live in live, the work we do, the way we move and the type of support we receive, will all keep us healthier for longer. We will build resilience, live happier, healthier lives, do the best for one another and provide the best care possible to be the best city for health and wellbeing.

In Leeds we believe that our greatest strength and our most important asset is our people. Wellbeing starts with people: our connections with family, friends and colleagues; the behaviour, care and compassion we show one another; the environment we create to live in together.

Our Health and Wellbeing Strategy is about how we put in place the best conditions in Leeds for people to live fulfilling lives – a healthy city with high quality services. Everyone in Leeds has a stake in creating a city which does the very best for its people. This strategy is our blueprint for how we will achieve that. It is led by the partners on the Leeds Health and Wellbeing Board and it belongs to everyone.

We're ambitious: we want Leeds to be the best city for health and wellbeing. Our first Health and Wellbeing Strategy, which ran from 2013-15, laid positive foundations for that. Leeds has seen a reduction in infant mortality as a result of our more preventative approach; we've been recognised for improvements in services for children; we became the first major city to successfully roll out an integrated, electronic patient care record; and early deaths from avoidable causes have decreased at the fastest rate in our most deprived wards.

These are achievements to be proud of, but they are only the start. We continue to face significant health inequalities between different groups. A relentless focus on reducing these inequalities will remain at the forefront of our efforts over the coming five years. That is why Leeds vision remains **to be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest**.

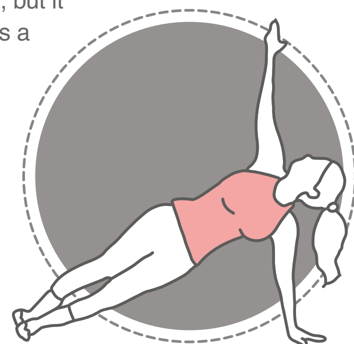
This new strategy has a wide remit. So many factors contribute to our health and wellbeing, meaning our challenge is to reflect the breadth of the agenda, whilst being specific about the areas we need to focus on to make the biggest difference. A simple statement of intent captures the connectivity between the multiple factors that contribute to people living healthier lives.

Underpinning this statement we've identified five outcomes – the conditions of wellbeing we want to realise for everyone in Leeds. We have twelve priority areas that we will focus on to make change happen, and some indicators by which we can measure our progress. Collectively, these outcomes, priorities and indicators give us a framework to test whether the work we do is making a difference to the people of Leeds. Other strategies and action plans will provide further detail on how specific parts of the citywide vision can be achieved over the next five years.

The launch of our new strategy comes at a particularly important and challenging moment for health and care services. As NHS England's Five Year Forward View recognises, to achieve consistently high quality care for everyone, respond to demographic change and achieve long-term financial sustainability across the health and care system, we must do things differently.

Leeds is well placed to respond. The network of national health leadership and research organisations in the city, along with our city's relatively strong economy and exceptional universities, creates a unique health and care infrastructure. Leeds is a pioneer in the use of information and technology. We have a thriving third sector and inspiring community assets. There has never been a stronger commitment to partnership working across health and care services. The change required is significant, but it is possible if we work towards a shared vision.

This strategy provides that vision. It invites everyone to play an active part in making Leeds a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.



Leeds Health and Wellbeing Strategy 2016-2021

We have a bold ambition:

'Leeds will be the best city for health and wellbeing'.

And a clear vision:

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

5 Outcomes

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1. People will live longer and have healthier lives
2. People will live full, active and independent lives
3. People's quality of life will be improved by access to quality services
4. People will be actively involved in their health and their care
5. People will live in healthy, safe and sustainable communities

Indicators

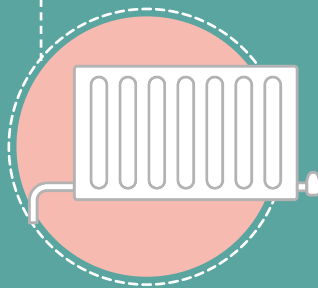
- Infant mortality
- Good educational attainment at 16
- People earning a Living Wage
- Incidents of domestic violence
- Incidents of hate crime
- People affording to heat their home
- Young people in employment, education or training
- Adults in employment
- Physically active adults
- Children above a healthy weight
- Avoidable years of life lost
- Adults who smoke
- People supported to manage their health condition
- Children's positive view of their wellbeing
- Early death for people with a serious mental illness
- Employment of people with a mental illness
- Unnecessary time patients spend in hospital
- Time older people spend in care homes
- Unnecessary hospital admissions
- Repeat emergency visits to hospital
- Carers supported

The Challenges

Overall, health in Leeds remains worse than the England average. Thousands of people in deprived areas live shorter lives than they should. Costs of providing high quality care continue to rise. This strategy helps us plan how to address key challenges, so health and wellbeing in Leeds can be better, fairer and sustainable.

Over the next 25 years the number of people who live in Leeds is predicted to grow by over 15 per cent. The number of people aged over 65 is estimated to rise by almost a third to over 150,000 by 2030. The city is going to provide more complex care for more people.

12% of households in Leeds are in fuel poverty



10yrs difference in life expectancy between Hunslet and Harewood

Improving health and wellbeing

Becoming a healthier, happier city requires improvements in living conditions and lifestyle choices.

164,000 people in Leeds live in areas ranked amongst the most deprived 10 per cent nationally. One in five children in Leeds live in poverty. People living in deprived neighbourhoods are more likely to experience multiple disadvantage, die earlier, and have more years in long-term ill health. This is wrong and it needs to change.

Improving health requires having better social and economic conditions. For example, people living in good quality affordable houses, achieving in education and working in good jobs.

The majority of early deaths are related to unhealthy lifestyles; smoking, excessive alcohol use, poor diet, and low levels of physical activity. More often than not, people who develop long term health conditions have two or more of these risk factors. Poor lifestyle choices shorten lives and burden health system. To be the best city for health and wellbeing everyone must work together to get mentally and physically healthier.

Improving health and care services

As more people develop multiple long term conditions, focus shifts from curing illnesses to managing health conditions. Health and care services need to adapt to these changes.

Too often care is organised around single illnesses rather than all of an individual's needs. Many people are treated in hospitals when care in their own homes and communities would be better for them. Services can sometimes be hard to access and difficult to navigate.

Leeds will focus on making care services more person-centred, integrated and preventative. All organisations need to work together to achieve this.

Improving health services needs to happen alongside achieving financial sustainability. This is a major challenge. Rising cost pressures means a potentially significant financial gap by 2021 across Leeds health and social care organisations. Making the best use of the collective resources across organisations will help us sustain and develop the city's health and care system.

£700million estimated funding gap between resources and requirements by 2021

10% reduction in emergency hospital admissions could help us afford teams of 2 GPs, 2 nurses and 6 community care workers (in each of the 13 neighbourhood areas in Leeds)

One city... everyone plays a part

Provide leadership and direction to help and influence everyone to achieve the 5 outcomes

Provide a public forum for decision making and engagement across health and wellbeing

Continually ask what we are all doing to reduce health inequalities, create a sustainable system and improve wellbeing

Support the priorities of the Leeds Health and Wellbeing Strategy

Create plans and strategies which help achieve specific priorities and outcomes of the Leeds Health and Wellbeing Strategy

Promote partnerships wherever possible, working as one organisation for Leeds

Provide and commission services which support the priorities of the Leeds Health and Wellbeing Strategy

Make plans with people, understanding their needs and designing joined-up services around the needs of local populations

Provide the best quality services possible, making most effective use of 'the Leeds Pound' - our collective resource in the city

Support vulnerable members of the community to be healthy and have strong social connections

Take ownership and responsibility for promoting community health and wellbeing

Make best use of community assets and leadership to create local solutions

Take ownership and responsibility for promoting personal health and wellbeing

Be proactive in accessing services which are available

Get involved in influencing and making change in Leeds

One health and care system... consistently asking

Can I get the right care quickly at times of crisis or emergency?

Can I live well in my community because the people and places close by enable me to?

Can I get effective testing and treatment as efficiently as possible?

Priorities

2 An Age Friendly City where people age well

1 in 5 people in Leeds are aged over 60. Our ageing population presents opportunities for the city and challenges for our health system. We want Leeds to be the best city in the UK to grow old in.

Being an **Age Friendly City** means promoting ageing positively and maximising opportunity for older people to contribute to the life of Leeds. We must build on the strengths of older people and recognise first and foremost their roles as employees, volunteers, investors and consumers. Our built environment, transport, housing must all promote independence and social inclusion.

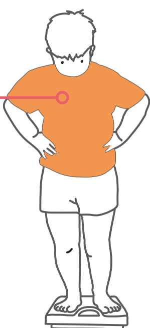
37,000
Estimated number of older people who experience social isolation or loneliness

Health and care services will focus on supporting independent living, reducing falls and reducing excess deaths during the winter. As a city we will talk with local communities about dying and bereavement to support people to plan for their last years of life.

1 A Child Friendly City and the best start in life

There is a huge opportunity to improve health and wellbeing outcomes by focusing on children and young people. The best start in life provides important foundations for good health and wellbeing throughout life.

34%
of children aged 11 in Leeds have an unhealthy weight



This means the best start for every Leeds baby from conception to age two, providing high quality, joined-up maternity and antenatal care guided by the mother's needs for supported families, strong attachments and positive infant wellbeing. It means professionals adopting the Leeds 'Think Family, Work Family' protocol, ensuring solutions are coordinated around needs and assets in families and the wider community.

Leeds must focus on reducing child obesity and the differences which exist across the city. Prevalence among children in the most deprived areas of Leeds is double that of children in the least deprived areas. We must address this through **long-term coordinated action**. For example, we can change environmental design, available food choices and education.

We must also continue to promote mental health and emotional wellbeing for all children and young people in Leeds. A transformation plan reviewing **the whole system of support for social, emotional and mental health and wellbeing** will focus on enabling children and young people to access services quickly, easily and effectively.

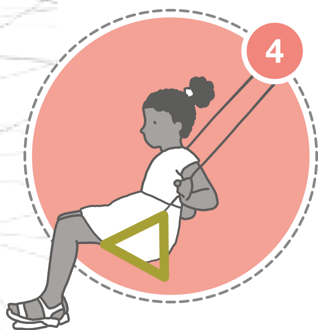
3 Strong, engaged and well-connected communities

The relationships and resources in communities are building blocks for good health. Leeds has brilliant and diverse communities, well-established neighbourhood networks and a thriving third sector; we must harness these strengths.

There are vulnerable groups and areas of the city which experience health inequalities. These include people in poverty, migrants, refugees and asylum seekers, the homeless and people with disabilities. People's health outcomes can also depend on specific characteristics, such as ethnicity, gender and sexuality, amongst others. For some groups, tailored work can help close the gap in health outcomes, sensitive to specific needs. This also applies for those with learning and/or physical disabilities who need specific support in order to thrive in the city. **Fair access to person-centred services, which build on individual and community strengths, will help reduce health inequalities in Leeds**.

Social isolation and loneliness can have a bad effect on people's health. This is particularly true for vulnerable groups and people with high levels of need. We want a city where no one is lonely, with diverse opportunities for people to live healthy, active and fulfilling lives.

Carers are crucial to our communities. Our 70,000 plus unpaid carers help health and social care to function, supporting thousands of people. We must continue to be recognise, value and support these carers. **We will identify the needs and contribution of carers early on when decisions are being made about care and support**. The physical, mental and economic wellbeing of carers also needs to be continually promoted.



Housing and the environment enable all people of Leeds to be healthy, social and active

To be a healthy city, our environment must promote positive wellbeing. This means Leeds houses are affordable, warm, secure, and support independent living. This includes developments as part of the 70,000 new homes proposed in Leeds between 2012 and 2028.

Green space, leisure provision and walking and cycling opportunities promote health and happiness. Considerations about future growth must ensure **adequate provision of quality and accessible open spaces**. Areas of Leeds with the lowest overall green space provision are predominantly inner city, high density housing areas. We need to address this to reduce health inequalities.

Physical inactivity is our 4th largest cause of disease and disability

As Leeds grows and care settings change, facilities must enable the best care to be provided in the right place for the most efficient use of resources. Health and social care organisations need to ensure **there are enough facilities and they are fit for purpose** for those who use them and work in them.

A strong economy with quality local jobs

A good job is really important for good health and wellbeing of working age people. To reduce social inequalities, Leeds needs a **strong local economy driving sustainable economic growth for all people** across the city. This includes creating more jobs and better jobs, tackling debt and addressing health related worklessness.

One of our biggest economic strengths as a city is our health and medical sector, with a wealth of talent and huge concentration of innovative organisations. With collaboration across private, public, academic and community organisations, **Leeds is perfectly placed to be a great location for health innovation**.

We must also recognise that health and care organisations employ a huge number of people in the city. We must do all we can to promote the health and wellbeing of the workforce and reduce social inequalities through how people are employed.

Get more people, more physically active, more often

If everybody at every age gets more physically active, more often, we will see a major improvement in health and happiness. We can reduce obesity, improve our wellbeing, become more socially connected and recover better from health problems.

One in five adults in Leeds is inactive. As a general rule, **the more we move, the greater the benefit**. The biggest benefit will be for those who are currently inactive. We should focus efforts here.

We want Leeds to be the most active big city in England. This requires wide-ranging action, including inspiring people to be active and targeting participation in sports and other activities to specific geographic areas and groups. It means **including physical activity as part of treatment** more. It also means making **active travel** the easiest and best option wherever possible, with lots more walking and cycling due to good infrastructure, creative planning and behaviour change.

Maximise the benefits from information and technology

New technology can give people more control of their health and care and enable more coordinated working between organisations.

This includes **continuing the development of the Leeds Care Record** to ensure professionals directly involved in care have access to the most up-to-date information. People want to tell their story once and choose the channel they use to communicate. Joined-up information enables this.

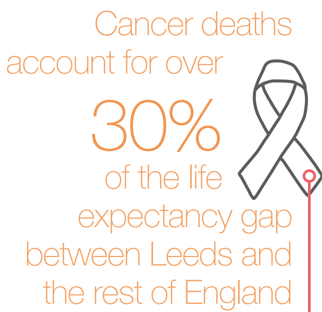
We also want patients to have access to and control over their personal health records. Linked to this, for planning and decision making, we need to make better use of the data which is held by organisations in Leeds.

We want to make **better use of technological innovations in patient care**, particularly for long term conditions management. This will support people to more effectively manage their own conditions in ways which suit them.

A stronger focus on prevention

There are some specific areas where we can make a really big difference to prevent ill health.

We need to maintain a continued focus on obesity, smoking and harmful drinking. A radical upgrade in prevention requires **a whole-city approach**. Obesity is a huge local and national challenge. It is preventable, but is currently rising due to poor diet, low levels of physical activity and environments which encourage unhealthy weight.



About half of people born after 1960 will develop some form of cancer during their lifetime. Many of these can be linked to lifestyle choices. Cancer prevention, early diagnosis and successful therapy will reduce inequalities and save money. Leeds must pursue a sustained programme to increase public awareness of lifestyles which **increase the risk of cancer and support lifestyle changes.**

Our services need to be more proactive and preventative in their approach. This will involve making more use of evidence-based interventions at the early stages of disease. Local, timely and easy access to tests and treatment will be important to prevent conditions getting worse, together with a focus on earlier identification of those at higher risk of hospital admission. These approaches should help people remain healthy and independent for longer.

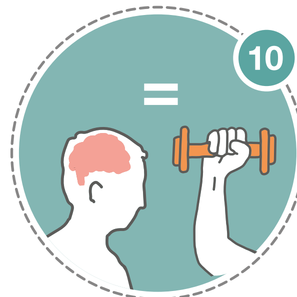
To **protect the health of Leeds'** communities, infection prevention and control, and environmental hazards such as air quality and excess seasonal deaths will be improved by a coordinated local and regional partnership approach. The Leeds Health Protection Board lead on this key agenda.

Support self-care, with more people managing their own conditions

Long term conditions are the leading causes of death and disability in Leeds and account for most of our health and care spending. Cases of cancer, diabetes, respiratory disease, dementia and cardiovascular disease will increase as the population of Leeds grows and ages. There will be a rise in the number of people living with at least two health conditions and this is most common in deprived areas of the city. We must see a shift in the way care is provided to enable people to better manage their own health conditions.

We must focus on **supporting people to maintain independence and wellbeing within local communities** for as long as possible. People need to be more involved in decision making and their own care planning by setting goals, monitoring symptoms and solving problems. To do this, **care must be person-centred, coordinated around all of an individual's needs** through networks of care rather than single organisations treating single conditions.

To have more active involvement in health and care we all need to make the most appropriate use of services. **We need to make sure the best thing for people to do is the easiest thing for people to do**. This means having better and more coordinated information to make it easier for people to understand what to access and when.



Promote mental health and physical health equally

Our ambitions for mental health are crucial for reducing health inequalities. Good employment, opportunities to learn, decent housing, financial inclusion and debt are all key determinants of emotional wellbeing and good mental health. **Improving mental health is everyone's business**. We want to see this led by employers, service providers and communities.

People with severe mental illness die on average

15-20 years

earlier than the rest of the population

The Leeds Mental Health Framework will be implemented to improve services across the city. By redesigning community mental health services with improved information and advice and more joined up working we can improve access and reduce repeat assessments. Care for people experiencing a mental health crisis will be improved, with crisis resolution available 24/7 and more provision within health and social care.

105,000 people in the city suffer from anxiety and depression

We need improved **integration of mental and physical health services** around all the needs of individuals. This means addressing the physical health needs of those living with mental illness, and always considering the mental and emotional wellbeing of those with physical illness.

Three quarters of lifetime mental illness (except dementia) begins by the age of 25, so mental health and wellbeing support for children and families is a priority. This includes early support for women during pregnancy and the first few months post-birth, improved links with schools and better experiences for service users as they move between children and adult services.

A valued, well-trained and supported workforce

We have a highly motivated, creative and caring workforce in our city, working hard to deliver high quality care for people in Leeds. This workforce, many of whom live as well as work in the city, are a huge asset for making change happen.

We should **work as one workforce for Leeds**. Shared values and collaborative working will support joined-up services. New population-based models of care will require the development of multi-disciplinary working across organisational boundaries. **Better workforce planning** can ensure the workforce is the right size and has the knowledge and skills needed to meet future demographic challenges.

Working fully in partnership with the third sector and those in caring and volunteer roles in the community will be crucial to make the most of our city wide assets.

57,000 people work in health and care in Leeds

Leeds is one of the best places in the UK to work in health and social care. We need to build on this through **world-class education and training**, attracting people who reflect the full diversity of our population. This will ensure we continue to build the very best, modern and fit for purpose workforce for Leeds now and in the future.

The best care, in the right place, at the right time

For more effective, efficient health and care we need to **move more services from hospitals to community settings**. This needs **population–based, integrated models of care, sensitive to the needs of local communities**. This must be supported by **better integration** between physical and mental health care with care provided in and out of hospital.

Services closer to home will be **provided by integrated multidisciplinary teams** working proactively to reduce unplanned care and avoidable hospital admissions. They will improve coordination for getting people back home after a hospital stay. These teams will be rooted in neighbourhoods and communities, with coordination between primary, community, mental health and social care. They will need to ensure **care is high quality, accessible, timely and person-centred.**

Providing care in the most appropriate setting will ensure our health and social care system can cope with surges in demand with effective urgent and emergency care provision.

Our health and social care commissioner and provider organisations will lead the coordination of these changes over the coming years, starting with the city's five year **Sustainability and Transformation Plan**. How services are configured and where they are placed will change over the coming years, so **engagement with local populations** is really important.

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LEEDS BECKETT UNIVERSITY

The State of Men's Health in Leeds: A Summary

Professor Alan White, Leeds Beckett University
Dr. Amanda Seims, Leeds Beckett University
Robert Newton, Leeds Beckett University and
Leeds City Council

ISBN: 978-1-907240-68-3

About this report

This report is part of a project between the Centre for Men's Health at Leeds Beckett University and Leeds City Council, examining the state of men's health in Leeds. It should be read alongside the Main Report and Data Report of this project, which provide a full and detailed assessment of the state of men's health in Leeds.

Data

All data quoted in this report is from the most up-to-date source as at August 2015. Full referencing and data sources are available from 'The State of Men's Health in Leeds: Main Report' and 'The State of Men's Health in Leeds: Data Report'.

Authors

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The Centre for Men's Health, Leeds Beckett University

The Centre for Men's Health is a part of the Institute for Health & Wellbeing at Leeds Beckett University. The Centre has extensive research and consultancy experience on a broad range of areas relevant to men's health. The Centre is recognised as a world leader in the area of men's health and has been at the forefront of many of the most influential developments in this field.

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Foreword

Leeds is a great city to live and work in. Over 750,000 people live here within fantastic and diverse communities and Leeds is home to 25,000 businesses. The city is ambitious and we want to be the best city in the UK for health and wellbeing.

In order to be the best city for health and wellbeing we need to address inequalities, so that more people live in thriving communities, achieve a good level of education and have decent jobs. The social and economic conditions in which we live are the biggest factors which influence how long, happy and healthy our lives are. 164,000 people in Leeds live in areas ranked amongst the top 10 per cent most deprived areas in the country and these areas of the city are more likely to have a population with poorer health compared to wealthier areas of the city. There is a 10 year difference in life expectancy between Hunslet and Harewood. We need to ensure that difference is addressed; our city's shared ambition in the Leeds Health and Wellbeing Strategy sets out to do just that.

To be the best city for health and wellbeing, person-centred services which are integrated around individual needs are also really important. Everyone is different, and our health is affected by our ethnicity, our gender, our sexuality, our relationships and our character. The way that services are designed and how we are treated needs to reflect these differences, so this means putting individuals at the centre.

Men and women's health are different. I look forward to the spotlight being thrown onto the differences in experience and outcomes for women in a future study. Lots of men in Leeds experience challenges to good health and have poorer health outcomes than they should. This report, produced as a result of collaboration between researchers and health and care professionals, brings to our attention the inequalities that thousands of men experience and how services should be sensitive to each individual's differences.

I welcome this report, because in Leeds men's health matters and men's health can be better.

Cllr Lisa Mulherin, Executive Member for Children and Families at Leeds City Council and member of the Leeds Health and Wellbeing Board

Understanding men and their health

There are about 368,000 males who live in Leeds. As a general rule, they are more likely to live unhealthy lives and die younger than females.

Biology does have different effects on the health of men and women. However, socio-economic conditions and cultural factors have a major impact on the most common health risks to men and what can be done about them. We need to understand these risk factors and health outcomes in order to know how to improve men's health in Leeds.

The status and place of men in society and their families is important. There can be a historic expectation on men to be the breadwinners, providing sufficiency and security for families. Unemployment, fragile relationships and poverty can all have a negative effect on the physical and mental wellbeing of men. Poor physical or emotional health can threaten some men's identity and they may feel such 'weakness' will make others see them as being 'less of a man'.

The freedom boys have to develop language about emotions, feelings and relationships is often more restricted than for girls, and can affect how they manage emotional and mental health problems throughout their lives.

Health and social care services need to recognise how risk factors, masculine identities and social relationships all affect how services are accessed and used by men.

Across nearly all causes of death, men in Leeds are more likely than women to die at a younger age. The majority of men's health problems are preventable and are related to their lifestyle or their social conditions.

Men's health matters.

Men's health can be better.

Men in Leeds

- There are approximately 368,000 males in Leeds. The biggest rise in population over the next 20 years is expected in older men.
- Almost four out of ten men aged 50 years or over have a disability that affects their lives in some way on a daily basis.
- The death rate for cardiovascular disease, cancer and respiratory disease is higher for men than women.
- Men are more likely to lead unhealthy lives compared to women, which increases the risk of poor health. Risk factors are generally more common among men living in less affluent areas of Leeds. However, many men living in wealthier areas are overweight, consume excessive alcohol and work long hours.
- There are approximately 2,000 men who are single parents with dependent children.
- Around 6,000 men of working age provide 20 or more hours of unpaid care each week.
- Boys are less likely to achieve a good level of basic education and higher grade GCSEs compared to girls.
- The suicide rate is **five times** higher for men than women.
- Approximately 15 per cent of the male population in Leeds are of non-white ethnicity and the younger population are more ethnically diverse compared to older males. It's important for services to be sensitive towards their specific health and cultural needs.
- **The majority of men's health problems are *preventable* and are related to their lifestyle or the social conditions they live and work in.**

Leeds General Infirmary

Main causes of premature death for men in Leeds

Two of every ten male deaths occur before the age of 65 years, compared to one in ten female deaths.

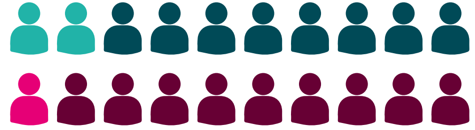


Figure 1 shows us that cancer is the top cause of death for both males and females aged under 75 years, followed by cardiovascular disease. It also shows that the death rate for men is greater than for women across all causes of death.

Figure 1: Common causes of death for males and females in Leeds aged under 75 years

Cancers
Cardiovascular disease
Lung cancer
Respiratory diseases
COPD
Bowel cancer
Prostate cancer
Accidents
Oesophagus cancer
Suicide
Stroke
Stomach cancer
Road traffic accidents
Falls
Skin cancer

0 50 100 150 200

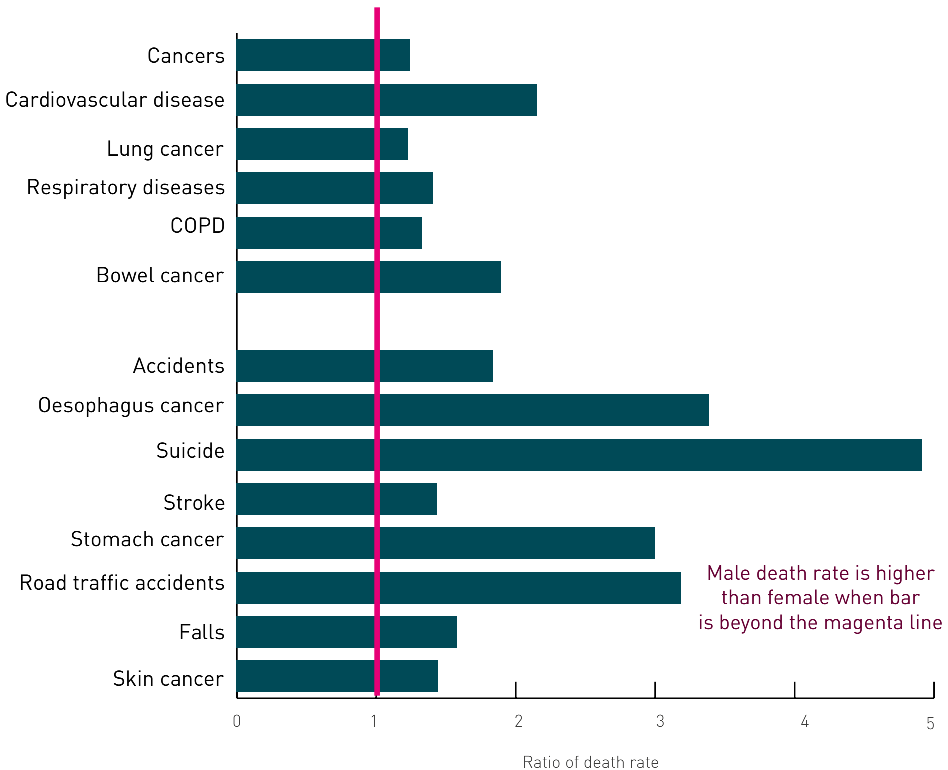
Death rate (per 100,000 of the population)

Male
Female

The average age a man born in Leeds can expect to live to is 78.9. A woman can expect to live to 82.4.

If we compare the death rate of men to that of women across all major causes, we can see that suicide has the greatest impact on men out of all causes of death – the suicide death rate is five times higher for men in Leeds compared to women.

Figure 2: Ratio of male death rates to female death rates in Leeds for those aged under 75



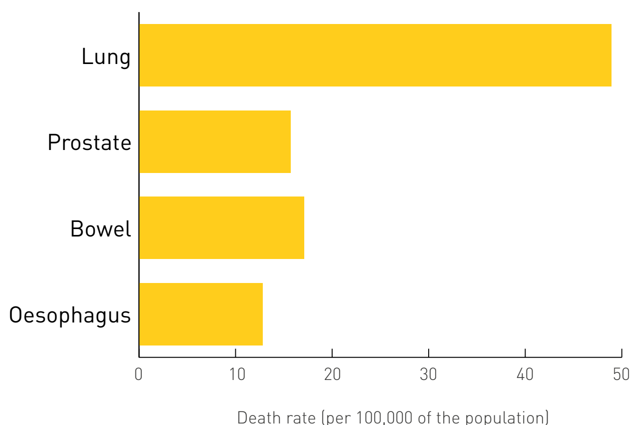
Cancer

For men aged under 75 years old in Leeds, cancer is the leading cause of death and the second highest cause of death for all ages.

A similar proportion of males and females in Leeds are diagnosed with cancer, however men are more likely to die from cancer.

Lung cancer results in the most cancer deaths for men in Leeds (Figure 3). The rate of lung cancer deaths is 40 per cent higher for men than women and 23 per cent higher for men aged under 75 years compared to women.

Figure 3: Male death rates in Leeds for the most common forms of cancer for those aged under 75



The male death rate for bowel cancer is almost double the female rate.

Men's greater cancer risk is largely due to lifestyle factors and health behaviours – men generally have higher smoking rates, alcohol consumption and poorer diets compared to women.

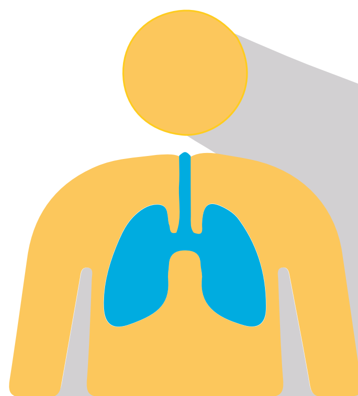
Healthier lifestyles and early detection can reduce the risk from cancer.

It is important men are aware of the symptoms of prostate cancer to ensure early diagnosis and effective treatment. This is particularly important for men from black ethnic groups as they have a higher risk of developing prostate cancer.

Everyone in Leeds between the ages of 60 and 75 receives a free bowel cancer screening test through the post. While 55 per cent of women completed their tests, only 45 per cent of men completed theirs. Of those who completed their tests, 2.4 per cent of men and 1.2 per cent of women tested positive for bowel cancer. This means that men are less likely to be screened for bowel cancer, yet more likely to benefit from it.

Men with a cough for more than three weeks should speak to their GP to discuss whether they need a chest x-ray. Men aged over 50 with a cough for more than three weeks can access a walk-in service to receive a free chest x-ray.

More campaigns should be targeted at men to support their engagement with bowel cancer screening and the early detection of cancer.



CASE STUDY:
BLACK HEALTH INITIATIVE (BHI)

Black Health Initiative's Men's Health MOTs are based within communities in Leeds and encourage men to look at behavioural change. The Health MOTs provide factual information, and health professionals are on hand to take measurements such as blood pressure and blood sugar levels. This information can be taken to GPs and used to encourage the men to access NHS Health Checks.

Blacka was diagnosed with prostate cancer at around the age of 50 and is also living with diabetes and asthma. Through the initiative, Blacka learned about the importance of balanced meals and healthy portion sizes and was given a plate that reflected his cultural foods. Light exercise sessions and social activities were incorporated into the MOT.

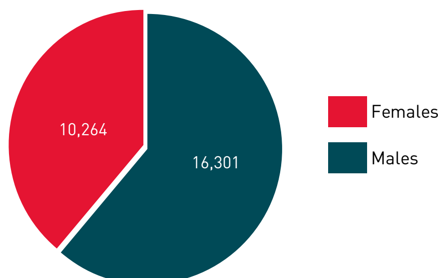
The MOT sessions have helped reduce Blacka's social isolation, while also providing him with much needed information on health that he would not otherwise have accessed, or only accessed at point of crisis.

Cardiovascular disease

Cardiovascular disease (CVD) is the leading cause of death for males and females of all ages, and the second highest cause of death for males and females aged under 75 years.

Men are more likely to develop CVD at a younger age, and die prematurely. For men under 75, the death rates from CVD is double that of women and the death rate for stroke are nearly 45 per cent higher.

Figure 4: Number of males and females (aged 25 or older) in Leeds registered as having coronary heart disease

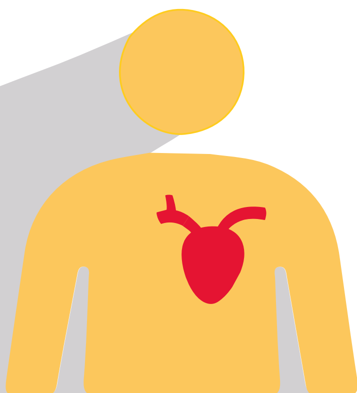


The total number of men in Leeds known to be living with coronary heart disease is 59 per cent higher compared to women (Figure 4).

Men are more likely to be overweight, smoke and drink harmful levels of alcohol. These all increase the risk of having cardiovascular disease.

Adults aged 40 and over are invited to complete an NHS Health Check with their GP. Men in Leeds are targeted as a priority but women are more likely to attend.

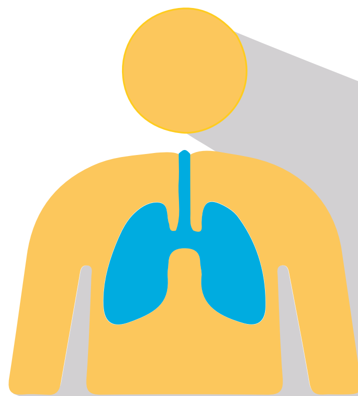
Men in Leeds are typically more likely than women to be diagnosed with a health condition (such as high blood pressure or diabetes) through these Health Checks.



Encouraging and supporting men to engage with NHS Health Checks is important for the early detection of disease and effective treatment.

Respiratory disease

Respiratory diseases are a collection of diseases which affect breathing, such as lung disease and asthma. In Leeds, the death rate for respiratory disease (excluding pneumonia and influenza) is 41 per cent higher for men aged under 75 years compared to women.



In at least 10 areas in Leeds, the death rate from respiratory disease for men aged under 75 is at least 70 per cent higher than the citywide average. These areas are commonly among the most deprived in Leeds.

The incidence of chronic obstructive pulmonary disorder (COPD) is similar for males and females in Leeds, but death rates from COPD across Leeds are 33 per cent higher for men aged under 75 compared to women.

Men's increased risk of dying from respiratory disease is mainly a result of historically higher rates of smoking or working in hazardous environments.

Nationally, the number of men smoking is steadily falling, and with the decrease in heavy manufacturing and mining, and increase in the use of protective equipment in the workplace, there should be a reduction in the chronic lung conditions.

CASE STUDY:
LEEDS MEN'S HEALTH AND WELLBEING NETWORK

When it started in 1998, the Leeds Men's Health and Wellbeing Network was one of the first of its kind in England. As well as supporting existing service users, the network started reaching out to men in the wider community and developed into a lobbying and campaigning organisation on behalf of men.

In recent years, the network has focused on Men's Health Week in June each year. This has included targeting men in areas where men's health is the poorest. The network has continued to grow and in 2014 they produced a strategic plan, an action plan and an information leaflet.

The network has been a strong advocate for men's health in Leeds and has engaged in lobbying the council whenever possible to get perspectives of men's health considered across the city.

Suicide

In Leeds, the suicide rate is five times greater for men than it is for women.

Suicide rates in the UK have been increasing and this is replicated in Leeds.

Many women also attempt suicide. However, less die as a result as they tend to use less violent means than men.

However, men are generally less likely than women to speak to someone about suicidal thoughts. Many of the men in Leeds who died from suicide had not previously contacted local health and social care services and were therefore not known to be at risk.

Employment problems, social isolation, relationship breakdown, loss of contact with children, bullying, long term health problems and poor socio-economic status are all common contributors to suicide.

Suicide has a huge long-term impact on the lives of friends and family.

The Leeds Crisis Card provides contact details for organisations in Leeds that can offer help and advice to anyone dealing with a crisis, including experiencing suicidal thoughts, abuse or struggling with debt.

CASE STUDY:
MEN IN SHEDS

Men in Sheds brings men from a variety of backgrounds together and delivers a range of practical activities to build their confidence, skills, encourage social activity and improve their health. The men share ideas and skills built up over a lifetime, proving that you are never too old to learn.

Men come together and use a well-equipped workshop to make a range of products which can be sold or used to help members of their community. The Shed is more than just a building, as it allows a network of relationships to form between the members. These networks and relationships are important for good mental health and wellbeing.

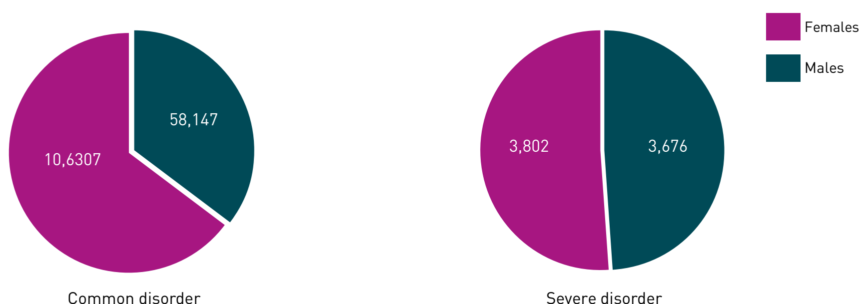
Mental health and wellbeing

Are mental health issues in men in Leeds being identified?

Women are much more likely than men to be registered as having a common mental health problem such as anxiety or depression.

However, the number of men and women with a severe mental health illness such as schizophrenia or bipolar are similar (Figure 5).

Figure 5: Number of adults in Leeds registered as having a common or severe mental health disorder



Men take up more psychiatric hospital beds due to mental health issues. However, women are greater users of counselling services and have higher rates of referral to mental health services. Consuming high levels of alcohol, drug taking, aggression, offending and self-harm are often indicators of poor emotional wellbeing in men.This suggests that more men may be struggling with their mental health than we know of.

Wellbeing interventions and mental health services should encourage the recognition of mental health issues in men, reduce stigma around accessing help and improve the information available to men.

Domestic violence

Domestic violence is 'the abuse of power and control over one person by another, which can take many different forms, including physical, sexual, emotional, verbal and financial abuse'.[1]

Men are more often the perpetrators of domestic violence, however it is important to recognise that men can also be victims of domestic violence, and often find this hard to report. Awareness of local support available to people and understanding the challenges and key issues people face is important.

Preventing the causes of domestic violence should be a key aim. When violent men are removed from homes without any form of remedial support, problems are more likely to be replicated. Sometimes men need guidance and support as they may have been victims of abuse themselves.

Accidents

For men aged under 75 in Leeds, the death rate due to accidents is more than 80 per cent higher than it is for women.

Men are more likely to be in occupations that put them at risk and are more likely to complete home DIY.

Men are also more likely to drive - for men aged under 75 in Leeds, the death rate due to road traffic accidents is three times higher than for females.

It is positive to see that deaths from accidents are generally falling within the UK due to stringent health and safety legislation at work, road safety measures, and a more risk-aware society.

Working with men as victims and as perpetrators can help break the cycle of misery caused for all concerned. Programmes need to take into consideration the co-occurrence with other health problems, such as alcohol dependence and mental health problems.

[1] From Leeds City Council's Scrutiny Report, Tackling Domestic Violence and Abuse (2014)

Lifestyles

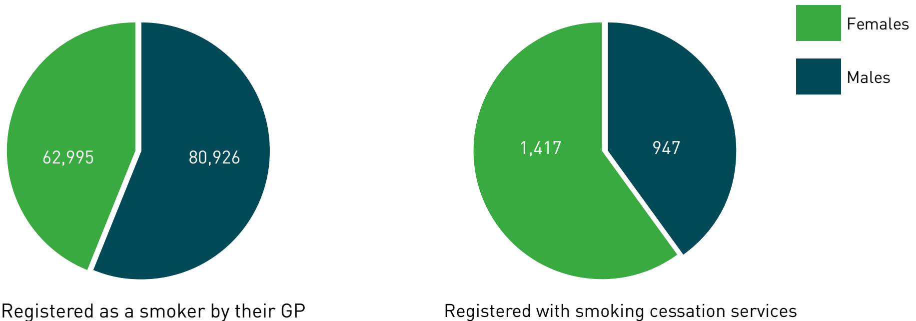
Men in Leeds are generally more likely to live unhealthy lives than women.

Despite this, men are less likely to use healthy living services than women, even though they are more likely to have a positive outcome as a result of using these services.

Smoking

Men are more likely to smoke than women.

Figure 6: Number of smokers versus number of smoking cessation service users across Leeds



Women are more likely to use smoking cessation services, however men using smoking cessation services are more likely than women to quit and quit successfully on their first attempt.

Targeting more men to use smoking cessation services could have significant benefits.

Alcohol

In Leeds, the male rate of death due to alcoholism, alcohol poisoning and liver disease is 25 per cent higher than men nationally. In Leeds, the number of men recorded as consuming a level of alcohol which increases the risk of harm to their health was double that of women.

In 2013 the male hospital admission rates in Leeds due to alcohol were more than double those for females.

Of those undergoing alcohol treatment, 63 per cent were men.

Weight and Physical Activity

Almost half of the males in Leeds with weight recorded by their GP are above what is considered a normal weight.

Around 30 per cent of males (aged 16-74) asked by their GP in Leeds were classed as 'inactive'. Being inactive can lead to becoming overweight.

In 14 localities in the city, over 40 per cent of male residents assessed were inactive.

Only 28 per cent of registered weight management service users in Leeds are male, however men are more likely to lose weight through the support of weight management services than women.

Fewer men are working in manual jobs with high levels of physical activity than previously, while more men are working in professional or service jobs with high levels of sitting down.

GPs are less likely to know the weight, smoking status and physical activity level of male patients compared to female patients.

The Leeds Let's Get Active scheme offers men in Leeds the opportunity to participate in free activities such as health walks, walking football, male-only swimming sessions and cycle training, and it also provides free access to council leisure centres during off-peak times.

CASE STUDY:
NEW WORTLEY COMMUNITY CENTRE

New Wortley Community Centre provides services, activities and support to the people of New Wortley. Simon (aged 47) lives on his own in one of the tower blocks and is a long term resident of New Wortley. Despite regular job searches and training courses, he has been unemployed since 2002. Simon has difficulty reading and writing and feels this is the main reason preventing him finding work.

He has been involved with activity groups at New Wortley Community Centre for the past 18 months and feels that this has been very beneficial.

He said: *"It gets me out of the house doing useful stuff and keeps me fit and active. It feels good to be part of a team, meeting new people and learning skills like landscape gardening. I think the groups have given more confidence to people. The centre gives me a reason to get up in the morning. It makes me feel happier about myself and keeps me from being depressed."*

Education, housing and employment

Men in less affluent areas of the city have significantly worse health than those living in more wealthy areas. The majority of this health inequality can be attributed to the quality of their education, employment and living conditions.

Education

Throughout the school years in Leeds, boys fare worse than girls when it comes to educational attainment.

In some poorer areas of Leeds, seven out of 10 boys are not achieving five or more GCSEs (including English and maths) at grades A to C. This may impact on their ability to obtain good jobs.*

The educational attainment of boys in care is generally similar to, or worse than, boys in the lowest achieving areas of Leeds.

In 2011, 15 per cent of men in Leeds had no qualifications and, in nine local areas, more than 30 per cent of men had no qualifications.

CASE STUDY: SPACE2

Space2 promotes arts-based health and wellbeing programmes within Leeds' most challenged neighbourhoods. Lewis, 17, had severe learning difficulties, was very quiet, lacked confidence and hated travelling by public transport. He felt isolated and was without the level of independence he might have liked.

In 2011, Lewis joined Space2's East Arts Fest project, making films in Seacroft. He loved the film-making process and learned a huge amount of skills, gaining a Bronze Arts Award. He also enjoyed meeting new people and said: *"That was the first time I have ever got up and spoken alone in front of a group of people – I can't believe I just did that!"*

Last summer, he joined a young people's film and cookery course at Space2. Lewis says he is significantly more confident and would recommend the projects to others. He is now very independent and uses public transport, cooks at home, volunteers at a charity shop and attends college, where he has also started cooking.

Mum Stephanie said: *"He is more determined than ever to be treated as an adult and independently. Space2 has definitely contributed to his development."*

Employment

Work brings money in, but it also has a fundamental influence on social status, social roles and self-esteem.

In Leeds, those who are unemployed and seeking work are most likely to be male.

This gender gap for being out of work is greater; in Leeds than the national average. Nationally there are a third more men than women who are workless for more than two years; in Leeds this rises to 60 per cent.

Of those in work, 10 per cent of men work at least 49 hours per week, which can impact on family relationships and social lives.

Housing and Living Arrangements

Having access to good quality, affordable housing which enables people to be socially connected is an important determinant of good health.

Almost one in five men live alone.

Nearly two thirds of residents in the city's council-owned high-rise flats are male. This type of housing can be linked to high levels of depression and social isolation. Male residents of these flats are typically aged between 31 and 60.

Men are more likely than women to become homeless.

CASE STUDY:
YORK STREET HEALTH PRACTICE - TONY'S STORY

Tony was a homeless man in his mid-40s, shy, with low self-esteem and a history of drug abuse. He left home following a family argument and later ended up in hospital due to increasing health issues and in a wheelchair as a result of an accident. A care navigator from the Homeless Accommodation Leeds Pathway project based at York Street Health Practice visited Tony in hospital to assess his social, housing and benefit needs.

By working together in a holistic way, focusing on collaborative intervention and cross-sector planning, Tony's self-esteem and confidence improved and he said *"this is my chance to change things"*.

So what should we do about it? Recommendations for the City of Leeds
1. Build on assets - use the roles men play in Leeds life

Men as Learners

Boys need to catch up in schools, and this is particularly important in deprived areas. Education needs to focus on how we can create the best possible environment for boys to learn, behave and socialise. Education is for life, and innovative and engaging ways need to be found to encourage more adult males to keep gaining qualifications. This is particularly important for those who leave school without any qualifications, as this can account for a significant part of health inequalities.

Men as Workers

Men spend a large amount of their time at work and, for many, employment shapes much of their personal identity. Employers should engage with their workforce to reduce stress and work-related burden. Flexible working, benefits and leave entitlements can help men to invest time in the contribution they make outside of their working lives. But not all men are in work. Unemployment hits men hard, with detrimental effects on their physical and emotional health. Support for men being made redundant or suffering the effects of the recession should be recognised as an important health priority.

Men as Fathers

We should focus on the role of men as father figures and improve the support they receive. There should be more support for men during pregnancy, longer paternity leave, improved services for fathers and toddlers, assistance for lone fathers, help to maintain contact with children when separation occurs, recognition of the important role which grandfathers play, and many more.

Men as Friends

There is a large number of men in Leeds who are socially isolated, which has a significant detrimental effect on their health and wellbeing. They need to increase their social networks and improve the quality of their relationships. We can address the risk of social isolation through active support for vulnerable men of all ages using assets which exist in communities in Leeds. Good examples include Men in Sheds, gardening initiatives, walking groups, father groups and male carer networks, among many others. The city should continue to establish similar initiatives.

CASE STUDY:
LEEDS DADS

Leeds Dads is a support organisation that aims to promote the wellbeing of children in Leeds by keeping a diverse community of dads actively engaged in the parenting of their children. It supports dads to connect with their children and build strong and lasting relationships to aid their physical, mental and emotional health. It allows dads to share the ‘dad experience’ and it offers expert and experienced parental advice and support.

Dads come together for social interaction and support through a range of meet-ups and low cost or free activities, such as outings to museums and playgrounds, dads’ nights out and special events at Easter and Christmas.

“Most rewarding is seeing the kids grow together as friends, which is marvellous. And in the same way, many of the dads have bonded and friendships have flourished”.

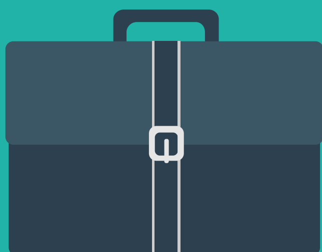
2. Tackle the big issues - priorities for health improvement

SMOKING AND ALCOHOL

There should be continued efforts to address smoking and alcohol behaviour, coupled with a rethink on a male gendered approach to tackling smoking and alcohol consumption in the areas of highest prevalence. Smoking cessation and drug and alcohol services should be linked to and integrated with other health services. This would help to maximise uptake and combat the clustering effect of lifestyle risk.

PHYSICAL ACTIVITY AND DIET

Men who move more are happier, smarter, more socially connected, fitter and healthier. This must be combined with corresponding improvements in diet to make a real difference to the upsurge in obesity levels. Men should discuss their weight and physical activity more with their GP.



EMPLOYMENT

Continued efforts across the city are required for sustainable economic growth which creates more jobs and better jobs for men in Leeds. More support is needed for those hit by unemployment or the effects of the recession.

MENTAL HEALTH

Greater attention should be placed on helping men with mental and emotional health problems. There could be targeted mental health campaigns for men and training of front-line workers to spot emerging issues for the mental wellbeing of men. More men need to recognise symptoms of poor emotional health and speak openly to their GP, friends and family.

ACCESSING SERVICES

Health services need to reach out and target men more effectively and men need to take the opportunities offered. This is particularly relevant for health checks and screening opportunities, where there could be increased uptake if more consideration was given to the timing, location, marketing and style of these services. Weight management services must become more responsive to men's needs, and be designed to make them male friendly and appealing.

Finally, and very importantly, services need to be integrated. The conditions described in this report are often clustered, with men experiencing at least one of the problems, often linked to a combination of socio-economic conditions. Integrated services would help provide whole-person care and encourage better and more effective use of services.

3. Make incremental changes for big impacts

- In all planning Leeds should consider how services should be developed to better meet the needs of men.
- In all official documents, move to talking about 'men' and 'women' and not 'the population'; 'boys' and 'girls', not 'children'; and 'mothers' and 'fathers', not 'parents', to ensure the impact of policy on gender is considered.
- Schools should continue to focus on how to specifically support boys to improve their achievements in education.
- Investment should be considered a high priority in those areas of Leeds where men's health issues are most pronounced.
- Services in Leeds should develop specific guidelines on how to target men, with greater use of integrated service provision.
- Employers should take more responsibility for the health and wellbeing of their staff, with services which would benefit both male and female workers.
- Community groups that have had success in reaching out and targeting men should be supported and encouraged to give guidance to those groups who are struggling to recruit men.
- A men's health campaign could raise the overall awareness of the issues faced by men in Leeds.
- Partnerships are needed with religious leaders to promote men's health and to establish men's health initiatives within religious settings.

Next steps

It is now important to hear from men themselves as well as service providers, to ensure we have a complete picture of the issues facing men and how they should be addressed. A report on the state of women's health in Leeds could be funded to ensure all services are meeting the needs of both men and women.

Further information

Where can I get support with my health and wellbeing?

The NHS website provides information on:

- Cancer signs and symptoms, treatment options and links to other cancer-related resources **www.nhs.uk/conditions/cancer**
- Cardiovascular disease signs and symptoms, risk factors and links to common types of cardiovascular disease **www.nhs.uk/conditions/cardiovascular-disease**
- The Leeds Crisis Card provides contact details for organisations in Leeds who can offer help and advice to anyone dealing with a crisis such as experiencing suicidal thoughts, problems with housing, debt or abuse. Contact details for local support services can be found online at **www.leeds.gov.uk/docs/CrisisCard.pdf**
- You can also get information from GP surgeries, pharmacies, council 'One Stop' shops and libraries.

Where can I get support for improving my lifestyle?

- The 'One You Leeds' website contains details of healthy lifestyle services in Leeds (including help with stopping smoking, weight management, reducing alcohol consumption and getting physically active) as well as information on self-management. **www.oneyouleeds.org.uk**

Where can I find support for delivering a health and wellbeing service?

- The Public Health Resource Centre (PHRC) offers support to anyone in Leeds with a responsibility or professional interest in public health or promoting health and wellbeing. Resources can be accessed via **www.leeds.gov.uk/phrc**
- The Centre for Men's Health at Leeds Beckett University has extensive research, evaluation and consultancy experience. If you have a specific project you would like to discuss or, for general information about our consultancy services, please contact the University Enterprise office on 0113 81 21904 or Dr Julian Sorrell, Business Development Manager, on 07780 493016. For more information, please visit **www.leedsbeckett.ac.uk/menshealth**
- The national Men's Health Forum provide information, advice and advocacy on the health of men and boys. They have produced a number of 'How To' guides covering weight-loss and mental health services and self-management support. For more information, please visit **www.menshealthforum.org.uk**

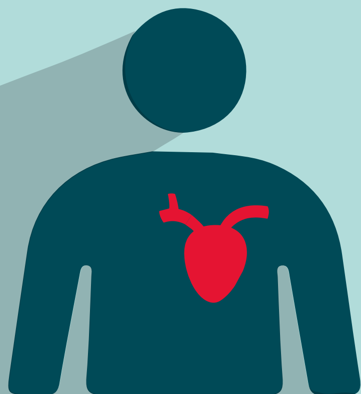
How can I contact the local services listed in this booklet?

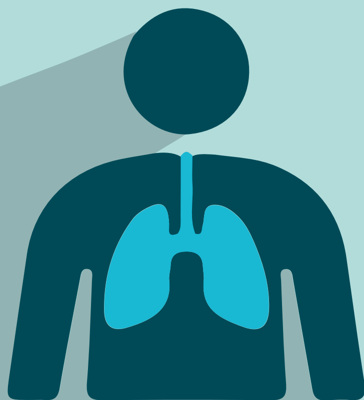
- Black Health Initiative, 231 ChapeltownRoad, Leeds. LS7 3DX **www.blackhealthinitiative.org/** Tel 0113 3070300
- Men in Sheds, Barkston House, Croydon Street, Holbeck, LS11 9RT | **www.groundwork.org.uk/men-in-sheds-leeds** | Will Core,Tel 0113 238 0601
- New Wortley Community Centre, 40 Tong Road, Leeds. LS12 1LZ | **http://newwortleycc.org/** | Tel 01132793466
- Space2, Leeds Media Centre, 21 Savile Mount, Leeds, LS7 3HZ |**www.space2.org.uk/** Tel 0113 320 0159
- Leeds Dads | email **leeds.dads@nct.org.uk**

Where can I find a full copy of the report on men's health in Leeds?

To view this report and the corresponding detailed data report please visit **www.leedsbeckett.ac.uk/stateofmenshealth**

This map represents the Leeds areas that the services mentioned in this report are in.





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Agenda Item 15

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: 28 June 2016

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) fulfil 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 2016/17.

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) fulfil 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 fulfil 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. 2016/17) 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 2016/17, 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 previous Scrutiny Board in June 2015. This is the first opportunity to provide similar, updated information, during the new municipal year (2016/17).

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 2016/17, 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 2016/17.

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

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

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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.

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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.

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[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].

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[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.

[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

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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

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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*